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Flood- and Erosion-led Displacement in Dhemaji and Dhakuwakhana (Lakhimpur): Concerns over Health Entitlements of the People[1]

Before going into the subject "Flood, erosion, displacement and health rights" - let us get an understanding of the Brahmaputra basin on which the life and livelihood of the people of Assam largely depends.

Brahmaputra Basin Outline

"The Brahmaputra is a major international river covering a drainage area of 580,000 sq. km, 50.5 percent of which lie in China, 33.6 percent in India, 8.1 percent in Bangladesh and 7.8 percent in Bhutan. Its basin in India is shared by Arunachal Pradesh (41.88%), Assam (36.33%), Nagaland (5.57%), Meghalaya (6.10%), Sikkim (3.75%) and West Bengal (6.47%).

"The gradient of the Brahmaputra River is as steep as 4.3 to 16.8 m/km in the gorge section upward of Pashighat, but near Guwahati it is as flat as 0.1 m per km. This dramatic reduction in the slope of the Brahmaputra has resulted in unloading of huge sediments in the valley downstream that it accumulates during its passage through the hilly terrain (highly susceptible to erosion). During the total course of its journey, numerous tributaries feed it and it has been found that the north bank tributaries generally flowing in shallow braided channels have steep slopes, carry heavy silt and are flashy in character.

"The geo-physical character of Brahmaputra and its tributaries has resulted in carrying of enormous quantity of sediments from the hills and on reaching the plains deposition of the same on their own beds and on the flood plain. The same has resulted in rise of the river bed, shifting of river course and intensive deposition of sand along the bank-zone affecting the life and livelihood of the people extremely."

According to a study carried out by the UNESCO under its International Hydrological Decade program, the Brahmaputra ranks fourth amongst the rivers of the world for known maximum historic flood discharge.

The Brahmaputra is also one of the major sediment transporting rivers of the world. Its annual sediment load is estimated to be about 397 million tonnes with a flow of 477 billion cubic metres during 1978- 2003, at Pancharatna. This river has the highest sediment yield next only to the Yellow River in China. Its tributaries also carry high sediment load, which is normally more than 1,000 tonnes per square kilometers per year. The high sediment load in the river leads to reduction in the carrying capacity of river and overtopping of banks and inundation of surrounding land, causing floods.

In Assam, floods and erosion cause enormous damages to the crops, livestock, land, property and in turn in the sector of education, health etc. Floods occur in the Brahmaputra valley year after year: the floods of 1954, 1962, 1966, 1972, 1973, 1974, 1977, 1978, 1983, 1984, 1988, 1992, 1998, 2000, 2004 and 2007 were very severe though floods of less magnitude occur almost every year.

The National Flood Commission has estimated the area vulnerable to floods in Assam as 31.60 lakh hectares against 335.16 lakh hectares for the whole of India. Assam thus accounts for 9.4 per cent of total flood prone area of the country. Of this mass area the Dhemaji and Dhakuwakhana Sub-Division of Lakhimpur District constitute a major part.

In 1985, at certain points, the level of river Brahmaputra in Assam was compared to the level that prevailed in 1952. The 1985 levels of the riverbeds were higher by five metres from that of 1952. And in certain areas, the riverbed of Brahmaputra was found to be equal to the ground levels of the area around.

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Recent Damage Due to Floods in Brahmaputra Basin

Table1: Flood Damage in Assam (1953-2002)

Year	Area affected in Lakh Hectare	Population Affected in Lakh	Total Damage (Rs. Crores)
1998	0.972	4.698	700.00
2000	1.000	3.900	244.06
2001	0.200	0.540	11.14
2002	1.960	6.960	210.95
Source: www.sdmassam.nic.in			

Table 2: Flood Damage (2000-2004)

Factor	Unit	2000	2001	2002	2003	2004
1. Area affected	Ha.	966053	239511	674148	932113	3142685
2. Population affected	Nos.	3888385	542634	7550581	5651954	13493392
3. Human lives lost	Nos.	36	4	65	52	497
4. Loss of cattle	Nos.	19988	15	4294	4319	65967
5. No of Villages Affected	Nos.	5090	1277	6807	7565	12235
6. Area eroded	Ha.	NA	5348	429657	12589	7829
7. Value of crops lost	Rs. in lakhs	17351	835	14559	14700	NA
8. Value of houses damaged	Rs. in lakhs	1648	259	4118	1869	NA
9. Total value of damages	Rs.in lakhs	19000	1095	18678	16569	NA
Source: Water Resource Department, Govt of Assam (GOA)						

Assam Flood Damage 2007

An interim government statement estimated that 24 people were drowned in separate incidents and 6.7 million were displaced in the floods in 26 of Assam's 27 districts. "A total of 5,862 villages covering a land area of 870,000 hectares were affected in the floods, besides an estimated 355,000 hectares of cropland damaged." *[Source: www.nerve.in]*

Erosion

Let us have a look at the erosion statistics of Assam. According to Government of Assam, the State during the period 1954 to 2002 has lost 7% of its total geographical sources (refer to Tables 3 and 4). Since 1954, Assam's 17 riverine districts have lost seven per cent of their land area to erosion. An estimated 8000 hectares of land valued at US$ 20 million has been lost annually.

Table 3: Erosion Status in Assam

Sl. No.	*Description*	*Area in ha.*
(1)	Total area eroded due to erosion from 1954 to 1969	120786
(2)	Average rate of erosion	8015/yr
(3)	Total area eroded due to erosion from 1969 to 2002	265690
(4)	Total area eroded due to erosion from 1954 till 2002	386476*
(5)	Avg rate of erosion	7577/yr

**Adding the data on area eroded during the year 2003 & 2004 to the total area eroded during the period 1954-2002 shown in Table 3, the figure will be 406895.32 ha.*

Comments

Due to floods, Assam has suffered a loss of Rs 3,100 crores in the past five decades. Official estimates show that since 1954, various government agencies have completed as many as 631 flood control schemes and constructed about 4,458 km long dykes along the major rivers across the state. In order to protect a total of 31 lakh hectares of vulnerable land, which has been identified by the National Flood Commission, only 16 lakh hectares could be protected from floods in 53 years. Official records say that total loss in the early 80s was about Rs 228 crores. And it has been gradually

Table 4: Significant Erosion Reaches of Assam

Sl.No.	Description	Area in ha.
(1)	Rahmoriah	298
(2)	Nemati(near Jorhat)	328
(3)	Majuli	42000
(4)	Kareng Chapori/ Arne Chapori/ Matmora/Baligaon etc.(Dhemaji)	10000
(5)	Laharighat-Bhurapara-Maisalu (Morigaon District)	15000
(6)	Palasbari-Gumi area (Kamrup) Including old Palasbari township area	10000
(7)	Mukalmua area (Nalbari Districts) 10000 families affected	80000
(8)	Bahari-Baghbar area	8000
(9)	Goalpara area (Chamari- hazirghat) including South Salmari township. 60000 families affected	40000
(10)	Dhuburi patarmari area	2500
Source: Website on Disaster Management by GOA		

increasing with every passing year.

The above facts and figures clearly reflect that whatever policy the Government of India or Government of Assam have adopted to address flood and erosion in Assam have failed miserably and the people of the region have been suffering for decades in several aspects. In this paper we try to focus on one aspect of the resulting human suffering - denied totally by the State policy framework – namely Flood, Erosion-Led Displacement and its Impact on Health of the People.

Background

One can find all the three kinds of Internally Displaced Persons (IDPs) in Assam as well as in whole of the North-East India, i.e.,

1. Conflict-induced IDPs

2. Development-induced IDPs and

3. Natural disaster/environment-induced IDPs (many prefer to call them Environmental Refugees).

Data on IDP is very scanty. Most difficult is to find data on natural disaster-/environment-induced displacement of the population. Next in order of difficulty is to gather data on development-induced displacement. Assam along with the whole of North-East has experienced a massive development-induced displacement of population during the postcolonial period. Compared to these two categories, it is relatively easier to collect data on conflict-induced displacement of population. It is mainly because the media normally does not miss on reporting conflict because it is more or less an important political event.

As mentioned earlier it is difficult to estimate the number of IDPs caused by environmental degradation, i.e. flood, riverbank erosion, landslide, etc., and its implications on health issues. However, some reasonable conclusions can be drawn about the enormity of the problem. As a result of continuous environmental degradation, flood and riverbank erosion in the plains of Assam have become endemic. This has caused considerable death, destruction and population displacement. The intensity of flood, riverbank erosion and landslide has increased substantially over the years in terms of area and numbers of affected. The plight of the riverbank erosion-induced IDPs are much more severe than that of the victims of flood. The victims of floods at least can go back to their original land once the floodwater recedes. However, the riverbank erosion-induced IDPs cannot go back to their land. Because, the land does not exist: their land has become part of the river's new/extended bed. It is not only the mighty river Brahmaputra but also the innumerable small and medium-sized rivers that also cause havoc in the plains of Assam, i.e., in the Brahmaputra Valley and in the Barak Valley.

According to an official report, the river Brahmaputra eroded 429,657 hectares of prime agricultural land. Roughly, 7% of the land in the plains has been eroded between 1951-2000. Let us compare the erosion and displacement phenomenon from a different perspective. Taking into account the erosion in Assam where approximately 4300 sq. km geographical area has been lost to erosion and taking the per sq. km. population displaced as 186 (half of the population density of Assam), the figure comes to 799, 800. This works out to about 15,000 every year for the last 50 years. Today this lot of population constitutes the most pauperized community in Assam's plains. In the absence of proper resettlement and rehabilitation policy, most of them have experienced multiple displacements.

The routine questions that come to mind immediately are: Where are these people now? Where have they migrated? Have they migrated to urban areas in search of livelihood? Have they resettled in the forestland? If they have shifted to the forestland, then tomorrow will they be evicted from the forestlands blaming them as 'encroachers'? How would accessibility to effective health services of the people be ensured even as the whole nation is taking pride in the launching of NRHM 2005-12? Will the right to health of children, adolescent girls, and pregnant and lactating mothers be ensured when the whole nation is boasting on implementing ICDS and Mid-Day Meals?

Let us carry ahead the discussion in the light of Government's policy frameworks.

State Policy Framework and Flood Erosion of Affected/ Displaced People

1. National Rehabilitation and Resettlement Bill 2007

According to the Statement of Objects and Reasons of the Rehabilitation and Resettlement Bill, 2007, it will be primarily applicable to the rehabilitation and resettlement of persons adversely affected by the acquisition of lands for projects. However, involuntary displacement of people may be caused by other factors also, and the provisions of the Bill may apply to the rehabilitation and resettlement of persons involuntarily displaced permanently due to any other reason. The Preamble to the Bill reads: "A

Rivers of Dhemaji and Dhakuakhana

Introduction

Situated on the North Bank of the River Brahmaputra, the Dhemaji district and Dhakuakhana Civil Sub-division is bounded by the Brahmaputra River in the South and Subansiri River in the West. In addition, a number of tributaries from the North join the Brahmaputra in this region one after the other. This region covers one of the heaviest rainfall areas in Assam due to which these areas experience regular annual floods, especially after the Great Earthquake of 1950, which left the entire riverine system of the area severely disturbed. During the months of May to September with the onset of South East monsoon rains, huge volumes of floodwater starts spilling all along the 720 Km. length of embankments of the River Brahmaputra in Assam, out of which 132 Km. are within the jurisdiction of Dhemaji E & D Division. The intensity of floods can well be imagined during the months when the waters of the Brahmaputra synchronize with that of the other tributaries.

Both naming and describing the course of rivers in these areas are greatly difficult tasks. Many reasons can be assigned for this inconvenience:

- Frequent and rapid change of river courses
- Comparatively recent settlement areas
- Lack of knowledge on regional geography among local people
- Repetition and renaming of rivers
- Lack of hierarchical order of naming
- Lack of written historical reviews
- Difficulties in phonetical assimilation
- Mingling of varied linguistic groups
- Very complicated and inhospitable riverine areas
- Absence or lack of toposheets of required detail

Names of some major rivers and tributaries of the region

1. Brahmaputra 2. Silley 3. Sibia 4. Leko 5. Jonai Korong 6. Dikhari 7. Narod 8. Somkhong 9. Tongani 10. Burisuti 11. Simen 12. Dimow 13. Gainadi 14. Moridhal 15. Jiadhal/Kumotia 16. Korha/Sila 17. Charikaria 18. Nonoi 19. Sampara Suti 20. Subansiri 21. Other small tribulets

[Ref: Dhemaji E & D Report May – 2001]

Source: <http://dhemaji.nic.in/flood/rivers.htm>

The Dhemaji District exhibits many paleochannels, ditches, swampy land, waterlogged area, rivers, natural levees, waste land, etc. and their distribution itself speaks about the devastation and extent of the flood problem. The shifting of channels is so abrupt and uncertain that the whole district can be said to be the flood plain area of some river. So, it is almost unscientific and risky to demarcate as well as classify the land use pattern to be suitable either for cultivation or for human settlement.

Some Important Rivers of the Region

The Brahmaputra

The Brahmaputra originates at a place 30°31'N (31°30; Assm. Dist. Gaz. Lakhimpur, 1976) latitude and 80°80'E (82° E; Assm. Dist. Gaz. Lakhimpur, 1976) longitude, near the upper waters of the Indus and Sutlej, and a little to the east of the Mansarovar Lake in Tibet between the Kailash range and the Himalayan range lying at an altitude of 5150m. Then it travels along a trough north of the Himalayas running parallel to the main Himalayan range before it comes out from a glacier called *Chema Yangdung*. In the source region the river is known as *Matsang Tsangpo* or *Tamchok Khambab*. Further downstream, it is known as *Tsangpo* (means purifier). After flowing about 1700 km in Tibet, the river enters into Arunachal Pradesh near Korba; sweeping towards south around the Easternmost Himalayan Ranges at a few kilometers east of Namcha-Barwa by the name of *Siang* in Arunachal through deep gorges, rapids and cascades. The bending is well marked near the longitude 94° E near *Pemkoi Sung*, ten miles below *Gyala Singdon*. In this mountainous part, two left-bank tributaries - the *Yange Chang Chu* and *Yomme* - and one right-bank tributary, the *Siyom*, joins the Brahmaputra. It flows about 200 km in the region and appears in the plains near Pasighat taking the name of *Dihang*. The *Dihang* then follows a braided pattern for about 35-km before it meets the *Dibang* from the North and the *Lohit* from the East near Kobo. From this tri-junction, the river assumes a gigantic size and takes the name of the Brahmaputra. The river then flows towards the Southeast and then due west again in a braided pattern. It is so broad in these parts that its breadth from one bank to another is sometimes 10 km wide. About 120 km downstream from its tri-junction with the *Dibang* and the *Lohit*, just below the

confluence of *Burhi-Dihing*, the Brahmaputra bifurcates giving out a fairly large branch in the Right Bank. This branch is known as the *Kherkutia* upto the confluence of the *Subansiri* and then as the *Lohit*. This branch receives several large tributaries in Lakhimpur and reunites with the Brahmaputra at Luitmukh about 100 km downstream. In between this branch and the Brahmaputra, there lies the famous Majuli island. It is believed that a few hundred years ago, the Brahmaputra flowed along the *Kherkutia-Luit* channel and the *Burhi-Dihing* used to flow along the present course of the Brahmaputra. But due to Southward shift, the Brahmaputra met with *Burhi-Dihing* and the bulk of the former's water began to flow along what was the lower course of the then *Burhi-Dihing*.

Tributaries: The Brahmaputra receives many tributaries throughout its length. The important right bank tributaries are the Jiadhal-Kumatiya system, the Subansiri–Ranganadi–Dikrong–Buroi–Borgang –Ghiladhari–Jiabharali–Gabharu–Belsiri-Jiadhansiri System, Pagladiya–Mora pagladiya–Tihu–Pohumara–Beki–Chaulkhowa–Moramanas–Manas-Ai system, Champawati–Saralbhanga–Gaurang-Tarang system, and Gadadhar–Gangadhar-Sonkosh system. Of the left bank system, the important ones are the Dibru-Doomdooma-Dhola system, Sessa-Burhidihing system, Disang-Dimow system, Dikhow-Janji-Teok-Bhogdoi-Kakodoonga system, Dhansiri-Dipholu-Kollong-Kopili-Digaru system, Kulsi-Dudhnoi-Krishnai system and Jingiram-Ghagra-Dilani system. The tributaries of the Brahmaputra for most of their length drain the steep slope of the Himalayas to the south where rainfall is heavy. Consequently they not only carry heavy runoff, particularly where slopes are denuded of forest, but also very large volume of detritus, the result of excessive soil erosion, to risen the land surface in the plains by bank spill. The major portion of the heavily silt laden floodwaters carried to the Brahmaputra not only aggravates its flood congestion, but also adds to the silt charge of the river.

Drainage basin: The Brahmaputra drainage system covers an area of 1.75 Lakh km^2 out of the total area of 2.25 Lakh km^2 of the whole region. It covers the whole of Arunachal Pradesh, the northern part of Meghalaya and the northwestern part of Nagaland. Most of its 1.75 Lakh km^2 area receives an average annual rainfall of 200 cm. The maximum discharge of the river at Dhubri is 0.7 million cusec.

Channel bars: The mass of silt brought down from the Himalayas is sufficient to form sandbanks and even islands in the lower parts of the valley, wherever it is blocked by any impediment in the river. Thus the characteristics of the main channel alters and gives rise to an intricate network of waterways. Broad streams diverse from the main river and rejoins it after a long separate existence of uncontrollable meanders.

Cross-section: The dry season channel varies in width from 500 feet to a few thousand feet. Large stretches of sand *chars* extend for several miles at many places, until a bank sufficiently high is formed to limit the width of the channel during the flood season, but not enough to prevent inundation during floods. In the vicinity of Guwahati and Goalpara the width of river is about 35000 ft. flowing between more or less permanent banks with greatest depths varying from about 50-60 ft. during dry season to 130-150 ft. during rainy seasons.

Floods: Though the tributaries, sub-tributaries, streams & nalas have great contribution to the overall flood situation in Dhemaji district, the damage caused by the Brahmaputra is the greatest. The Brahmaputra behaves as a braided channel near Dhemaji and further down stream. The alluvial deposits within the main channel lead to sideward migration of the banks. Therefore, besides the flood problem of the Brahmaputra, intensive bank erosion is another problem. The primary cause of erosion has been established to be the instability of the river, caused by the high volume of silt charge, much beyond its carrying capacity. Between Kobo and Dhubri, the south bank of the valley has undergone erosion over a length of 355 km. and the north bank over a length of 230 km during the period 1923-1954.

Historical facts: During the regime of King Kamleswar Singha (1709), a total placer gold deposit of 1,80,000 tolas was extracted from placer deposits. The gold flakes collected from Subansiri river sand was comparatively larger (max^{m}. length 0.5" and breadth 0 .01").

River	Gold (%)	Silver (%)	Alkali metal (%)
Brahmaputra	88.281	–	–
Subansiri	93.880	9.240	0.91

Bill to provide for the rehabilitation and resettlement of persons affected by the acquisition of land for projects of public purpose or involuntary displacement due to any other reason, and for matters connected therewith or incidental thereto."

Though the reference to displacement owing to factors other than acquisition of lands for projects in the above Bill is wide, it is general, vague and non-specific. It does not explicitly cover different categories of displaced persons; in particular, it does not cover conflict-induced displacement or disaster-induced displacement. Thus the protective cover of this significant legislation is limited by the vague reference to "involuntary displacement due to any other reason."

2. The Government of India's disaster response policy, largely centered on the Disaster Management Act 2005, has nothing on the Rehabilitation and Resettlement (R&R) of the flood- and erosion-displaced populations and also nothing on ensuring right to health of such people.

2.1 The revised items and norms of assistance from the Calamity Relief Fund (CRF) and the National Calamity Contingency Fund issued by the Disaster Management Division of the Ministry of Home Affairs, Government of India, has nothing holistic about R&R of the flood- and erosion-displaced populations. The revised document only speaks about providing gratuitous relief of Rs 15,000 per hectare to the small and marginal farmers who have lost substantial portions of land due to landslide, avalanche, and change of course of rivers. The assistance will be provided only to those whose ownership of the land lost is 'legitimate' as per the revenue records. It is well known that a maximum number of families inhabiting the riverine villages of Assam do not possess legitimate documents (or land records) and thus their right to R&R gets ignored and in turn their right to health, education, etc.

3. The much-heralded Assam Relief Manual 1976 states nothing about R&R of the flood- and erosion-affected population. The only provision in the Assam Relief Manual 1976 that addresses rehabilitation of the natural calamity-affected population is that of "rehabilitation loan to the people of Assam affected by flood erosion, cyclone, fire, earthquake and other natural calamity." The rehabilitation loan which was made official on 3rd September 1957 is very complex in nature, speaks about extending loan to the extent of Rs 1000 at Deputy Commissioner's level and Rs 500 at the Sub-Divisional Officer level per case – which any way is far below the minimum required standard as of today. Nothing is mentioned about ensuring health services for this lot of population.

Conclusion

The numbers of flood- and erosion-induced IDPs are increasing alarmingly throughout Assam. With no mechanism on the part of the State to rehabilitate and resettle them, a huge chunk of population throughout Assam has been already pauperized. This lot of population who possessed agro-based livelihood has lost their land either totally or a part of the same, which in turn has affected their livelihood.

Displacement and its Impact on the Health of the People of Dhemaji District and Dhakuakhana Sub-Division of Lakhimpur District

Assam ranks 14th amongst the 15 low-performing States in descending order in terms of Human Development Index (HDI) where as Dhemaji District ranks 20th among the 23 Districts when placed in descending order. While the HDI value derived for the State of Assam as a whole is 0.407, the HDI value of Dhemaji District is 0.277. For health, the index for the whole of Assam is 0.343 whereas for Dhemaji District it is 0.186. Rural-urban disparities are high in several of the indicators. Life expectancy at birth is 54.1 in rural areas as compared to 63.3 in urban areas. About 52 percent of children are underweight in rural areas as compared to 37 percent in urban areas. These disparities are a matter of concern especially if we consider the fact that the level of urbanization in Assam is quite low. Around 10 per cent of the population lives in urban areas in Assam, where the figure is 1.85% for Dhemaji District. The corresponding figure at the all-India level is 30 percent.

Apart from the above stated facts and figures, working experience of our group, RVC, in the flood plains of Dhemaji shows the prevalence of high morbidity and mortality due to water-borne and vector-borne diseases. A pilot study was conducted by RVC in 26 riverine villages of Dhemaji District in 2003 with support from Karpunpuli Gaon Bikash Kini Kebang (a community-based organization) on the prevalence of water-borne and vector-borne diseases in the flood- and erosion-led displaced riverine villages during the pre-flood period (month of February 2003 and March 2003). In

the study, 3422 morbidity cases (Jaundice/Diarrhea/ Viral Fever/Severe Cough/Skin disease) have been recorded and of which more than 80% were children (0 to 14 years). Moreover 28 cases of mortality were reported from 11 villages, out of which 18 were children. Considering the gravity of the situation, the findings were shared with the Office of the Joint Director Health Services, Dhemaji District and Office of the Deputy Commissioner, Dhemaji District by the Kebang.

The poor health indicators in the District Dhemaji is largely due to not receiving State-sponsored health services by the community because of dilapidated surface communication system out of flood, damage of infrastructure, lack of resources, both of infrastructure and of skilled health personnel, and above all constant displacement of the riverine people and resettlement activities carried out by them. During a recent survey undertaken by RVC as Mother NGO for District Dhemaji with support from four Field NGOs, it was found that continuous displacement of the flood-affected people altogether deprives people from availing local services from the State Health service mechanism. During the survey in Jonai Development Block of Dhemaji District, it was found that scattered population (resettling themselves in small hamlets on their own initiative after being affected by flood or bank line erosion) is one of the main reasons affecting the health of the people, because this lot of population cannot avail health services provided by the State Department. For instance, take the following villages: (1) Rabha Kathoni (12 families), (2) Santipur (09 families), (3) Berachapori (21 villages). All these villages coming under Bahirchilai Sub-Centre (Jonai PHC) are resettled villages during the period 2000-2007. This lot of the population is excluded at the time of immunization drive. They cannot even avail services under the NRHM supported institutional delivery mechanism.

Recently a survey/FGD was conducted in two panchayats (namely Matmora and Kherkattta) of Dhakuakhana Sub-Division on the impact of flood- and erosion-induced displacement on health. The villages included in the survey were: Matmora, Baghchuk, Juria, Ujoni Akoria, Maj Akoria, Namoni Akoria, No. 1 Pithiyal, No.2 Pithiyal and Khamun Birina of Matmora Panchayat as well as Ujoni Janjhi, Namoni Janjhi, Jamuguri Kherkattta, Alimur Modarguri under Kherkattta Panchayat. The survey focused on both primary and secondary data. During the discussion of primary data, it was found that the people who have been displaced and living on the embankment are largely deprived of effective health services and have been suffering from cough, skin-diseases, etc. Women folk were suffering from white-discharge. Not availing services due to rapid displacement and constant preoccupation with resettling are the main reasons affecting the health of the people. Malnutrition is a major concern among children and pregnant and lactating mothers. During the discussion with the PHC in-charge, it became clear that reaching out to the non-reachable (constantly engaged in resettling themselves due to bank-line erosion), is one of the major problems on ensuring health services to the people. During the discussion it was pointed out that under a sub-centre, a population of 3000-5000 is covered during normal times, but due to resettlement, the population under a sub-centre shoots up which in turn puts constraints on the health personnel to ensure effective health services to the displaced communities. Like in any part of Dhemaji District, breached surface communication, and continuous displacement and in turn resettlement initiatives in remote areas (Char areas) are making the people more and more vulnerable to health problems.

The above facts and figures reveal that inadequate health infrastructure, viz., sub-centre, Primary Health Centres (PHC) and hospitals, etc., the quality of service provision, lack of adequate complementary infrastructure such as roads, etc., have made health services effectively inaccessible to people. Moreover, poor living conditions in villages without adequate infrastructure such as electricity, roads and sanitation make it nearly impossible for doctors and other health workers to work in the rural Public Health sector. Above all constant bank-line erosion followed by resettlement initiatives by the people that too in scarcely inhabited location are putting the people in more and more vulnerable situation. After the launching of the National Rural Health Mission 2005-12, the situation has started changing but there still is a long way to go. Containing erosion as well as R&R of the displaced people has to be seen as an important aspect of the right to health of the people affected by flood and erosion.

A holistic approach is immediately needed on the part of the State for proper rehabilitation and resettlement of this lot of IDPs – and with specific initiatives towards providing health entitlements. Initiatives needed to be started through intensive public consultation putting the affected people at the center of consultation.

This document has been published with the objective to initiate the process of public discussion among all in the affected community.

We'll not Give up Even One Inch of Land!

- Dayamani Barla[1]

In the name of development, Jharkhand's resources are being provided to industry and multinational corporations (MNCs) at terrible cost to the environment and to human life. This article briefly surveys the history of development projects in the state, the pains of displacement suffered by the people and their struggle against it. It takes a specific look at the mega projects of Mittal and Jindal and the people's current resolve to stop them.

A storm of dust engulfs the sky,
spreading darkness all around.
Our land – wrested by ancestors from the jaws of snakes and bears
– flies away as dust and the darkness keeps on deepening.

- Ulgulaal song

The Situation of Jharkhand

In the 60 years since India's Independence some eighty lakhs (800,000) of Jharkhandis have been displaced by various projects in the name of development. Among these displaced persons, barely six percent have been rehabilitated. *Where are the rest? What kind of conditions do they live in?*

No political leader or government bureaucrat wants to know about it. Those who owned land until yesterday today wander around to earn a meal with no food in their stomachs, no clothes on their bodies and hardly a shelter to speak of. Without medical care they suffer diseases of poverty and die untimely deaths. Peasants of earlier days, they now toil for a scarce daily wage, or as bonded labourers, their daughters forced into domestic work in big cities. But now displaced persons are beginning to tell about it, asking, *What have we got in the name of development?*

In recent years, with intensification of the neo-liberal capitalist system, various MNCs have stepped up their efforts to occupy the forests and agricultural lands of Jharkhand. Thus, while they capture and violate the natural resources – the water, forests, mountains and rivers – the system converts the fundamental rights of citizens – food, education and health – into market commodities! They declare the traditional agriculture of the people as backward, and under the national agriculture policy they impose foreign cash crops upon the peasants. As farming becomes unstable and loss-making, the peasants are caught in debt traps so that today Jharkhand faces serious food insecurity. At the same time, while just decades back the population was around 60% adivasi (tribal), the 2001 census figure fell to only 26%. Among these people today, about 80% of the women are anemic, 85% of children suffer from malnutrition, and 70% of the youth are unemployed.

Industry

For more than a century Jharkhand's vast mineral wealth has attracted mining interests and infrastructure projects like rail and roadways. Prior to independence the focus was on iron ore, copper, coal mining and the initiation of steel production by the Tatas. Post-independence, a host of 'development projects' – dams, mines, thermal power and steel plants – found their base here. Among them are Lalpania dam, Chandil dam, coal mines of CCL, BCCL and ECL, the uranium mines of UCIL, Bokaro's thermal and steel plants, Ranchi's heavy engineering corporation and a host of other mines and industries. The government of Jharkhand State as of date has signed over 70 MOUs with multinational corporations. Some of the biggest projects are those of Mittal and Jindal. The Mittal Company, in conjunction with the European conglomerate Arcelor, envisions setting up a steel plant of 12 million tonne annual capacity. For this it plans to acquire 10, 000 hectares in several blocks of Khunti and Gumla districts: in Khunti from Torpa (16 villages), Rania (7 villages) and Karra (11 villages) blocks and in Gumla from Kamadara block (11 villages). But time has shown that whenever big projects like these come into an area, innumerable ancillary enterprises spring up. All of them stake a further claim on the land and resources at the tremendous cost of destruction of the landscape and disorganisation in the people's livelihoods and culture.

The Pain of Displacement

On 16-17 September 2006 at Jamshedpur, INSAF (Indian Social Action Forum) held a workshop focusing on the displacement issue. It was attended by 42 participants from Jharkhand's districts of Ranchi, Gumla, Kharsawan and Bokaro. The participants had surveyed not only areas where displacement had occurred but also where displaced people had resettled. They also discussed the history and limitations of the

[1] *Based on two pamphlets in Hindi by Ms. Dayamani Barla entitled* Ham Ek Inch Bhi Jameen Nahi Denge *(We'll Not Give Even an Inch of Land) and* Visthapan Ka Dard *(The Pain of Displacement), this article was compiled by T. Vijayendra (t.vijayendra@gmail.com) and edited by Mira Sadgopal (miradakin@gmail.com). Information about the Koel-Karo movement has been added from the* Enquiry into the Police Firing at Tapkara and Resistance to the Koel-Karo Project *by the Indian People's Tribunal (2002). The compiler and editor are responsible for errors of commission and omission. Interested readers can access the original documents, etc. from Dayamani Barla, Jharkhand INSAF, New Garden Sirom Toli, Club Rd, Ranchi, Jharkhand 834001. Mobile: 9431104386.*

people's movement against displacement. The movement indeed had given voice to the people and had won inspiring victories. But it had not reached its goals as it accepted the policies of development and this changed its course.

The survey gave poignant voice to many of the displaced persons. Binod Sinku lives in Nandup rehabilitation colony with his wife Dashama and three children. He said,

"In my original village, Nandup, my parents had more than 5 acres of land. Their livelihood was agriculture and they also had cattle, goats and chicken. They also had fruit trees. We had enough to eat and lived well."

Dashama added,

There is little to be happy about here – we are forced to survive in this little space, our children, even relatives who visit, all cramped together...Who would live here? We do not get fuel wood or greens to eat or fodder for animals. Back in our village we would grow vegetables or if not that, some thing or the other was always there to eat. There was enough rice for the family throughout the year. Here we have to buy everything in the Rs.70/- that we get at the end of a working day. Water is in such short supply. At four every morning I go to fill vessels at the common tap. If you come here in summer we can't even offer you a glass of water."

Dukhni Digi, who lost her home to one of the projects, lamented,

"The company drove us out of our home without giving us jobs …Therefore (it's best to) remain together and just do not think of giving up your land…"

Another said,

"Before we were displaced, we were told there would be a road, electricity, water, school and hospital. But we got nothing. Yes, they built a school of three rooms but that also fell down and now there isn't even a brick. From our family of thirteen, six of us came to Bokaro for daily wage work – no permanent job, no house either. We live in a hut and whenever the Government wishes, they come and demolish it."

The story repeats with minor variation. Some got trivial compensation, some received a small sub-standard space to live... many got only promises so they had to build illegal huts. A few wells were built but found to be unusable, some got ration cards but many did not, and so on and so forth.

Who's Development? Who will get Jobs? Who will get Rehabilitated?

Innumerable questions remain unanswered. *Having lost home, livelihood, social structure, culture and identity – who will be taught in the schools? Without food in our bellies and cloth on our bodies – who among us will get care in the company hospital? The children of the displaced – how many of them will get education? How many will get industrial training?* Even stretching ones imagination beyond belief, it does not look possible. A company goes to a place out of narrow business interest alone, aiming to earn profit – not social welfare. This is the plain truth. Wherever a company comes in to start an industry, the fate of the place and its people are sealed.

In the climate of stiff competition in today's global market, areas where capitalist interests can invest grow fewer and tighter. So they make even people's basic needs of water, food, education and health care into saleable commodities. And they are out to capture all of the people's natural resources as well. So whenever the government or a company's executives set out to acquire land, they say they will rehabilitate the people and will pay them compensation. *But how will they rehabilitate? What will they compensate, and with what? Will they compensate the loss of language, culture, social values, and history? … Or the disappearance of trees, plants, animals and environment?* We descendants of adivasi society know now and through bitter experience that our socio-cultural systems, livelihoods and identities can neither be rehabilitated nor can they be compensated.

The Koel-Karo Movement: A Victory

As early as the mid-fifties, the Government proposed a hydroelectric power project with dams on the rivers Koel and Karo in Bihar. A survey was begun in the submergence zone and road construction started around 1960, yet the people were kept unaware that this project would submerge 55,000 acres of forest, agricultural and village lands, destroy 245 villages and displace a two and a half lakhs (250,000) population. The project blueprint was ready in 1973 but still the people were not taken into confidence.

When land acquisition began in the mid-seventies, the people were shocked to learn about the impending inundation. The people of both Koel and Karo areas in Gumla and Ranchi districts united to form the Koel-Karo Jan Sangathan (KKJS), protesting against the Government keeping them in the dark. In 1978 they erected a 'people's barricade' at Derang, stopping work and forcing the government to negotiate to permit the unloading of cement and steel from railway wagons. While allowing that, the KKJS prevented transportation of the materials and equipment from the station. Subsequently, Ranchi's Deputy Commissioner put the project on hold. In 1980 a joint survey begun, but after surveying only two villages the filled-in schedules disappeared from the project office.

In 1983 the KKJS itself prepared a plan for

comprehensive rehabilitation, including economic, social, cultural and religious resettlement. When the Chotanagpur Commissioner appealed to the KKJS leaders to allow dam construction in 1984, the spokespersons ask him to resettle Kocha village (Koel area) and Thethera village (Karo area) first. In the following year, after tripartite discussions on the KKJS proposal, the government agreed in principle to resettle the two villages as a model, but then did nothing. At this, the movement raised a single demand: cancel the project! The government then announced that, if necessary, it would use force to advance work on the project and it moved a camp of CRPF jawans into the submergence zone. After public outcry at Lohajimi and women's protests of harassment, the camp was removed. Further the government tried to conduct its survey using police help, but the project-affected people engaged in total non-cooperation and forced them to withdraw. Following that the status quo prevailed for a decade.

In mid-1995, the Bihar government announced that on the 5th of July Prime Minister Narsimha Rao would lay the Project's foundation stone. Throughout June the people mobilised and thousands participated in rallies and *satyagraha* in every village and tola. On the 1st of July, the protests culminated in imposing a "janata curfew" against persons, vehicles and equipment related to the project and they erected more barricades. Massive rallies at Basia (Gumla Dt.) and Torpa (Ranchi Dt.), addressed by KKJS leaders and MLAs swearing that they would not permit this destructive project and raising the slogan, "We will give our life but not our land!" The PM's programme was canceled.

In January of 2001, soon after the State of Jharkhand was created, the KKJS obtained an appointment for 5th February 2001 to request Chief Minister Babulal Marandi to finally write off the Koel-Karo Hydroelectric Power Project. But on 1st February the police uprooted the Derang Barricade and beat up some people. The next day thousands gathered at Tapkara in protest and the police fired, killing 8 persons and wounding 35. Despite this use of force, as of now, the Government has still not succeeded in building the dam and the movement goes on.

The Koel-Karo people's organisation runs on collective leadership that rises above political parties, caste and religion. The resources are generated by collecting a handful of rice from each family. Its basis is cultural identity and existence. The locals say that no amount of money can compensate for our culture, language and religion.

Opposing the Netarhat Field Firing Range: a Successful Satyagraha

In the late 'sixties the Central Government acquired 1471 square kilometres of land carved out from 245 villages in Palamau and Gumla district for an army field-firing range. Hence for the last four decades the army has been using this area periodically for practice in firing its big guns. During the practice periods, many people lost their lives or limbs from stray bullets and missiles. To save themselves they had to leave the area with cattle, goats and chickens. Women gave birth under trees, in the hot sun or heavy rain. Because those who stayed behind were heavily exploited. Soldiers would slaughter their goats and chickens and destroy their standing crops with heavy vehicles. And they raped the women.

After long suffering, in March 1993 the villagers decided not to tolerate this mass atrocity any more. With collective determination all 245 villages – about one and a half lakh (150,000) people – joined in practising civil disobedience or *satyagraha* for eight days at Tutwapani village in Jokipokhar. When the army vehicles arrived for routine firing practice on the 22nd and 23rd of March, the huge number of demonstrators prevented their entry and sent them back. Since then the army has not been able to return to the area for firing practice. The villagers' struggle could succeed because of collective leadership. This movement also rose above politics and fought on the basis of social and cultural identity.

Chandil Dam and Sitarampur Reservoir: Defeats to take Note of

According to close observers, the people's struggle against displacement by the Chandil Dam project reached a high stage. There was even a police firing on the activists. However, the leadership was not collective – it was in the hands of individuals who did not distance the struggle from politics. They did not stake the struggle on socio-cultural identity and existence, but rather they gave priority to the compensation issue. After the firing, as the displaced people believe, only two persons changed their stand and welcomed the government's development policy. But this weakened the movement and so in the end the people were displaced. The movement that had begun with cries for protection of jal-jungal-jameen (water-forest-land), language, culture and village society got reduced to a demand for employment that would guarantee food alone.

The Sitarampur Reservoir supplies water to the industrial city of Tatanagar. When the reservoir was to be built, the villagers started a movement against it. This was a people's movement, but four persons in the struggle changed sides. As a result the movement broke down and the reservoir was built, forcing the villagers in the catchment area to leave. The people became homeless. Today those who once owned land struggle to demand jobs.

The Lesson and the Message

Adivasis – the original settlers – have always bonded with the water, forest and land (*jal-jangal-jameen*), lived as caretakers, as settler peasants on the land. 'Development' takes their forests, rivers and hills away from them, robs them of their peasanthood. It replaces that with a certificate of development that is supposed to erase their displacement. With this false certificate they wander hopelessly from door to door for jobs.

The movement against displacement can overcome and succeed only if it is conveyed through the protection of *jal-jungal-jameen*, and of language, culture and social justice. The movement's leadership must stay local and collective. It must rise above partisan politics, guiding its struggles by the resources of genuine cultural identity. If, on the other hand, mere compensation gains priority and the government's development policies are welcomed, the movement will certainly weaken and abandon the displaced people to wander endlessly for filling their bellies.

In the struggle against Arcelor-Mittal today, many different groups of people, women, youth, village committees, all have come together in Rania, Karra and Torpa blocks of Khunti district and Kamadara block of Gumla district under the banner of Adivasi-Mulvasi Astitva Raksha Manch (Forum to Protect the Existence of Adivasis and Mulvasis[1]). They have opened a front against displacement. Grasping the lesson to be learned, they have resolved not to accept the government's development policy, and they assert,

"WE'LL NOT GIVE UP EVEN ONE INCH OF LAND!"

[1] *'mulvasi' is a term used to mean later non-adivasi settlers (of several generations ago) into the adivasi (tribal) areas who also identify harmoniously with the land and the original people. Their inclusion has broadened the movement.*

Dayamani Barla: The Real Person of Steel

Dayamani Barla's is an inspiring story of a tribal woman who decided to stand up and campaign for issues that continue to erase, erode and impoverish tribal societies in Jharkhand in the name of development.

Born in a village in Gumla district of Jharkhand to a landless family, Dayamani's father was forced to give up his house to usurious moneylenders when she was still young. Her mother had to find work as a domestic in Ranchi and Dayamani had to work to supplement the family income from the age of nine. But she also continued to study, and worked to support her family by giving tuitions and typing, at the rate of Rs. 1 per hour. Many children under such circumstances would have given up education. But Dayamani persisted and cleared not just high school but even university. She did her Masters in Commerce from Ranchi University and went on to be an award-winning journalist and author. She was clear from the start that she wanted to use her pen to give a voice to those who are otherwise not heard.

Dayamani, has been writing articles in Hindi in regular newspapers and magazines like *Prabhat Khabhar* for the last ten years. Her writings powerfully articulate the exploitation faced by tribal communities, especially women. She strongly believes that by taking the voices of the tribal communities to the common public on issues of tribal women's empowerment, health, local self-governance and on Government's Tribal policies, common people can be made aware of the real situations on the ground and thus participate and influence development policies in the right direction.

She has been a powerful campaigner working shoulder-to-shoulder with the community on different issues ranging from eviction of tribals due to the Koel Karo Project, hazards of Uranium mining to forced prostitution of tribal women. A recipient of the Counter Media Award for better rural journalism (2000) and the National Foundation for India Fellowship (2004), Dayamani runs a local tea-shop for a regular living which she claims is also one of the best places to listen to the voices of the people! Currently, she is leading the fight against Arcelor-Mittal's plans to set up a giant steel plant in Jharkhand. Why should she oppose industry that will create jobs in her State? Because she believes that the price that the tribals pay when they are displaced from their lands cannot be compensated through a few jobs or money. "Natural resources to us are not merely means of livelihood but our identity, dignity, autonomy and culture have been built on them for generations," she is reported as saying. She believes that the location of such a huge plant will adversely affect the forests and water sources in the region.

In 2008, Dayamani Barla was chosen for the Chingari Award for Women Against Corporate Crime. The award itself is remarkable because it has been instituted by two women who took on one of the biggest corporations in the world, Union Carbide in 1984 after one of the worst industrial disasters killed thousands of people in Bhopal. Rasheeda Bee and Champa Devi Shukla won the Goldman Environmental Prize in 2004 for their work in Bhopal to get justice for the victims. Instead of using the sizeable award money for their needs as they could have given that they were victims of the gas disaster, they decided to invest it in a trust that would recognise each year a woman struggling on the same issues as them.

In Dayamani Barla they have found a worthy recipient for the award. Like Rasheeda Bee and Champa Devi, Dayamani knows the cost of fighting against the powerful. There are many lessons one can learn from the struggles and lives of women like Dayamani.

(Source:Formulations interalia from the net and Kalpana Sharma's article "Woman of steel" in The Hindu *magazine section, Dec 28, 2008.)*

Gravest Displacement.... Bravest Resistance- Part I

The Struggle of Adivasis of Bastar, Chhattisgarh Against Imperialist Corporate Landgrab.

- Sudha Bhardwaj[1]

The rule of law does not do away with the unequal distribution of wealth and power but reinforces that inequality with the authority of law. It allocates wealth and poverty in such complicated and indirect ways as to leave the victim bewildered. - Howard Zinn

Why this Essay?

I don't live in Bastar, and I am not an adivasi.

But I have been active in the working class movement of Chhattisgarh for the past 22 years, a movement that became legendary under the charismatic leadership of Comrade Shankar Guha Niyogi. And I strongly feel that understanding what is happening in Bastar today is of the greatest significance not only to us in Chhattisgarh, but to all those who want to understand imperialist onslaught and corporate land grab, particularly in the resource-rich adivasi areas; for all those involved nationwide in the anti-displacement movement which is day on day becoming a fierce life-and-death struggle against all odds; and in fact for all of us in the peoples' movements who are faced with the abysmally criminal failure of democratic institutions and shrinking democratic spaces on the one hand, and growing repression on the other.

The working class of Chhattisgarh have tried to demonstrate through their organized efforts that they are not victims, they are creators - creators of the wealth of today, creators of the socialist society of tomorrow. Their struggle is not for economic gains alone, but to enrich every aspect of life - cultural, social and political, hence their union is a "24 hour union", not an "8 hour union". A union which struggles to reclaim the anticolonial history of the adivasi here Veer Narayan Singh; and which makes the antialcoholism movement, not a moral, but a political fight led by women. They have asserted that it is real live democracy - of mass participation, vigorous debate and collective discipline - and not the passive "raising of hands" type formal democracy, that is the spirit of their organization. But above all, they have demonstrated that the working class cannot rest while any other toiling people are suffering injustice and exploitation. And so, the workers of Chhattisgarh have marched in Harsud in the Narmada Valley, and served the gas-affected in Bhopal and the earthquake victims at Latur; they sent rice to Bailadila after the massacre of 1978 and to Balco after the anti-privatisation strike of 2001; they struck work to release water for the peasants of Balod, and in solidarity against the repression of Honda workers at Gurgaon. A declared Marxist-Leninist, Com.Niyogi often quoted the famous Leninist dictum that trade union struggles are the primary school that prepares the working class to shoulder its historic responsibility. And the most immediate, the most urgent question today is our response to the enormous human sufferings brought about by imperialist exploitation and the ruthless cruelties committed to enforce it even in the face of popular opposition.

In the numerous industrial areas across Chhattisgarh today, the very blood of young contract labourers is being sucked as they labour for 12-14 hours, for far less than minimum wages, without weekly holidays, and without safety or medical facility, to generate the enormous wealth of "Chhattisgarh Shining!" Unionizing them doesn't only mean facing the goondas of the industrialists, risking the loss of precarious jobs, sustaining an uncompromising struggle against great odds, and developing a mature and bold leadership that can withstand both carrot and stick - though this is a tall enough order. It also means struggling against the serious imperialist onslaught against the people of Chhattisgarh.

An onslaught where gigantic multinationals like Holcim and Lafarge are gobbling up the cement sector, they have already acquired ACC, Ambuja, and Raymond Cements. Taking advantage of rich limestone deposits, they are manufacturing the cheapest cement in the world, earning superprofits and planning to set up new capacities. Between them and the big Indian cement manufacturers like Aditya Birla they have formed the "Chhattisgarh Cement Manufacturers Association" a cartel that has its office at a stones throw from Chief Minister Raman Singh's residence – a proximity symbolic of their stranglehold influence over the state administration. These companies are blatantly violating well-established Indian labour standards that

[1] *This essay is dedicated to the memory of Tapasi Malik, Dula Mandal, Lakhiram Tuddu, Satyabhama... Whose names we know, and the hundreds of adivasis of Bastar whose names will remain unknown till we claim them.*

prohibit the use of contract labour in cement manufacture, and mandate that contract labour be paid at par with regular workers, i.e at the rate of the Cement Wage Board. (Holcim, for instance, has appealed against an Award obtained by our union to regularize 573 contract workers whose contracts were held to be sham and bogus.)They are refusing to abide by the State Rehabilitation Policy which prescribes permanent jobs for those displaced by their plants, and they are in fact creating an explosive situation in the rural areas by employing outsiders in preference to the affected peasants. Under the leadership of the Pragatisheel Cement Shramik Sangh and the Chhattisgarh Mukti Morcha (Mazdoor Karyakarta Committee) – workers, peasants and particularly women – have been militantly struggling and have had some success in enforcing minimum wages and getting some affected peasants employed in these factories. But we still need to forge a unity of all cement workers in Chhattisgarh, across union lines, to wage a serious struggle demanding that multinationals implement the law of the land.

On the other hand, the local small and medium steel industry of Chhattisgarh is facing a severe crisis, hundreds of units – mini steel plants, sponge iron units, rolling mills - are closing down, and thousands of workers are facing the threat of retrenchment. This crisis is another facet of the imperialist onslaught. The best quality iron ore of Chhattisgarh is literally flowing out as slurry, day after day, to be shipped out to Japan costing it a mere Rs. 400 a tonne. The State government is only too keen to sign MOUs with the big corporate houses – Tata, Essar, Mittal, Jindal…. and to practically gift away the best deposits of iron ore as captive mines at a measly royalty of less than Rs. 50 a tonne. But the local industry is having to purchase iron ore at open market rates, which had touched upto Rs. 5800 per tonne recently. Along with our union the Jan Adharit Engineering Mazdoor Union, the CMM has been continuously protesting against these pro-imperialist policies in order to save local industry and jobs, and exhorting the local industrialists not to be "penny wise and pound foolish" in trying to make up the lakhs of losses on raw material costs by squeezing a few thousands out of the workers legal wages.

But, increasingly it is becoming more clear to us that the factories are not the only battleground against imprerialist and monopoly capital, the hardest struggles are in the countryside where these companies are zeroing in on mineral resources, and are engaged in a land grab on an unbelievable scale. Whether for coal blocks in Raigarh, or a power plant in Premnagar, cement plants in Tilda, or a large industrial area in Rajnandgaon, bauxite mining in Sarguja and Jashpur, sponge iron plants in Raipur or diamond mining in Devbhog. Peasants everywhere – particularly adivasis and dalits - are facing and resisting displacement – compromising weakly at some places, facing repression determinedly at others. 41 and now 65 more villages near Raipur are to be displaced for a glittering new capital region of Corporate Chhattisgarh; 9 villages for an army camp next to the new High Court premises close to Bilaspur; 7 villages for an air force base in Rajnandgaon. Not to mention displacement for a Tiger Reserve, Elephant Reserve, Wild life Sanctuaries etc. in Bilaspur, Jashpur and Dhamtari districts… The list is endless.

CMM has been active in the anti-displacement movement – in opposing the demolition of urban *bastis*, particularly in the industrial areas where the lowly paid contract workers live; in organising the already displaced peasants around industrial establishments to demand jobs; and in playing a prominent role along with the Sanyukta Kisan Morcha in stalling the acquisition of 7 villages at Rajnandgaon for a Special Industrial Zone. It has expressed solidarity with the Raigarh Bachao Sangharsh Samiti which has been fighting the total domination of the Jindal group with its 'private army'. A group notorious for land grabbing, brokering of material inputs for local small industry, rampant exploitation of workers and pollution of the air, soil and water of Raigarh district. A peasant woman Satyabhama had lost her life, ironically on the 26th of January 1998, when being force-fed to break the indefinite fast she had undertaken to save the waters of the Kelo river from pollution by Jindal. (In yet another example of the obscene hypocrisies that we now take for granted like Satyam winning the Golden Peacock Global Award for corporate governance, the Jindal Steel and Power Limited recently received the "Srishti Green Cube Award 2007 for Good Green Governance" from Sheela Dikshit, the Chief Minister of Delhi!) The CMM has also been an active participant in the anti-displacement front Visthapan Virodhi Jan Vikas Andolan, which was launched at Ranchi on 23rd March 2007, and which has been attempting to unite the people's resistance to displacement countrywide.

The struggle to bring the MOUs of Tata and Essar in Bastar and Dantewada into the public domain; the fake gramsabhas in Lohandiguda and Dhurli blocks conducted at gunpoint to obtain consent for land acquisition, and presided over by the Salwa Judum

supremo and District Investment Promotion Board Chairman Mahendra Karma; the arrests of vocal villagers including when they were on their way to keep a scheduled appointment with the Governor; the slapping of cases under the National Security Act on activists of the Adivasi Mahasabha; the FIRs that were finally lodged, after epeated complaints, against sundry dalals of Tata for the "fake compensations" given to the wrong persons and even in the name of the dead; these are events about which I and the CMM have had personal knowledge, and about which we have continuously raised our voice. CMM had organized torchlight processions in several industrial centres protesting against the arrest of Manish Kunjam and other leaders of the Adivasi Mahasabha on the eve of the gram sabhas organized in Lohandiguda and Bhansi to protest land acquisition.

But I could only grasp the enormity of the information blackout – the silence, half truths and sheer lies – call it the "wall of silence", that exists between Bastar and the rest of Chhattisgarh, when as an active member of the Chhattisgarh PUCL, I joined several fact finding teams to investigate into fake encounters. When we found out that the shiksha karmis and student killed in Gollapalli allegedly in "Naxalite cross fire" had actually been murdered by the police and SAF even after they had repeatedly asserted their identity; when the "dreaded Naxalites encountered" in Nayapara turned out to be adivasis who had returned to their ancestoral village in search of work; when the theory of "accidental firing because of hidden Naxalites" in the Cherpal Salwa Judum camp was boldly rubbished by the villagers in the camp who were furious at the killing of a woman and a small baby by a trigger happy CRPF jawan. In the media we repeatedly saw a total silence about ordinary people on the one hand, and cymbal-clashing war-cries against Maoists, always pictured as AK-47 toting with sinisterly covered faces, on the other. Each time we uncovered the truth, which, mind you, was absolutely self-evident to the local people, and tried to cross the "wall", it was buried again under a heap of papers – false statements, half-hearted enquiries, politically loaded commentaries and the inevitable conclusions justifying the atrocities. In short, back to square one. This is another attempt to scale that wall.

Ravi Tiwari, General Secretary of the Chhattisgarh Cement Manufacturers' Association accidently blurts out the truth when he states in an article dated 25/9/2007 in the *Jansatta*: "This State is as rich under its soil, as those who dwell on it are economically impoverished." He tells us that Chhattisgarh has more than 28 precious mineral resources including limestone, dolomite, coal, iron ore, diamond, gold, quartzite, tin ore, tin metal, granite, corrundum, marble, beryl, bauxite, uranium, alexandrite, copper, silica, fluorite and garnet. In September 2008, a road blockade by hundreds of villagers of the "Jameen Bachao Sangharsh Samiti" stalled a proposal for acquiring an area of over 105 square kilometers situated in 30 villages of Kunkuri Tehsil of district Jashpur to the Jindal Power and Steel Limited "to prospect for gold, diamond, platinum group of minerals, precious and semiprecious gemstones".

The way companies are zeroing on mineral resources is illustrated by the cement sector. There are about 8225 million tones of limestone in Chhattisgarh, predominantly in the Raipur, Durg, Janjgir, Bilaspur, Rajnandgaon, Kawardha and Bastar districts, a large proportion of which is cement grade. Today more than 6% of the country's cement is produced here by 7 large and 4 small cement plants with a total capacity of nearly 10.5 million tones. In the past decade the unit of the public sector Cement Corporation of India at Mandhar has closed down and the well-known brands of ACC and Ambuja have been taken over by the Swiss multinational Holcim. Indeed 12.5% of Holcim's total sales internationally are now from its 24 Indian plants. The French multinational Lafarge has also taken over two cement plants in Chhattisgarh. In its last term the Raman Singh government has signed MOUs with 11 companies, for setting up new plants as well as expanding old ones. If these new capacities are achieved, it would more than triple the cement production to about 36 million tones.

Seven percent of the country's bauxite, about 198 million tones, is available in the Sarguja, Jashpur, Kawardha, Kanker and Bastar districts. It is being mined at present in Sarguja by the now privatized Balco (Sterlite) company in Chhattisgarh and Birla's Hindalco company of Uttar Pradesh. More than 200 adivasi families have lost their lands to Hindalco so far and the process is still continuing. Although theoretically a lease agreement is executed, which states that the company would restore the land to its original condition as far as is practicable, but in reality no rent whatsoever is paid, and in the name of employment one person from the affected family works as lowly paid contract labour. Discontent is rife among these landless adivasi miners. It is pertinent that Dheeraj Jaiswal, a notorious SPO in erstwhile SP Kalluri's retinue, and charged of many fake encounters and rapes in the name of fighting Naxals, doubles up

as a goonda for Hindalco, patrolling the area in the company jeep to keep its labour in order. Bauxite is processed into aluminium, an important input in the aviation and defence industry. There is a global scarcity of this mineral, so the corporate hawks are always on the lookout for potential deposits.

Sixteen percent of the country's coal, a whopping 39,545 million tones is to be found in the Raigarh, Sarguja, Koriya and Korba districts of northern Chhattisgarh. On 5th January 2007, the adivasis of Village Khamariya, Tehsil Tamnar were subjected to vicious and brutal lathicharge when in a public hearing ostensibly arranged by the district administration, but clearly dominated by the Jindal company, they raised objections to giving up their lands to the Jindal Coal Mines. The public hearings for environmental clearances to three more power projects including AES Chhattisgarh Power (a joint venture with the American energy giant) were recently stalled by villagers protesting that they had not been notified and that they apprehended widespread pollution. The Indian Farmers Fertilizer Cooperative Ltd (IFFCO) hadto withdraw its proposal of setting up a 1000 mw coal-based thermal power plant in Premnagar in Sarguja district in March after strong protests. The villagers organized in the "Gram Sabha Parishad" had attacked IFFCO officials conducting "secret surveys" and had protested the diversion of the Atem river for the plant. When the company persisted and got their leader arrested, over 1,000 people marched to the police station to get him released. The new site subsequently chosen by IFFCO, 10km away, also came into serious controversy in November 2008, when villagers who had passed a resolution against the project, found that their Sarpanch was being whisked away secretly to a meeting in a police jeep, disguised as a policeman! All this would have been amusing, had it not been so dead serious.

The very first notification issued by the BJP govt. of Chhattisgarh after its recent electoral victory was of the splitting up of the Chhattisgarh State Electricity Board into 5 separate companies, a move which had been consistently resisted by the workers' and engineers' associations. This move is widely seen as a hidden privatization, and foreign, particularly American, companies are also reported to be in the bidding. Chhattisgarh produces the cheapest electricity in the country and private players after taking over the CSEB would use cut-throat competition to push other State Electricity Boards out of the running. It would also mean a neglect of rural electrification because it entails greater distribution costs. The workers of CSEB, particularly the independent "Vidyut Karmachari Janta Union" are on strike, and ESMA has been invoked against them.

For the proposed power plant of the CSEB at Bhaiyathan in Sarguja, a private developer - Indiabulls Power Generation Ltd would be the main player, the CSEB basically providing the fig-leaf with a 26% stake, since the coal blocks have been allotted in its name.

Even otherwise, in the coal sector, the presence of the coal mafia is so overpowering that an MP of Dhanbad has alleged in a letter to the concerned Parliamentary Committee that "SECL could earn only Rs 800 crore profit in the fiscal year 2006-07 whereas it (the earning) could have been more than Rs 30,000 crore if the government could have reduced the pilferage." In particular, it is an open secret that in Chhattisgarh, the Aryan CoalBeneficiaries company (which virtually runs the pro-BJP daily newspaper Haribhoomi) has a monopoly over the washery business and therefore makes a lot of money at SECL's expense.

With the changes in mining policy permitting foreign companies, the Arrow company has started drilling the first of thirteen wells at the Tatapani-Ramkola blocks approximately 90 km south of Ambikapur in district Sarguja. The well is being drilled by the Australian drilling company South West Pinnacle Drilling and coal is expected to be touched at a depth of 500-900m.

One-fifth of the country's iron ore – about 2336 million tones averaging 68% purity is found in the Dantewada, Kanker, Rajnandgaon, Bastar and Durg districts. The Bhilai Steel Plant is one of the world's most efficient steel plants, yet it is being deliberately tripped up by private players particularly Jindal Steel & Power. The scramble for the best deposits have started between the public sector NMDC and the Tata and Essar groups, with litigation pending in the Delhi High Court. But this is not all. It is claimed that Tata has acquired Corus. And that Essar Steel is to buy the American steel firm Esmark. Last year, Essar bought Minnesota Steel for an undisclosed sum, only days after it also agreed to acquire Canadian firm Algoma Steel for $1.6bn. The elite of India choose to regard these events as a coming of age of India Inc. and a mark of our becoming a global superpower. The Esmark chief executive James Bouchard, is more forthright and says "Esmark needed a strategic partner as raw material and transport costs rose". In other words, Essar and Tata are going to be the Indian face of the big foreign mining companies who are facing a raw material crunch today. All these acquisitions have been financed by hefty loans from FFIs, which are going to be a stone around the

necks of these companies in the present financial crisis.

On 17th May 2008, about 5,000 tribals from 25 villages took out a two-day 'padyatra' under the banner of 'Adivasi Mahasabha' from Bhansi, where the proposed steel plant of Essar is to come up, to Faraspal of district Dantewada, to protest mining of iron ore from the Bailadila mountains. They claimed that the government has granted mining leases to 96 industrial houses besides Tata and Essar in the Bailadila area and demanded that the mountains, 40 km long and 10km wide, which contained iron ore deposits to the tune of 300 crore tonnes should not be given on lease to private companies for mining as it could pose a threat to the existence of the mountains as also the culture of local tribals.

As regards the earnings of the state, Praveen Patel of the Tribal Welfare Society reveals some startling details:

"There is nothing to take pride in the news that Chhattisgarh has earned Rs.7 billion in mineral royalty on coal, bauxite and iron ores during the first nine months of the current fiscal year 2007-08.

The government states that over 2 lakh tonnes of iron ore has been excavated in first nine months but what about the rate of Royalty earned in iron ore only? Why are those figures not shared with the public. Let me throw some idea to lift the veil. As per my information, the average royalty of iron ore which the state has collected is about Rs. 27/- per metric tonne only whereas the current international rates of iron ore are in the range of above US $ 210. It would have been better, if the government would have stated bluntly that they are allowing the daylight robbery of iron ore, the parallel of which is not seen anywhere else in the world."

The Bastar region is one of the richest in mineral resources – not only in iron ore, but also perhaps a host of other unexplored minerals including limestone, bauxite, and even diamond and uranium. In 2005 it was not only with Tata and Essar and Texas Power Generation that confidential MOUs were signed allotting ironore deposits, coal blocks, and hectares and hectares of land. Scores of companies were given prospecting and mining licenses. Some of these MOUs were signed abroad, and rumours were rife about the enrichment of bureaucrats and politicians, and also of course contribution to the party coffers. Unfortunately for the powers that be, however, there happened to be lakhs of adivasis – neglected, exploited and oppressed by the "mainstream" - literally sitting on top of these most precious assets, and even more unfortunately for them, since the early 80's the Naxal movement had dug deep roots there. The estimate of the then Director General of Police DGP Rathore was that there were about 50,000 "Sangham" (or members of the peasant committees and women and youth organizations) of the Maoists in the year 2005. And so started the "Salwa Judum", a massive and brutal ground clearing operation that was to affect about 3.5 lakhs of adivasis in 644 villages, the most widespread displacement anywhere in the country. "Draining out the water and killing the fish" was the expression used by Mahendra Karma.

"Jan Denge, Jameen Nahi Denge!" A Fierce Resolve

"Those who are going to become homeless and uprooted in this race of so-called development, they will also be finally forced to accept the bitter truth that they cannot stop the loot of their lands and resources by any democratic and non-violent means. This is a dangerous situation. Even a combative organization like "Narmada Bachao Andolan", which included a large number of educated persons, has accepted the bitter truth that there is no administrative or legal means of preventing the loot of resources. Now it is only through unity and by force that these plunderers can be stopped. That is the reason why today, in Kalingnagar, Nandigram etc. there is a situation of "do or die". All these struggles are proving to be landmarks in stopping the loot. The people of these areas have firmly resolved that come what may, they will not let any government officer set foot on their land. In these circumstances if the government uses force, violence may erupt."

-Prashant Bhushan, Advocate, Supreme Court
Stop Land Acquisition", Nai Azadi Udghosh, February 2007 (Translation ours)

All over the country the peasantry is up in arms against the policy of land acquisition and Special Economic Zones. Jhajjar in Haryana, Dadri in Uttar Pradesh, Raigarh and Madgaon in Maharashtra, the Chengara struggle of Kerala, the struggles in Polavaram and Kakinada in Andhra Pradesh, agitations against the acquisition for JP Cement in Rewa and for Reliance, Essar and Hindalco in Singrauli, Madhya Pradesh.... Within a year of the passage of the SEZ Act, 300 SEZs had been sanctioned giving 1,40,000 hectares of land to private companies. The draconian provisions of the Land Acquisition Act, 1894 do not give the peasant any remedy once the state rejects any objections he/she makes, and declares that his/her land has to be acquired for public purpose. The Judiciary of this country, led by the apex court, has been, if anything,

implementing the policies of imperialist globalization more consistently and harshly than the Executive. It has refused to review what is considered "public purpose" by the government in the name of not interfering with government policy. It has stated that the directive principles - which hold that a) the resources of the people held in trust by governments must be used for the greatest common good, and b) that the concentration of wealth in a few hands should be discouraged - are not enforceable by a court of law. In other words, the "socialism" of the Preamble has no place in this era. Our Indian Judiciary has gone a step ahead of the British colonial masters who at least distinguished between "acquisition for companies" and "acquisition for public purpose" by providing for them in two separate chapters of the Land Acquisition Act. In fact, earlier, when the government acquired for companies, it was necessary to follow the rules framed in this regard, which mandated that the government enquire whether other alternative non-agricultural land was available or not, and whether the company had made adequate efforts to purchase the land itself, before it stepped in. Under the euphemism of "public private partnership", development has been redefined to mean that public resources are to be used for private profits! So much for the Constitution!

Interestingly the Secretary of the United Nations Food and Agriculture Organisation came out with a report recently, expressing grave concern that rich countries and rich companies were taking over vast tracts of lands in poor nations, seriously jeopardizing food security. The report gave an instance of 10 lakh hectares of land being taken over in Madagascar where conditions of starvation are prevailing among the rural masses. In fact the report went a step further and said this tendency could be described as "neo-colonialism"! Our country is indeed faithfully following this path charted out for it.

The loot of precious mineral resources has further intensified from adivasi areas all over the country since 2005. And the adivasis, with their sense of identity and dignity, their communal way of life in co-existence with nature, and their strength of collectivity have been resisting it with all the strength at their command. The eastern states of Jharkhand, Orissa and Chhattisgarh and the contiguous parts of West Bengal and Madhya Pradesh have become the storm centre of this resistance. As part of a People's Tribunal into the police firing that took place in Tapkara block close to Ranchi, we witnessed large defiant mobilizations of adivasi people and saw the "janta barrier" they had put up to keep out government and NHPC officials trying to implement the Koel Karo dam project. The project had finally to be given up. In Jharkhand alone, 46 MOUs have been signed including with Arcelor Mittal, but so far not even a single company has been able to set up its plant. Peoples' movements have sprung up spontaneously and are holding out their own against powerful companies. And no doubt the overarching presence of the Maoist movement in the background has prevented the State from deploying overwhelming force to crush the peoples' movements. The incident of police firing described below is considered to be one of the factors leading to the recent defeat of Sibu Soren.

In Orissa, the Hirakud dam was in the news for two reasons recently. One was that the oustees of the dam received compensation after 4-5 decades. The other was that the farmers of the area were strongly protesting the diversion of water from the Hirakud dam to industry. This in a nutshell spells out the cruel apathy that development has been for tribal people, and lays bare hthe sound reasoning behind what appears to be a stubborn or irrational resistance to acquisition and industrialization. That is, that not only the displaced but even the so-called beneficiaries are bound to be cheated when the state's singular concern is to aid the fattening of private capital, and incidentally the fattening of its own representativesin the bargain.

"Farmers say they will not accept anything less than a complete ban on industrial use of the dam water. On March 23 2008, Bhagat Singh's 76th martyrdom day the farmers renewed their pledge to continue their fight for water. They gathered at 'Chasi Rekha', a border wall inside the reservoir beyond which industrial units are not allowed to draw water. Holding the dam water in their palms, they pledged: "We will not allow company raj on Hirakud water. "On November 6, 2007, some 30,000 farmers had gathered at the reservoir in Sambalpur district. Many were injured in police lathicharge (see 'Groundswell', *Down To Earth*, December 31, 2007). Soon after the incident, Chief Minister Naveen Patnaik announced a Rs 200-crore package for the repair and renovation of the Hirakud canal system. Lingaraj, convenor of the Western Orissa Farmers Coordination Committee, says the package is aimed at diverting attention from the core issue of water diversion.

They want the government to cancel all post-2003 agreements with industrial units and reach water to over 20,000 hectares in the command area. Another of their demands is that Patnaik should punish

companies illegally drawing water from the dam.
Ranjan K Panda

Meanwhile the private violence by company goons of POSCO and the Tatas against the adivasi communities has been intensifying. Abhay Sahoo, the popular leader of the Posco Pratirodh Sangram Samiti was arrested on 12th October 2008 when he was undergoing treatment at Bhutmundei, Paradeep and 23 false cases were foisted on him so as to deny him bail.

The events of Orissa have forced the organizations and activists of the anti-displacement movements to think and debate how to resist state violence and private corporate violence, and to assert the right of the people to resist under all circumstances and by all means. We in CMM also experienced this when we visited the Boringpader village in Lanjigarh (Niyamgiri) district Kalahandi in 2005. When a police jeep was seen in the distance, the entire village came out - women, men and children with whatever they could lay hands on – bows and arrows, axes, sickles and sticks. The jeep stopped at a distance and a policeman came out with his hands raised in a gesture of peaceful intentions. When he came closer he told the leaders apologetically that he had been sent from the police station to get the details of the visitors. After taking those he left, and the people relaxed. Later the villagers explained that the first time they had taken out a procession against the Vedanta company, the company goons had attacked them ferociously, people had fled in fright and had been chased away for several kilometres. Ever since then, they said, they always carry their traditional weapons and no-one has dared to attack their processions and meetings!

Global Mining Companies see Maoists as the Greatest Challenge to their Penetration

In his article, *"The State As Landlord: Naxalism feeds off genuine issues. It calls for policy, not police"*, in the weekly magazine 'Outlook', Prem Shankar Jha writes:-

"Lakshmi Mittal of Arcelor fame is finally about to deliver on his promise to invest in his home country. The plans he has unveiled are mind-boggling: Rs 1,00,000 crore ($24 billion) to be invested in two steel plants and iron ore mines in Jharkhand and Orissa that will produce 24 million tonnes of steel when they come on stream. Planning for the project is going well: all that remains is to identify a source of iron ore for its Orissa plant. Herein lies the rub. For, if the Maoist insurgency in central India continues to develop at its present speed, he may never find the iron ore he needs to operate his plants……

While India Inc dreams of overtaking China, the Maoist insurgency has intensified. Since '04, there have been more than 50 'swarm' attacks on jails, police stations and armouries. All have met with total success. In two attacks in Orissa last month, the Maoists captured 1,600 weapons, including machine guns and AK-47s.

In Orissa, 12,000 out of 30,000 posts in the police are vacant, and in three districts they have stopped wearing their uniforms. But Orissa pales into insignificance before the intensity of the uprising in Chhattisgarh, which recorded 531 incidents and 413 deaths in 2007. The Maoists have a single rallying cry: "Development projects are taking away our land and our traditional rights. We will not allow them to proceed." They are succeeding."'

Manjeet Kriplani echoes similar sentiments in his article, *"In India, Death to Global Business. How a violent - and spreading - Maoist insurgency threatens the country's runaway growth"* in the American journal 'Businenessweek':

"On the night of April 24, a group of 300 men and women armed with bows and arrows and sickles and led by gun-wielding commanders emerged swiftly and silently from the dense forest in India's Chhattisgarh state. The guerillas descended on an iron ore processing plant owned by Essar Steel, one of India's biggest companies. There the attackers torched the heavy machinery on the site, plus 53 buses and trucks. Press reports say they also left a note: Stop shipping local resources out of the state, or else!.....

India has lots of unmined iron ore and coal - the essential ingredients of steel and electric power. Anxious to revive their moribund economies, the poor but resource rich states of eastern India have given mining and land rights to Indian and multinational companies. Yet these deposits lie mostly in territory where the Naxals operate. Chhattisgarh, a state in eastern India across from Mumbai and a hotbed of activity, has 23% of India's iron ore deposits and abundant coal. It has signed memoranda of understanding and other agreements worth billions with Tata Steel and Arcelor Mittal, De Beers Consolidated Mines, BHP Hilton and Rio Tinto. Other states have cut similar deals. And US companies like Caterpillar want to sell mining equipment to the mining companies now digging in eastern India…."

- (To be concluded next issue)

Breach of Land Laws in Jharkhand

- Gladson Dungdung[1]

45 adivasi families were duped into selling their lands near Bokaro, Jharkhand, lured by promises of jobs in a garment factory that was never built. This is only one of thousands of cases of adivasi land alienation in Jharkhand, 100 years after the Chhotanagpur Tenancy Act prohibited transfer of adivasi lands to non-adivasis.

The alienation of adivasis from their land is not a new issue in Jharkhand. According to the Ministry of Rural Development's Annual Report 2004-2005, Jharkhand tops the list of adivasi land alienation in the country, with 86,291 cases involving 10,48,93 acres of land.

The Chhotanagpur Tenancy Act 1908, which prohibits the transfer of adivasi land to non-adivasis, marked its 100th year on November 11, 2008, as adivasis across the state demanded immediate action against breaches in the law that have resulted in the loss of over 22,00,000 acres of land since Independence.

The case of the adivasi village of Tetulia, located near the steel city of Bokaro, in Jharkhand, is an important example of land alienation through breach of law. The village has completely lost its identity and is now known as Bari Cooperative; 250 posh buildings have replaced the earlier mud houses and non-adivasis are now the proud owners of land that once belonged to the Santhal adivasis. Forty-five Santhal families used to live in the village but their lands were grabbed and they were forced to leave the area. The few who survive live in mud houses outside the cooperative area.

The Bari Cooperative Society was established in 1980 by two property dealers, R K Singh and B K Singh, who approached the local adivasis with a proposal to establish a cloth factory. Besides money for their land they were also promised jobs. Finally, the dealers managed to acquire 50 acres of land for the Bari Cooperative Society for which they paid less than the promised Rs 1,000 per acre. Forty-year-old Pankisto Manjhi says: "I was given just 10 kg of rice for three acres of land." Fagu Manjhi (60), whose 1.27 acres of land were also acquired for the cooperative, was given a job as guard for a monthly salary of Rs 800. But when the cooperative was closed, he was left high and dry. Likewise, Kari Manjhi had 9.26 acres of land of which 4.24 acres were taken by the Bari Cooperative and 2.36 acres captured by migrant Biharis. He has only 2.66 acres left with him; despite filing a case in the Bokaro Civil Court against the Bari Cooperative in 2006, nothing has happened.

Interestingly, though the land was bought under the guise of setting up a garment factory it closed down just a few days later and the owners constructed posh buildings on the land which they sold to non-adivasis at the market rate. When the matter was brought to light, Deputy Commissioner, Bokaro, Amrendra Pratap Singh conducted an investigation in 2005 and found that 95% of the buildings had been built on adivasi land, in serious violation of the Chhotanagpur Tenancy Act. Unfortunately, no action has been taken.

Twenty-eight long years have passed since the adivasi land was grabbed in the name of a garment factory. And justice has still not been done.

The alienation of adivasis from their land is not a new issue in the state of Jharkhand. It began in the medieval period and flourished during the British Raj. The British-Indian government introduced the zamindari system by enforcing the Permanent Settlement Act in 1793 which caused an upheaval among adivasi communities. Consequently, there was a series of adivasi uprisings in the state. The Santhal uprising in Santhal Pargana, the Kolh revolution in Kolhan, and Birsa Ulgulan in Chhotanagpur that resulted in the enforcement of three pieces of legislation — the Chhotanagpur Tenancy Act 1908, Wilkinson's Rules 1837, and the Santhal Pargana Tenancy Act 1949. The prime objectives of these laws were protection of adivasi lands, traditional selfgovernance and preservation of culture. However, these laws have been seriously violated.

In 1969, the Bihar Scheduled Areas Regulation Act was enforced for the prevention of illegal land transfers and of adivasis. An area regulation court was set up and the deputy commissioner (DC) given special rights over the sale and transfer of adivasi land. According to the provision, an adivasi could not sell or transfer land even to another adivasi without the DC's permission.

When the special court started functioning, a huge

[1] *Gladson Dungdung is a human rights activist based in Jharkhand.*

number of cases were registered.

According to a government report, 60,464 cases concerning 85,777.22 acres of illegal transfer of land were registered till 2001-2002. Of these, 34,608 cases relating to 46,797.36 acres of land were considered for hearing, and the remaining 25,856 cases relating o 38,979.86 acres of land were dismissed.

After the hearing, however, a mere 21,445 cases, relating to 29,829.7 acres of land, were given over to the original holders; the rest remains with non-adivasis. A total of 2,608 illegal land transfer cases were registered in 2003-2004, 2,657 cases in 2004-2005, and 3,230 cases in 2005-2006 — clear indication of an increase in the number of cases of illegal land alienation. According to the Union Ministry of Rural Development's Annual Report 2004-2005, Jharkhand tops the list of adivasi land alienation in the country with 86,291 cases involving 10,48,93 acres of land.

Bandi Oraon, a prominent adivasi leader and vice-chairperson of the National Commission for Scheduled Castes and Scheduled Tribes, has conducted a study on implementation of various laws meant to protect the illegal transfer of adivasi land to non-adivasis in the state. The study was confined to 15.703 cases registered with the Ranchi collectorate with respect to adivasis living in and around Ranchi city.

The study reveals that a mere 41.46% of cases were accepted for hearing; 26.82% were rejected and 31.72% kept pending. Interestingly, however, 96% of the cases heard resulted in actual possession being given.

Non-adivasis often employ underhand methods to acquire adivasi land. The 'best' and most widely used trick among non-adivasis to buy adivasi land is to marry an adivasi girl and register the land in her name. Many adivasis too are forced to surrender their land to moneylenders after being trapped in the debt cycle. And, there are the usual threats, coercion and preparation of illegal documents to acquire land. Authorising the deputy commissioner for land transfers works to the disadvantage of adivasis as many non-adivasi officers justify land transfer to non-adivasis. In some cases, the courts have defined the laws in favour of non-adivasis.

The amendment of the Chhotanagpur Tenancy Act in 1947 for the purposes of urbanisation, industrialisation and various 'development' projects also deprived hundreds of adivasis of their land. Indeed, the laws on land have all been misused, violated and interpreted against adivasis by policymakers, bureaucrats and nonadivasis.

Under these mitigating circumstances, how can the issue be resolved?

The National Advisory Council constituted by the Government of India sent a recommendation to the government on January 19, 2005, that has ample provisions to address the issue. According to the recommendation, the state is required to play a proactive role in monitoring the restoration of lands to adivasis. It calls for transparency and access to land records (at the village level) by adivasis in the local language, speedy disposal of cases where adivasis are involved, and consideration of oral evidence where records are not available. All pending land disputes must be settled at the earliest so that adivasis do not face harassment at the hands of non-adivasis, revenue officials and others. There must be regular updates of land records, regular jamabandhis and the display of revenue details at the village level. Often where lands have been restored to adivasis, non-adivasis obtain stay orders from the courts; this must be discouraged. All states with scheduled areas should have a prohibitory clause on the transfer of lands by tribals.

The council strongly recommends that there should be no displacement of adivasis for any project (mining, energy or any other) in scheduled areas. The Land Acquisition Act may be amended in line with the PESA Act, 1996, so that the rights of people are protected in fifth schedule areas. The setting up of industries in scheduled areas without assessing their impact on the adivasi economy should stop forthwith. No agricultural land or land used for community purposes must be allowed to be transferred or purchased to set up industry. At no cost should the laws of the fifth and sixth schedules of the Constitution be considered for amendment to open up areas of control or ownership to private non-adivasi individuals, industries or institutions. The honest implementation of legislation and the recommendations of this council would go a long way in addressing the problem of tribal land alienation.

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The Art of not Writing

- Shubhranshu Choudhary[1]

How does the media in Chhattisgarh report the conflict between the Naxalites and the Salwa Judum, or the conflict between local communities and corporations? Quite simply, it doesn't. The pressures on journalists in Chhattisgarh are unique. They are paid not to report stories that are critical of the powers-that-be, whether they are industrial lobbies or state authorities.

I was in Bhairamgarh to cover a Salwa Judum rally. Bhairamgarh is a small town in the Bijapur district of southern Chhattisgarh where the State is engaged in a bloody war with the Maoists.

According to the government, the Salwa Judum is a "spontaneous people's movement" against Maoists; human rights activists call it a brutal State-created militia.

The rally was scheduled to pass along narrow tribal paths deep in the jungle where no vehicle can go. So the Salwa Judum leader Mahendra Karma very kindly arranged for me to ride on the back of a motorcycle.

The bike moved easily through the jungle, weaving in and out of several tribal groups en route to the rally. I discovered in the course of my conversation with the bike rider that he was a local journalist. Indeed, the ride turned into a crash course in local journalism for me. The journalist worked for one of the top dailies in Chhattisgarh.

"How much salary do you get," I asked him. "I do not get a salary," he replied. "Oh, so how do you earn a living?" "By not writing," was the answer.

Noting my surprise, he clarified. "Journalism here is the art of not writing," he said. "I earn around Rs 5,000 every month by not writing."

I still could not make sense of what he was saying.

"Being journalists, we know who is doing what; the ins and the outs of corrupt practice, and the perpetrators," he continued. "We get a fee for not writing about the corruption.

That is our salary."

He added: "Not only do we not get a salary, we spend from our own pockets to collect and send the news to the head office. It is still worth our while. There are a handful of journalists in the district headquarters who do get a token salary. But in reality they earn many times more than that."

"It is an easy profession for making money," he explained. "As we know good things about the Salwa Judum, similarly we also know all the bad things about the Salwa Judum. But we do not write about the bad things, for obvious reasons," he added, watching leader of the Salwa Judum, Mahendra Karma, who was standing nearby.

Karma is also leader of the opposition in Chhattisgarh.

Almost every newspaper in Chhattisgarh still refers to the Salwa Judum as a "peaceful people's movement" even though there are numerous reports in the national press about human rights violations perpetrated by the group.

After the rally, I proceeded to Dhurli village to cover a possible meeting between Essar and local villagers. The corporate house was seeking a no objection certificate (NOC) from local landowners to set up a plant.

When we reached Dhurli, a group of villagers approached us and said threateningly:

"You must be a broker for Essar." They spotted our camera, paused a bit, but then added: "All journalists are also brokers of the industrialists. You must leave the village.

We do not want to talk to you."

I was shocked at the level of hatred for journalists in the village.

In Dantewada town, after hearing my story, some journalists explained to me in great detail how much Essar was paying journalists to "keep their mouths shut". They could not give me any proof, unfortunately.

People in Dhurli had told me: "Tell the government, if they want to take our land they must first kill us. They can take this land only over our dead bodies."

Back in Delhi, I was amazed to read a report by the Indo Asian News Service claiming that the people of Dhurli had agreed to give their land to Essar. They

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[1] *Shubhranshu Choudhary is a founder-member of the Citizens' Journalism Initiative in Chhattisgarh, Cgnet,<www.cgnet.in>.*

were so happy with Essar's rehabilitation package, the report said, that they had written a letter to the government expressing their willingness to give away their land.

The report received prominent coverage by newspapers like *The Times of India, The Hindu Business Line* and *The Economic Times.*

It also furnished details of how many people had signed the letter and to whom the letter had been given.

I could not believe it! The story must be true, I thought, if so many papers had carried it.

After reflecting on this for a few days, I could not help calling the officer named in the newspaper report. SDM Ambalgam was shocked: "What letter? And which newspaper are you talking about," she asked. "I have not got any letter, and no one has agreed to give land as far as I know." "Have they given the letter to another officer," I ventured to ask. "No. I am the officer in charge of land acquisition here. Even if they had given the letter to another officer it would have come to me," she replied. "I can't believe what you are saying," she added.

I faxed the articles to Ambalgam, at her request.

She issued a show cause notice to Essar asking for an explanation for the news item. The article also featured a quote from the head of Essar in Chhattisgarh commenting on the "letter from the villagers".

According to Ambalgam, Essar replied saying it had been misled by the reporter. Ambalgam was subsequently transferred from Dantewada. No one followed the matter up with the reporter or the newspaper.

That incident prompted me to look more carefully at news items being generated from Raipur in the national newspapers. This is what I found.

The Indian Express carried a report on the front page saying that Naxals had killed three farmers because they had continued farming in defiance of a Naxal ban on all farm activities.

I had not heard of any Naxal ban on farming whilst I was there!

A few phone calls told me that the three people had indeed been killed by Naxals but that the killings had no connection with farming. Farming was on full swing in Chintagufa village, I was told.

"These people were killed because of their alleged connection with the police, not because they were farming," former sarpanch of Chintagufa told me over the phone.

If I was able to speak to the people of Chintagufa by phone to crosscheck a story from Delhi, why couldn't journalists from Raipur do the same? I wrote about this in my column in a local daily the following week.

No one took notice of the article. In fact, the very next day The Times of India carried the same old story about Naxals attacking farmers because of the ban.

Some journalists told me, off the record, from which intelligence officer's desk the story had been generated. But they could not provide any proof. "The officer gave the story only to his trusted ones," a journalist explained.

In the meantime I had begun working on a story about farmer suicides in Chhattisgarh. I was shocked to find that, according to National Crime Records Bureau figures, Chhattisgarh has the highest number of farmer suicides in the country, each year.

Despite the alarming numbers, and eight years after the state came into existence, not a single journalist in Chhattisgarh had written about it!

I mentioned this in my column. Shortly after, there was an article on the front page of the paper with the headline, 'Everybody loves a good fraud; untruth of farmer suicides in Chhattisgarh'. The article called the National Crime Records Bureau data a lie, to which, astonishingly, the Bureau did not respond — a basic journalistic procedural requirement.

My column in the local newspaper was stopped. After years I was suddenly told that my writing was inaccurate and full of lies!

Journalists who do not wish to be named have told me: "We want to write the story of farmer suicides. We can see it happening around us. But the story will go against the government and then the government will stop (publishing) advertisements in our newspapers. So we cannot write the story."

Kamlesh Painkra's story

The story of Kamlesh Painkra probably best explains the situation of journalists in Chhattisgarh today.

Painkra was the first journalist to write about human

rights violations by the Salwa Judum. Following his report, he was told by the local superintendent of police (SP) to apologise and admit that his story had been a mistake.

When Painkra refused, he lost his job. His brother, who was a teacher, was put behind bars, ostensibly for sheltering Naxalites.

The district administration cancelled Painkra's licence to sell public distribution system (PDS) grain in the local market for no apparent reason. It was his main source of income.

Painkra was finally forced to flee his home, taking his family with him, when a friendly policeman told him that the police was going to kill him in an "encounter". They still live like refugees.

No local newspaper reported his ordeal.

I tried to help out by asking a few editor friends to hire him as their Dantewada district correspondent. Painkra now lives in Dantewada after fleeing his home district of Bijapur.

Painkra was hired, but the fine print of his appointment letter was interesting. The letter stated that his salary would be Rs 3,000 a month. It went on to say that he would also have to collect advertisements worth Rs 20,000 every month and that his salary would be a proportion of the amount he managed to collect.

"That means that if the advertising money goes down the salary will go down accordingly," Painkra explained.

He declined the offer, saying: "If I have to collect Rs 20,000 every month in a town with a population of less than 25,000, you can imagine from whom I will have to collect the advertisements. How can I do any journalism after that?"

Last month, the Central Reserve Police Force (CRPF) bulldozed Painkra's house in Bijapur to make room for a volleyball ground for soldiers. There were no reports in the papers about this. Painkra's family was not informed of the demolition. Nor was any compensation paid to them.

The pressures on journalists in Chhattisgarh are special.

Some time ago, the Naxals sent an audio CD to every newspaper office in Raipur. The CD contained, among other things, a recording of a conversation, via walkie-talkie, between the same superintendent of police, Bijapur, who had threatened Painkra, and his deputy.

During the conversation, the SP tells his subordinate: "Keep an eye on the area and if you see any journalists just kill them."

The government reacted by saying the recording was bogus. Police officials in private accept that the voice was indeed that of the SP and that the Naxals had tuned into his conversation on the walkie-talkie.

No national newspaper covered the news. The SP was sent to work in the State Human Rights Commission.

[Reproduced with thanks from *InfoChange News & Features*, February 2009.]

Narendra Modi Backing a Tainted Doctor?

- Joydeep Ray

Tuesday, March 31, 2009, (Sabarkantha, Modasa)

The BJP in Gujarat has given a ticket to Mahendrasinh Chauhan, one of the doctors accused of using old syringes during the recent Hepatitis B outbreak in Sabarkantha, to contest polls.

The people of Sabarkanth are up in arms and say the doctor has the backing of Modi.

Across his constituency, people are asking - why has the BJP given a ticket to the doctor?

"Doctors can't be blamed for spread of the virus and the deaths of villagers. I don't believe this. Companies supplied recycled syringes and innocent doctors used them," said Mahendrasinh Chauhan, candidate, Sabarkantha.

''This is the dubious policy of state BJP. On one side its government had arrested several such doctors for their involvements in the syringe racket. And after few days, they nominate one such doctor to represent people of Sabarkantha in the Parliament, '' said Madhusudhan Mistry, Congress candidate, Sabarkantha.

Locals say Chauhan is a BJP zillla panchayat member who has done no ground work in the constituency.

His private medical centre, Manav Mandir, was shut down after the controversy but now it's back in business.

Sources say he managed to stay out of the investigation and even got a ticket because he has the backing of Modi.

(Source: <http://www.ndtv.com/convergence/ndtv/story.aspx?id=NEWEN20090089256>)

Peak Oil and Reverse Migration in India

- T. Vijayendra[1]

What is Peak Oil?

Peak oil is the simplest label for the problem of energy resource depletion, or more specifically, the peak in global oil production. Oil is a finite, non-renewable resource, one that has powered phenomenal economic and population growth over the last century and a half. The rate of oil 'production', meaning extraction and refining (currently about 84 million barrels/day), has grown almost every year of the last century. Once we have used up about half of the original reserves, oil production becomes ever more likely stop growing and begins a terminal decline, hence 'peak'. The peak in oil production does not signify 'running out of oil', but it does mean the end of cheap oil, as we switch from a buyers' to a sellers' market. For economies leveraged on ever increasing quantities of cheap oil, the consequences may be dire. Without significant successful cultural reform, severe economic and social consequences seem inevitable.

From all the evidence available, peak oil has already occurred. It is affecting our society through shortages of petroleum products and all round increase in prices. In this article we will specifically look at reverse migration in India, though in some cases such as coal mining rural migration will continue to increase.

Migration and Reverse Migration

We will consider migration under following heads:

1. Normal/voluntary rural urban migration
2. Seasonal Migration
3. Forced Migration (Regulated)
4. Forced Migration (unregulated)
5. White Collar
6. Warlord, brigands and floating population

Normal/Voluntary Rural Urban Migration

India has an urban population of 300 million, greater than the population of USA or for that matter greater than any country except China. They live in a total of 400 urban agglomerates. Around 180 million people live in 35 cities that have a population grater than a million. The three metros, Mumbai, Kolkata and Delhi have more than 10 million whereas Hyderabad and Bengaluru have more than 5 million.

Most of urban population growth, apart from normal population growth has been contributed by rural urban migration in the twentieth century. It has been distributed over industry (jute and cotton to begin with and later in the manufacturing sector), mining, service (including transport-such as rickshaw pullers, tongawallahs and now drivers). Very often the new migrant begins in service sector and then some of them move onto industry. Some of the 'higher' jobs are obtained by the second generation and the third, fourth and so on. These are not in that sense migrants. Tea and coffee estates are special cases of rural-rural migration of permanent nature.

Reverse migration has been mainly due to 'reforms' or 'structural changes' in capital after the post liberalisation era in the 1990s. However even before that the traditional sectors of cotton and jute went through these processes and a large number of workers migrated back to rural areas. In West Bengal this process started even earlier, after the recession of 1966-67 and continued through 'flight of capital' during the first decade of the left regime.

Post-liberalisation saw a massive decline of manufacturing sector all over the country and job losses. However by this time the capacity of rural areas to take them has shrunk because the reforms have affected the rural areas too with large-scale farmers suicide being reported from large areas throughout the country. True, service, IT and garment export sectors increased but in terms of number of persons employed there was net a decline.

With Peak Oil there will be a decline in road transport industry leading to all round recession and job loss. It will affect all sectors. However reverse migration will occur only among those sections of population who have a relatively secure base in the rural areas. These will be largely those who had permanent jobs in the organised sector. Even then the stress in rural areas will be great in terms of water and cooking fuel. Massive transformation in agricultural practices will occur. Chemical fertilisers and pesticides will vanish rapidly; ground water will be unavailable because of fall in level and lack of electricity for the pumps. Draught animals will increase. As we said above some migration will

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continue in power sector, particularly in coal.

Seasonal Migration

Both rural-urban and rural-rural migration occurs. As a rule almost all first generation migrants visit their villages during harvest/festival season. The bulk of seasonal migration is in construction industry with specific groups like brick kiln workers having a fairly well-established calendar. Rural-rural migration takes place from Bihar, U. P., Chhatisgarh, Orissa, etc., to farms in Punjab and Haryana.

In post-liberalisation period there has been a boom in this sort of migration first due to boom in the construction industry and secondly the 'push' factor in the rural sector increased considerably due to adverse terms of trade in rural-urban exchange.

Post-Peak Oil will definitely witness a huge decline in this kind of migration. The downtrend in the construction industry is already visible. With the tendency of 'relocalisation' of agriculture due to increase in transport costs rural-rural migration will also decline. In terms of number this will be in terms of millions and will pose the biggest challenge to the rural sector.

Forced Migration (Regulated)

These are what have come to be known as 'development oustees'. That is they are those rural people whose lands have been acquired for some development project (dams, mines, firing range, industry etc.) and have been given a 'rehabilitation package'. These can include land, money, job or being relocated in an urban slum. In practically all cases these people have to leave their homes against their wishes (hence forced) but some semblance of compensation is tried (hence regulated). In most cases their lives are shattered, they face economic, social, cultural and health insecurities and end up living at a level far below what they were used to live.

Post-liberalisation has seen a dramatic increase in their numbers because the State got enormous liberty added by the middle class consent and the Parliament and the Judiciary being silent/vocal supporters of this gross violation of human rights.

Post-Peak Oil probably will see a decrease in their numbers as many of the projects will simply get abandoned and new projects will not even get a head start. Except in the power sector, especially in coal sector.

Forced Migration (Unregulated)

These are actually results of 'resource wars' in the post-Peak Oil era and will increase with increasing ferocity and human misery. Salwa Judum is a prime example. As is well known it is not just a vigilante movement to fight the Naxalites and the State out sourcing its police needs. It is to control and use the natural resources of the region. The tribals living in the camps or worse still who had to migrate to Andhra Pradesh are war refugees, except that they are not being recognised so and they get no relief. Now on there will not be any rehabilitation package but just war on people to get access to mineral resources, be it coal, iron ore, uranium, nickel and copper and so on. These all have peaked or about to peak and there will be a desperate struggle to get control of them.

White Collar

These are not so large in number but are highly visible and will suffer in a big way in the post-Peak Oil era. Their numbers dramatically increased due to boom in the IT sector and finance sector and subprime consumerism a la USA. A huge subprime consumer economy came into being in the metros. So salesmen, shops and malls, restaurants came into being. They will face a collapse and they will have nowhere to go. Foreclosures, bankruptcies and suicides will increase with the associated miseries.

Warlords, Brigands and Floating Population

Unless planned corrective measure are taken right away and a ordered transition to a low energy consumption society is planned and executed the future looks very bleak. And there is no sign that either the Indian state or the civil society is even aware of the problem. So the immediate future looks grim. As Irfan Habib described in *Mughal India*, after the death of Aurangazeb in 1707, India plunged into a lawless society. As agriculture became unviable, the peasants left their land and joined Shivaji's army to get one fourth of the produce of other peasants' land. But then those peasants too left the land and joined the army and so on. A period of complete chaos began marked by local warlords and the 'thugees'(wayside brigands) till 1757 when the Company won the Plassey War and got the Bengal Diwani. So also may be by 2030 or 2040 the society may stabilise at a lower level of energy consumption.

Literature Review on Forced Displacement and Health

Medico Friend Circle Annual Meet
January 16-17, 2009, Bongaigon

-Dhruv Mankad[1]

Introduction

Health impact of Forced (internal or across the border) displacement (or migration) due to conflicts (internal or across the border) or natural disaster is widely recognized. But, no definition of such events is available in the context of its health impact. There are guidelines from UNCHR, UN OCHA for humanitarian response to the situation. These guidelines include recommended State policies and practices to improve and protect the health of refugees, displaced persons etc. There are manuals prepared by various humanitarian response agencies about standards of refugee camps, primary health care for the refugees, pregnant women and children, preventing and responding to conflicts there including gender based violence, preventing AIDS in these camps and so on. However, there are no guidelines as to what civil society has to do when the State itself directly (e.g. Sardar Sarovar dam issue) or indirectly gets involved in forced displacement internally. (In Salwa Judum – is the Chhattisgarh Government involved directly or indirectly? This can be a nit picking exercise, as its health impact remains the same.)

When is it called Displacement when we are Displaced?

As per the Wikipedia,

"**Forced migration** (also called **deracination**) refers to the coerced movement of a person or persons away from their home or home region. It often connotes violent coercion, and is used interchangeably with the terms "displacement" or **forced displacement**. A specific form of forced migration is population transfer, which is a coherent policy to move unwanted persons, perhaps as an attempt at "ethnic cleansing". Someone who has experienced forced migration is a "forced migrant" or "displaced person" …

Forced migration has accompanied religious and political persecution, as well as war, throughout human history but has only become a topic of serious study and discussion relatively recently. This increased attention is the result of greater ease of travel, allowing displaced persons to flee to nations far removed from their homes, the creation of an international legal structure of human rights, and the realizations that the destabilizing effects of forced migration, especially in parts of Africa, the Middle East, south and central Asia, ripple out well beyond the immediate region."

(Source:<http://en.wikipedia.org/wiki/Forced_migration>)

This is a very comprehensive definition but seems to be missing out the State as a coercer, e.g., during a conflict situation if the State evacuates forcibly a single type of population, would it come under this definition? It also seems to be missing out the State as a coercer through a refusal of action.

Development-induced Displacement is a subset of forced displacement or migration.

Again as per Wikipedia:

> "(s)uch displacement is the forcing of communities and individuals out of their homes, often also their homelands, for the purposes of economic development. It has been historically associated with the construction of dams for hydroelectric power and irrigation purposes but also appears due to many other activities, such as mining."

The most well-known example of "development-induced displacement is a result of the construction of the Three Gorges Dam in China" (or Sardar Sarovar Dam in India.) Threatened displacements due to SEEPZ in Raigad district, Maharashtra or Tatas in Singur, West Bengal would also fall under this subset. Displacing slum dwellers, demolishing old shops, converting agricultural areas into non-agricultural ones under coercion are several such examples. In India all land acquisition is done by the state for any development work through public or private sources. Whether this is forced displacement needs to be clarified.

Finally, it is also not clear whether displacement or migration is considered to be voluntary or forced when an individual or a family or a community migrates for job seeking, seasonal employment, tilling land elsewhere during a period *when no other options are available*. Should it be considered 'forced migration or displacement'? Such migration includes simple job seeking away from one's homeland and breaking away from one's family to the horrendous child and women trafficking for sex work. This is important because

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there are studies to show that there is health impact due to any of these reasons.

Though WHO has mentioned disaster and migration as causes of ill health, it has not defined displacement as a proximal cause of illnesses. No recognized textbooks of preventive and social medicine, community medicine or public health has displacement as a defined theme.

Therefore, it would not be incorrect to say that displacement is still to be established as a defined definite cause of ill health having a public health magnitude and depth. In this case, a literature search and research should be considered in an exploratory stage.

Below, the table gives an updated review of available literature using the search engine on <http://www.google.co.in> and reading material received during the mfc Annual Meet at Bongaigaon, Jan 2009, Assam.

A Literature Review

A	**Forced Migration, Displacement, Armed Conflicts, Disaster, Refugees – an Overview**	
	Resources	**Summary**
1.	<http://en.wikipedia.org/wiki/Forced_migration>	A comprehensive information about displacement with a list of sources
2.	<http://www.forcedmigration.org>	Another comprehensive information about displacement
B.	**Forced Migration, Displacement, Armed Conflicts, Disaster, Refugees and Public Health, Health care**	
	Literature Reviewed	**Summary**
3.	*Armed Conflict as a Public Health Problem*, The Global Burden of Disease Working Papers (01.22): Murray C. et al, 2002. At <http://www.hsph.harvard.edu/burdenofdisease/publications/papers/Armed%20Conflict%20as%20a%20Public%20Health%20Problem.pdf>	The paper reviews the existing knowledge on the health consequences of conflict, suggest ways to improve measurement, and discuss the potential for risk assessment and for preventing and ameliorating the consequences of conflict.
4.	*Collective Violence* at <http://www.who.int/violence_injury_prevention/violence/global_campaign/en/collectiveviolfacts.pdf>.	Collective violence receives a high degree of public attention. Violent conflicts between nations & groups, state and group terrorism brings about the movement of large numbers of people displaced from their homes. The effects of these different types of event on public health are vast. This document informs about definition, extent, effects and preventive measure of collective violence
5.	*World Report on Violence and Health 2000.* Edited by Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano,WHO, 2000.	Armed conflict or collective violence is often the cause of forced displacement (internal or across the border) The WHO report 2000 focuses on the types of violence, its impact on health and need for preventing it.
6.	*Small arms and Forced Migration* Author: Robert Muggah. At <http://www.forcedmigration.org/guides/fmo002/fmo002.pdf >.	This paper highlights the complexity of issue of forced migrants under conflicts. Their vulnerability to become victims of small arm violence has roots in the small arm manufacturing and trading. Since protecting the refugee includes the need of small arms as a defending tool, it requires operational guidelines to minimize their vulnerability if the conflict takes place around or within the camp. This underlines the operational principles of armed intervention during terrorist attacks of the kind

		Mumbai faced recently. It has also an important message of the misuse of the camps during internal conflicts. The paper also focuses on the vulnerability of the humanitarian workers in this situation.
7.	"Empty arms: the effect of the arms trade on mothers and children," David P Southall and Bernadette A M O'Hare, *BMJ* 2002, 325: 1457-1461.	Trading in arms, both legal and illegal, is highly detrimental to the health of mothers and children in the countries where armed conflict occurs. This paper highlights illegal weapons exported into poor countries in conflict in Africa and Asia. Some of the important points highlighted are: ▪ More than 85% of the major conflicts since the second world war have been in poor countries ▪ Between 1986 and 1996, a major proportion of those dying as a result of armed conflicts were civilians, particularly women and children ▪ Huge differences in the health of mothers and children exist between the poor countries undergoing conflict and the predominantly rich countries exporting arms to them.
8.	"Health crisis amid the Maoist insurgency in India," *The Lancet*, Volume 371, Issue 9621, Pages 1323-1324, K. Solberg.	This paper narrates the situation in Chhattisgarh where the Naxalite (Maoist) and anti-Naxalite 'movement' (Salwa Judum) has created a health crisis. Conflicts and displacement causing mental and physical injuries, communicable diseases like malaria, problems with drinking water sources and sanitation are lucidly narrated.
9.	"Violence and mortality in West Darfur," *The Lancet*, Volume 364, Issue 9442, Pages 1290-1291, B.Woodruff, R.Kaiser.	This is an epidemiological study of the effect of armed incursions on mortality in Darfur, Sudan to provide a basis for appropriate assistance to internally displaced people. This study provides epidemiological evidence of this conflict's effect on civilians, confirming the serious nature of the crisis, and reinforcing findings from other war contexts.
10.	*Marginalised Minorities: An Overview of Internal Displacement in Asia.* <http://www.internal-displacement.org/8025708F004BE3B1/(httpInfoFiles)/8559DBE9DF43C83FC125742E0034AC1C/$file/Global_Overview_Asia_2007.pdf>	The publication covers the status of Internally Displaced People (IDP) mainly people displaced as a result of internal conflicts. Health care, health risks for children and women are one of the problems mentioned. The status of IDPs in Gujarat, North East and Chhattisgarh are specifically covered here.
11.	"Internal Migration and Health in China," Xiaojiang Hu, Sarah Cook, Miguel A Salazar, *The Lancet*, Volume 372, Issue 9651, Pages 1717 - 1719, 15 November 2008.	The authors point out to the rural migrants on their health and problems of health care in China. They share the Chinese medical fraternity's concerns about such a huge migration in China. They are: highly mobile group as both victims and vectors of infectitious diseases; second: the migrant population having worse maternal health than the urban population and third: occupational disease and injuries in migrant workers. The other aspects the

		authors mention are the health seeking behaviours of rural migrants, particularly the young migrants. It is a very relevant paper in Indian context.
12.	" 'Migrants'and 'Medical Refugees': A Short Report," Anurag Bhargava, Jan Swasthya Sahyog, Bilaspur. Paper presented at mfc Annual Meet, Jan 2009, Bongaigon, Assam.	A lucid sharing of a physician's experiences while working in a remote area in rural India. Though the migrants are sufferers economically as migration is mainly for livelihood, they are considered as a 'burden' by the public health system. This is so because they push down public health indicators and are often seen as one of the pools and vectors of many communicable diseases. They have difficulty in accessing health care services as they are considered more as medical refugees rather than medical tourist!
13.	"Migration, human rights, and health," *The Lancet*, Volume 362, Issue 9400, Pages 2019-2020. I. Wolffers, S. Verghis, M. Marin	This is an important paper analysing the global phenomena of migration. It narrates a variety of terms used - voluntary migration compared to forced displacement including internally displaced, documented and undocumented, temporary and permanent, regular and irregular ones. The papers points out that migrants accept jobs below their level of training. Despite increasing rates of skilled migration, migrant workers are most often recruited from the most vulnerable populations in poor countries. It also raises the fact that sometimes it is difficult to decide where recruiting stops and trafficking starts. Migrants generally have limited access to health facilities and resources in their new countries. They live in transnational communities with parallel identities and run high health risks. Most states view migrants as a health threat. Yet, it is migration itself that can cause health threats to migrants, which in turn causes risks for communities in receiving countries. Public-health programmes usually mirror official government policies, and public-health processes can be used to control migration.
14.	"Migration and health: a complex relation," Editorial in *The Lancet*, Volume 368, Issue 9541, Page 1039, 23 September 2006.	According to the Editorial, migration is linked to every one of the Millennium Development Goals, but the different causes and consequences underlying such movement make it difficult to identify beneficial action or policies. Suspicion, fear, and discrimination in host area within or across countries can exclude migrants from health and other services. Possibly, the immigrants may initially in better health than their peers as medical screening tests or completing hazardous journeys ensure that once settled abroad, they become vulnerable to illness and disease. Their even second-generation of immigrants can have significantly worse health than their native peers and increased rates of chronic illness. There are

		many all contributory factors for this difference: hazardous working conditions, poor housing, and labour exploitation etc. What's more, health authorities discriminate against temporary residents. "From a health perspective the priority is to balance complex and sometimes conflicting priorities to ensure that migration benefits, rather than hinders, development and health."
15.	*FMO Thematic Guide: Forced Migration and Public Health*, Bayard Roberts at <www.forcedmigration.org/guides/fmo030/fmo030.pdf>	This is a guide covering almost all aspects of forced migration: Health, humanitarianism, human rights and political writ of public health response to the situation. It highlights the international legal framework in which international humanitarian response work. It narrates the health impact including nutrition, mental health, reproductive health, communicable diseases, HIV etc., It mentions the mechanism for appraising the health care system for vulnerable population. It has a reference list for each aspect of forced migration.
16.	"Prioritising health care in complex emergencies," *The Lancet*, Volume 357, Issue 9266, Pages 1427-1429, R.Waldman.	Acute refugee crises such as those that have occurred recently in Goma, Bosnia, Somalia, Kosovo, East Timor, Angola, Sierra Leone, the Democratic Republic of Congo, to name but a few, are the emergency rooms of international public health. As with clinical emergency medicine, the primary objective of emergency relief is to stabilise the health of the refugee or internally displaced population, not to address the underlying causes. In fact, limiting the damage is often the most that can be achieved.
17.	"Communal Violence in Gujarat, India: Impact of Sexual Violence and Responsibilities of the Health Care System," Renu Khanna, *Reproductive Health Matters*, 2008; 16(31): 142–152.	Situations of chronic conflict across the globe make it imperative to draw attention to its gendered health consequences, particularly the violation of women's reproductive and sexual rights. This paper describes the history of that violence and highlights the mental and physical consequences of sexual and gender-based violence and the issues that need to be addressed by the police, the health care system and civil society. The paper calls for training health professionals to ensure non-discrimination during such conflict and social unrest. Their training should include conflict as a public health problem, their roles and responsibilities in prevention, treatment and documentation of this ''disease''. It also highlights the need to focus on the psychological impact of sexual assault on victims, and the legal significance of medical evidence in these cases.
18.	"Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: a systematic review," *The Lancet*,	Violence and rape are believed to fuel the HIV epidemic in countries affected by conflict. We compared HIV prevalence in populations directly affected by conflict with that in those not directly

	Volume 369, Issue 9580, Pages 2187-2195, P. Spiegel, A. Bennedsen, J. Claass, L. Bruns, N. Patterson, D. Yiweza, M. Schilperoord.	affected and in refugees versus the nearest surrounding host communities in sub-Saharan African countries. The paper shows that there is a need for mechanisms to provide time-sensitive information on the effect of conflict on incidence of HIV infection since during that conflict, forced displacement, and wide-scale rape increase prevalence or that refugees spread HIV infection in host communities.
19.	"Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS," Eknath Naik et al, *BMC International Health and Human Rights,* 2005, 5:1 pp 1-7. At <http://www.biomedcentral.com/1472-698X/5/1>	This research paper shows that over the years, displacement and rapid acculturation of the rural tribal population with distinct culture and practices has led to dramatic changes in their socio-cultural and value systems. Due to a poor health infrastructure, high levels of poverty and ignorance, these communities are highly vulnerable to various health problems, especially, communicable diseases including HIV/AIDS. The study shows that "…there is a dire need for targeted interventions in order to curtail the increasing threat of HIV and other STDs among these vulnerable populations."
20.	"Rapid Health Assessment of Refugees and Displaced Population," Evelyn Depoortere, Vincent Brown, 2006. At <http://www.refbooks.msf.org/msf_docs/en/Rapid_Health/Rapid_Health_en.pdf>	The guide focuses on why and how to assess rapidly health situation of displaced people in any emergencies
21.	"Resident Indians sans citizenship: what can be done for their health rights?", Jan Swasthya Sahyog, Bilaspur: <janswasthya@gmail.com>.	The document identifies agenda for advocacy for action regarding internally displaced and migrated population and its health. It suggests that a clear statement must be demanded from Govt of India about eligibility about migrants. Secondly, it also suggests considering the migrants as a community to be separately considered in programmes like NRHM. Their basic health can be tackled through training the community health worker. Thirdly, it suggests a network support system for social, legal and health care services.
22.	*Disaster Studies* http://fmo.qeh.ox.ac.uk/Repository/getPdf.asp?Path=DIS/1600/01/21&PageNo=89	A journal published in 1997 covers a variety of perspectives regarding problems of disaster victims. Disasters forces displacement and its consequences on health.
23.	*Distress Migration: Identity and Entitlements, A Study on Migrant Construction Workers and the Health Status of their Children in the National Capital Region,* 2007-2008. A Mobile Crèches Publication, 2008.	The study bears many important implications. It underlines the fact that health of migrants' children is a special concern. Since malnutrition is so widespread and persistent, health expenditure on children is a regular phenomenon. Caregiving and the health of children are closely related. The absence of crèches and AWCs deprives children of good quality child-care and growth monitoring. These children, because of their migrant status, have not been reached by SNP programmes and health programmes. This absence from government

		programmes has further removed them from the planning process. These invisible children with high levels of malnutrition over time join the unorganized unskilled workforce because they neither get the opportunity to acquire the required education or skills nor the health to sustain these in the organized workforce.
24.	*Child Labour in Cottonseed Production: A Case study of Cottonseed Farms in North Gujarat.* Ashok Khandelwal, Sudhir Katiyar, Madan Vaishnav. Dakshini Rajasthan Mazdoor Union, 2008.	As per this study "...seasonal migration is increasingly emerging as the chief mode of labour engagement across the country and especially in the rapidly growing Western economic cluster of Gujarat Maharashtra." The study finds that the child labour is extensively used for cross-pollination work by cottonseed producing farmers in north Gujarat. The estimated share of child labour is about one-third of the total labour force and the total number of child labour, depending upon the total size of the labour force, could be in the range of 60 thousand to one lakh. A little over forty percent workforce comprises of girls and women. The inhuman treatment has the psychological impact on the children as they develop a defeatist personality with resigned fate. Unprotected, unheard and spurned they become part of 'culture of silence' which is amply reflected in the silent suffering of abuses. Effects of pesticide on the health of children were also reported. Lack of response from the government is a major reason for persistence of this problem.
25.	"Trafficking of Children from a Tribal Region in Rajasthan," Manju Balana and Pradeep Bhargava, Institute of Development Studies, Jaipur.	This paper first explores the position of vulnerability of households from where children are trafficked for the purpose of exploitation manifesting primarily as bonded labour, where physical and sexual abuse at worksite is also not uncommon, However, the findings are complex - The irony is that these children though work for 12 hours a day for 60 or more days return home in better health. Households and the state despite their programmes fail to give enough nutritious food to children. but underline the fact that the transgenerational effect of poverty..
C.	**Forced Migration, Displacement, Disaster, Refugee, Armed Conflicts and Humanitarian Responses**	
26.	*Humanitarian Charter and Minimum Standards in Disaster Response.* At <http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,17/Itemid,203/lang,english/>.	A universally accepted manual for implementing the standards for primary health and health care services including shelter, food and water sanitation for the displaced due to disaster.
27.	"The problems of medical relief agencies," *The Lancet*, Volume 357, Issue 9257, Pages 713-714 T.Cullinan.	One of the greatest issues faced by relief agencies responding to medical emergencies around the world is how to extricate themselves from the situations in which they find themselves. The problems are usually greater for manmade disasters

		than for natural ones. Floods do recede, and hurricanes do blow over; the chaos they leave in their wake is tangible, quantifiable, and, at least in immediate health terms, reasonably short lived. It is usually quite easy for an experienced relief agency to determine what must be done and for a donor agency to respond - both knowing that all will be over in about 6 months
28.	"Long term displacement raises new health needs," Pat Anderson, *BMJ* 1999;318:1029 (17 April).	According to Pat Anderson, refugees displaced in a conflict situation may have an uncertainty of a level that any agency responding to the situation should have a long-term plan. According to him, describing the situation in Lebanon during the Arab-Israeli War, "People are coming to the hospitals but there is still a lot more to do. They are living in bad circumstances and it is not a healthy lifestyle for them. But they are survivors, and that is their strength."
29.	"Displaced populations and long-term humanitarian assistance," Maria Kett, *BMJ* 2005; 331:98-100 (9 July).	According to the paper, agencies must consider their long-term goals while responding for humanitarian assistance. Over an extended period, some internally displaced populations can create their own coping mechanisms., But many others become increasingly vulnerable and socially excluded. The end of displacement is a gradual process, requiring continued and sustainable support. This is particularly important for health care. Health professionals work in tandem with many other agencies and specialists in the field and have a vital role in the continuing care, assessment, and treatment of long term displaced populations.
D.	**Forced Migration, Displacement, Disaster, R Gender Perspective for the displaced wor**	**fugee, Armed Conflicts and Responses - Humanitarian en**
30.	"Refugee Women And A Gender Perspective Approach," at <http://www.unhcr.org/cgi-bin/texis/vtx/excom/opendoc.pdf?tbl=EXCOM&id=3cc41bce7>.	UNHCR guidelines for engendering perspective of displaced. An example that each refugee/displaced camps/settlements, their health and health care services needs to have a multidisciplinary and a multiperspective approaches. This includes cultural/ethnical, child and aging, men and women, adolescent approaches, etc.
31.	"Bibliography of Resources for Gendered Needs Assessments: Checklists and Guidelines," at <http://iraq.undg.org/uploads/doc/ACF1EC.doc>.	This paper is a checklist of resources about the policies, document, guidelines or surveillance tools for reviewing any responses to displacement involving women including water, sanitation, reproductive health, nutrition and violence,
E.	**Forced Migration, Displacement, Disaster, Refugee, Armed Conflicts and the role of State**	
32.	"Sometimes You Just Have To Leave: Domestic Threats and Forced Migration, 1964–1989," Christiana Davenport, Will Moore, Steven C Poe, *International Interactions*, 29:27–55, 2003. Also at	The study explores why persons flee their homes to become refugees and internally displaced persons. The authors contend that individuals will tend to flee when the integrity of their person is threatened to a placement where the conditions would be

	<http://www.bsos.umd.edu/gvpt/davenport/ii2003.pdf>.	better. The paper has analysed statistically data from 129 countries for the years 1964–1989. The findings support the conclusion that threats to personal integrity is of primary importance in leading people to abandon their homes. Actions by State for any reasons threaten personal integrity. The surprising conclusion is that after considering other factors, it is the countries moving toward democracy have higher number of forced migrants.
F.	**Forced Migration, Displacement, Armed Conflicts, Disaster, Refugees and Research Ethics**	
33.	"Ethics of research in refugee populations," Prof. Jennifer Leaning MD, *The Lancet*, Volume 357, Issue 9266, Pages 1432 - 1433, 5 May 2001.	A debate is now underway within the relief community about the proper ethical guidelines to apply when doing research in refugee populations and among internally displaced peoples (IDPs). The debate pivots on the tension between the need to develop evidence-based emergency health measures and the need to protect vulnerable populations from possible exploitation or harm. At a time when there is widespread support for the development of minimum international practice standards, there remains an acknowledged absence of good science behind much of what is done in the field.
34.	*FMO Research Guide: Forced Migration and Public Health*, Bayard Roberts, July 2004. At <http://www.forcedmigration.org/guides/fmo030/>.	A research guideline about forced migration and its impact on public health. It also connotes what are the legal and human rights provisions to prevent and treat the effects
G.	**Development Displacement and Health - a global, local focal issue**	
35.	"Flood and Erosion Led Displacement in Dhemaji and Dhakuwakhana (Lakhimpur) and Concerns Over Health Entitlements of the People," [Compiled by] Rural Volunteers Centre (RVC), Dhemaji, Assam, India, *mfc bulletin*, current issue.	A critical insight about the health impact on the community displaced by land erosion as a result of flood – a natural disaster. It is based on facts compiled by volunteers from the IDPs. It overviews the state policies, programmes and its responses to prevent such natural calamities, to provide adequate relief, to ensure adequate livelihood and health entitlement to the IDPs.
36.	"Mines, Mining and Displacement in India by Walter Fernandes" in *Managing the Social and Environmental Consequences of Coal Mining in India*. Dhanbad: Gurdeep Singh, David Laurence and Kuntala Lahiri-Dutt (eds). The Indian School of Mines University, pp. 333-344.	This paper overviews the effects of development through land acquisition by the mining industry on the livelihood, social life and health of IDPs particularly of women and children. It outlines the health impact including domestic violence and alcoholism
37.	"Peak Oil and Reverse Migration in India," T Vijayendra, *mfc bulletin,* current issue.	This is a paper predicting reversed migration as a result of recession – in this case peak oil as its main cause. It also overviews the effects of such migration. The paper predicts a chaos leading to violence between and among the people as a result of 'resource war'. An eerie forecast!

H.	***Forced Migration, Displacement, Disaster, Refugee, Armed Conflicts: Some Edutainment Resources***	
38.	*Hotel Rwanda,* Directed by Terry George, with Don Chiedle, Sophie Okonedo, Nick Nolte, and Joaquin Phoenix, 2004.	This film is a historical drama about the hotelier Paul Rusesabagina during the Rwandan Genocide of 1994. Rusesabagina's acts to save the lives of his family and more than a thousand other refugees, by granting them shelter in the besieged Hôtel des Mille Collines. It shows the impact on the health of temporary shelter situated within the area of internal conflicts. It also outlines the ethical dilemmas of the responding organizations during such conflicts.
39.	*Beyond Rangoon*, Directed by John Boorman, with Patricia Arquette, Frances McDormand, and Spalding Gray, 1995.	This is a film about an American tourist woman, a doctor on vacation in Burma (Myanmar) in 1988, the year in which the Uprising takes place. The film is based on a true story. She joins, albeit initially unintentionally, political rallies with university students protesting for democracy, and travels with the student leader U Aung Ko throughout Burma. There, they see the brutality of the military dictators of the State Law and Order Restoration Council (SLORC). Much of the film involves evading soldiers while attempting to make their way out of the country, which they eventually do. She decides to remain in Thailand treating refugees fleeing oppression.
40.	*Three Kings*, Directed by David Russell, with George Clooney, Mark Wahlberg, Ice Cube, and Spike Jonze, 1999.	This film revolves around three U.S. soldiers attempting to steal seized Kuwaiti gold bullion from the Iraqi bunkers. During their journey they become involved with a badly outgunned and desperate group of Iraqi Shia rebels who have risen against Saddam's regime but were abandoned by the Coalition. The film deals with the aftermath of George H. W. Bush's appeal to Iraqis to rise up against the tyranny, and the ensuing massacre as Saddam's loyalists put down the popular rebellion, killing many thousands of civilians. It depicts the health impact of such proxy wars not only to the civilians but to the soldiers as it is based on some reportedly true events.
41.	*Exodus,* An exhibition of photographs by Sebastia˜o Salgado, Barbican Gallery, London, until 1 June 2003. Reviewed by Sally Hargreaves medical journalist and researcher on international health issues, London. *BMJ* 2003; 326;716.	The nature of modern conflicts across the globe ensures that the majority of casualties are civilians, mostly women and children. Thus global displacement looks set to characterise this century as it did the last. As the aid community now braces itself for an increase in internally displaced people and refugees attempting to cross the Iraqi border into Turkey, Iran, Syria, and Jordan as the bombs drop on Iraq, you are left wondering whether there will ever be a way out of the cycle of human despair this exhibition encompasses. How long can we remain as informed spectators on the sideline watching such tragedy unfold before our eyes?

Barrio Adentro as Seen from the Perspective of a U.S. Health Professional

-Padma Balasubramanian[1]

The process of change that is being brought about in Venezuela and its positive results in the social area, supported by international organizations is becoming a constant motive for study in academic circles in the United States. The health mission Barrio Adentro (Inside the Barrio) is one of the areas of greatest interest.

This interest brought Dr. B. Padma, a doctor from Boston, specialized in endocrinology, diabetes, and metabolism, University Professor, and member of the American Association of Endocrinology to travel to Caracas last month to gain firsthand knowledge of Mission Barrio Adentro.

What follows is an interview that Dr. Padma gave to the press office of the Venezuelan Consulate in Boston upon her return.

What was the motivation to go to Venezuela?

I visited Venezuela for the first time in December of 2005. At the time, I had read a great deal about Hugo Chavez's victory in a fair election in 1998, the general strike, the failed coup against the popular government headed by Chavez and the inroads that were being made in health, education and workers' rights. After a very inspiring visit in December 2005, I decided to go back again in May 2008 as I was eager to experience the gains that were being made by the national accessible free health care program called Mission Barrio Adentro (Inside the Neighborhood). The program has drawn praise from the Latin American branch of the World Health Organization and the UNICEF. I am a physician with 12 years of experience in the U.S. and I believe that healthcare should not be a commodity and should be a fundamental human right. I had read extensively that the Barrio Adentro program was providing free and quality health care to hundreds of thousands of Venezuelan citizens who had never seen a doctor previously in their lives. I was excited to get the opportunity to take a tour and interview some health care professionals in Barrio Adentro II and III programs.

What is your opinion, as physician, of the Barrio Adentro Mission?

With the help of the Ministry of the Popular Power of Health and National Direction of Indigenous Health, I was able to get a tour of the Barrio Adentro II and Barrio Adentro III programs in May of 2008. Although it was a short visit, it was sufficient to give a very good idea of the tremendous work that is being done to prevent disease and promote the health of the Venezuelan people. I had a first hand experience of going to a clinica popular (popular clinic) in Catia, which is a populous working class neighborhood in Caracas. I interviewed a nurse and the doctor who was on duty at the clinic. The doctor and the nurse were both from Venezuela, they were happy to be able to deliver care to patients completely free of charge. I was informed that the clinic treated about 200 patients a day for various ailments that ranged from emergency visits secondary to trauma to patients with diabetes, hypertension and related complications like heart attacks and cerebrovascular events. In addition, the clinic treated patients with gynecological problems and also had a pediatric unit to treat children. The clinic was spotlessly clean and provided x-rays, electrocardiography and other radiology services. It provided 24 hour services, which were accessible to everyone and was in keeping with articles 83-85 of the Bolivarian constitution that enshrine free and quality health care to all citizens. I also visited an Integrated Diagnostic Center (CDI) and Integrated Rehabilitation Services (SRI) about which I will mention later. I had the distinct pleasure of meeting with the director of Barrio Adentro 3, a dynamic nephrologist, and her staff. The Barrio Adentro III program is upgrading and providing state of the art equipment and infrastructure to the existing hospitals in the country many of whom were deliberately neglected by previous administrations. In 2006, 42 hospitals were chosen for upgrades, which now have been extended to more than 90 hospitals. The final goal will be to improve all the 300 hospitals in the country. The Director of the University Hospital in Caracas told me that the premier teaching hospital in the country is a direct beneficiary of Barrio Adentro 3 program. It is known for its excellence in cardiac surgery and neurosurgery and offers free tertiary care to the population.

The Barrio Adentro program with its dedicated group of health care professionals is aiming to place free and quality primary health care as the cornerstone of the national health care system. Since its inception in 2003, it has delivered health care, both preventive

[1] *Reproduced with permission from <www.venezuelanalysis.com/print/3701>, August 7, 2008. The author is an endocrinologist based at Boston and can be contacted at <padma_balasubramanian@yahoo.com>*

and therapeutic, to vast sections of the population that previously never had set eyes on a doctor. The statistics are impressive-more than 2,700 community health centers (Consultorios Populares) have been constructed and more than 3,000 are under construction. The newly established Comprehensive Diagnostic Centers under Barrio Adentro II have handled more than 800,000 emergency room visits and since 2003 the doctors in the program have conducted over 40 million consultations. In my opinion, the Barrio Adentro program, which coordinates, with the subsidized pharmacies program called SUMED (Distribution of Medicine) and Mission Mercal (a network that distributes food and commodities at low cost) is emphasizing a holistic approach to health care.

What do you think of the Venezuela-Cuba collaboration?

The Venezuela–Cuba collaboration is based on human needs and not on profits. It is a beautiful example of international solidarity. This was a very heartening experience to witness first hand. It is well known that the Venezuelan government did not get a satisfactory response in 2003 when it appealed to the Venezuelan medical community to work in medically underserved areas in the country. The Cuban medical professionals on the other hand volunteered to be part of the humanitarian mission to deliver care to remote parts of Venezuela where doctors previously had seldom set foot. It is also well known that the Venezuelan government has been helping Cuba with its oil needs. There are more than 25,000 Cuban health professionals and about 10,500 Venezuelan health care professionals in the Barrio Adentro program. Recent statistics indicate 12,272 Cuban doctors and 1,935 Venezuelan doctors in the program.

I had the opportunity to tour a Comprehensive Diagnostic Center (CDI) and the Comprehensive Rehabilitation Center (SRI) which was attached to the CDI, both part of the Barrio Adentro II program in a middle class neighborhood called Los Dos Caminos in Caracas. The CDI and SRI have Cuban professionals from doctors and nurses to podiatrists, occupational therapists and speech therapists. The CDI had a well-stocked emergency room, an ICU with 4 beds, a general ward with several beds to treat illnesses from pneumonia to diabetic emergencies. I interviewed a patient a truck driver with diabetes and cellulitis (skin infection) who was touched by the loving and dedicated care he had received. He said it was fortunate to have Barrio Adentro to help poor patients like him who cannot afford treatment in private clinics. Patients were booked for endoscopic procedures on a routine basis. There are state of the art interventions available to treat patients with conditions like heart attacks, sepsis, asthma and heart failure.

I spent hours talking to the physician in charge whose responsibilities include seeing patients, teaching and some administration. She was happy with the successes of the Barrio Adentro program in saving lives and in promoting health care to communities that had very little access previously to health care. However, she was equally honest about the need to fight infectious diseases like dengue, malaria and diarrheal illnesses in Venezuela. Cuba of note has eradicated malaria since 1968, there have been no cases of diphtheria since 1971 and there are very few cases of gastroenteritis. Recent statistics in Venezuela are very heartening. There is a drop in the infant mortality rate from 21.4 per 1000 live births in 1998 to 13.9 at the present time. This is likely from expanded vaccinations program and reduction in infectious diseases. Every Cuban professional that I met exuded compassion and a passion to help their fellow human beings regardless of their color, nationality or political affiliation. They felt that serving the health care needs of people was of utmost importance and they would stay as long as they were needed. However, there was general optimism that Venezuela under the Bolivarian process is training enough medical professionals whose presence in the Barrio Adentro program will be increasingly seen in the future.

Is there something like Barrio Adentro in the US or India?

There is no program like the Barrio Adentro in the United States or India that I am aware of. The U.S. has some of the best doctors and hospitals in the world. However, it is no secret that more than 45 million Americans are without health insurance. Uninsured people don't often seek medical care except in an emergency situation. They are afraid of being saddled with debt. Among others, the Physicians for a National Health Program (PNHP), which has more than 10,000 chapters in the U.S, is advocating a comprehensive universal health care program to all Americans. The Indian health care system is one of the most privatized in the world. 40% of hospitalized Indians are forced to sell assets or borrow money. While a small section of the Indian population has prospered under neoliberal policies, the vast majority is being pauperized and is at the mercy of private hospitals and doctors in private practice.

Any thing else you would like to add?

I did not directly experience the work being done by the Barrio Adentro program with the indigenous

population in Venezuela who make up more than half a million. However, my conversations at the Ministry of the Popular Power of Health and National Direction of Indigenous Health were very positive. A doctor and dentist in the Ministry said that the public health system being built in Venezuela is sensitive to different people and cultures. The system is against having a paternalistic attitude and is encouraging the indigenous communities to be partners in their health care.

Finally, I would like to share two of my favorite quotes with you. One is by Reverend Martin Luther King who said "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." The other quote is by Rudolf Virchow the public health activist and pathologist who said "Health is Politics and Politics is Health." Cuba has showed us that a band aid approach will not eliminate disease and health care has to be in concert with a radical political and social transformation of the society. Now, Venezuela, through the Bolivarian process is addressing the injustice and inequality in health care through Mission Barrio Adentro and other social programs and this simply would not be possible if there was no political will.

TB Hospital Sold for 1 Rupee –
Private Players Jump into Medical Education in West Bengal

December 14, 2008

Privately owned educational institutions have been on a roll from the days of the Rajiv Gandhi's new economic policies. Here, in West Bengal, the left-front government joined the bandwagon a little late but has been quick to champion its cause with immense dedication – testified by the mushrooming of more than 150 professional degree colleges in last few years. The newest in the list is the KPC Medical College located at Jadavpur, in the south of Kolkata.

Only a few days ago, this was what was well-known as the K.S.Roy Tuberculosis Hospital, one of the oldest of its kind in the whole Asia. The 200 bighas of land and almost the entire infrastructure of the hospital was handed over to one NRI businessman Kali Choudhury at a price of INR 1 for setting up of a privately run medical college. But before that, the entire facility of the hospital was systematically rendered useless and the admission procedure was made as complicated as ever. Thus, functioning of the hospital was crippled. Alongside this, there was a steady campaign claiming that TB is not as deadly now as it used to be, and that percentage of TB patients is declining to indicate that there was o need to have such a super-specialty hospital. But it's not hard to detect the lie once you look at the 2008 WHO report where India tops the list of TB affected countries with the highest number of victims. In fact, one in every five TB affected persons in the world is an Indian. NTO reports that the number of multi-drug resistant Tuberculosis cases is ominously increasing and might actually complement the growth of AIDS infected cases in India. Clearly, only DOTS clinics are not enough to fight this menace. And placed in this scenario there's little reason that one can find in the dismantling of a fully grown TB combative infrastructure.

Even if one reconciles with the fact that there is no need for an entire hospital to treat TB patients, how can one come to terms with the fact that a public utility space built on public money is being gifted to private promoters to rake in the moolah in the name of producing degree doctors? Is there a surplus of public health care facility in Kolkata and West Bengal? Why can't the TB hospital be modified and changed into a general government hospital? These are obvious questions, which the government of the day sadly refuses to answer. Rather, the government is more interested in setting up a MBBS degree sales counter in the name of a private medical college, where all the regulations of the medical education in the country can be flouted with ready connivance of the state apparatus. It is difficult to understand how the proposed medical college 'managed' no objections when it hardly meets the standards set by the MCI. Even without setting up the 'Fee determination Committee' and the 'Admission Procedure Control Committee' (and thus blatantly ignoring the Supreme Court directive), the government gave go ahead to the college promoters to start the admission procedure. Guardians of the prospective students were made to sign declarations of agreeing to any fee structure that the authority deems fit. When a PIL was filed in the Kolkata High Court in this regard, an ad hoc price of 19.5 lakh for the 77 management quota seats and 6.5 lakhs for each of the 50 merit list seats was declared. Interestingly, where there have been hordes of litigations in the courts where different state governments challenge the private players in the determination of the fee structure, West Bengal government stands firm in solidarity with its private partner in the current PIL. Also, stories of gross manipulation of even the merit list, bypassing of the State level Engineering and Medical College entrance examinations (WBJEE) by holding separate tests are doing rounds.

This is not something isolated. A similar proposal of converting the Sagar Dutta Hospital in Kamarhati to a private medical college promoted by the Apollo group and several such other schemes are in the pipeline. The peoples' government is so deeply involved in opening up of the medical education and healthcare market that it can hardly see the damage it is inflicting on the already crumbling tertiary health care infrastructure. The people here have a task cut out to resist such subversion of public access to healthcare.

<http://sanhati.com/excerpted/1164/>

By Bishan Dutta. *Translated by Suvarup Saha, from Shramikshakti Newsletter, November 2008.*

Visiting Walong

Notes on my Visit to Arunachal Pradesh

-Dhruv Mankad[1]

Introduction

Arunachal Pradesh - the Land of the Rising Sun - is the largest state of the North East region where the dawn breaks. Literally speaking, it has the sunrise point of India – Dong village. The state is twice as large as Kerala. The diversity of the land and rivers, of grass, plants and trees, of birds and animals, of neighbourhoods, of crops and of the people residing there is such that it would not be wrong to call it a miniature India.

Public Private Partnership is something, which has taken roots after the NRHM has been launched. Several governments announced and tried to hand over the PHCs to voluntary organizations to manage it. The purpose was that they could apply innovative methods to make services more accessible and user friendly. States like Karnataka tried it quite successfully earlier. Arunachal Pradesh being a remote state it was a challenging field to provide Primary Health Care. Karuna Trust accepted this challenge and the Government handed over 9 PHCs covering approximately 2 lakh population (about 20%). I decided to visit at least one of the PHCs to learn the good practices applied at the PHCs by Karuna Trust.

Of course, there were nostalgic elements in urging me to visit Arunachal Pradesh. During the 1962 Indo-China war, as a 10-year old but avid reader of newspaper, I could recall Battles of Bomdi La and Walong as braveheart efforts of Indian soldiers! Later, during the 1965 Indo-Pak war, our social studies teacher replaced teaching with assignment to recall the previous Indian wars with narration about the army which fought such battles, the weapons and ammunition used etc. And once again, in 1975, as a fresh doctor in his first job seeking exercise, I had applied for MO, PHCs posts in Arunachal Pradesh – and Walong was one of them! So, once a happenstance, twice, a coincidence but thrice being a conspiracy, I *had* to go there. Now, the absurdity of the India-China War or war in general is clear but the old memories remain. So I went. This is a result of my investigations there!

Figure 1:
The Lohit River and the Road to Walong

Arunachal Pradesh: A Profile

About 11 lakhs (as many as we are at Nashik, the town I stay!) only live there in the whole of the State. It is distributed in an area of about 84,000 km^2 with population density of 13 per km^2. The State's neighbours are Bhutan in the West, Tibet-China in the North and the North-East, Myanmar in the East, Nagaland in the South East and Assam in the South. It has a 1600 km-long International Border with China – perhaps the longest any Indian State has.

Rivers originating from the Higher Himalayas and Arakan ranges cut across Arunachal Pradesh's hilly and rugged terrain. They flow as Brahmaputra's tributaries. Brahmaputra also cascades through the Himalayan range and enters India in the Upper Siang district. Arunachal Pradesh has three broad climatic zones: hot and humid subtropical in the foothills, cooler zone of lower Himalayan ranges and cold zone of Himadri area with mountains with snowcaps. Average rainfall in the State varies from 2000 to 8000 mm. About 61 percent of the State's area is covered by forest and 81% by trees. (Source: <http://www.fsi.nic.in/sfr2005/Chapter%208/Arunachal%20Pradesh.pdf>)

People here grow crops like maize, wheat, millet, rice, soyabean, peas and chick peas, potatoes, ginger, rapeseed and mustard, chillies and seasonal vegetables like pumpkins, cucumbers, cauliflower, cabbages, etc. Leafy vegetables like spinach, fenugreek, mustard (rai), heartleaf, etc. Most of this agriculture is jhum – slash forest and burn and cultivate. In the plains of Arunachal Pradesh, fruits like pineapple, apple, oranges, lemon, lichi, papaya, banana, plum, guava, cherries, peach

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walnut, and almond are also grown - and so are cardamom, mushroom and medicinal plants.

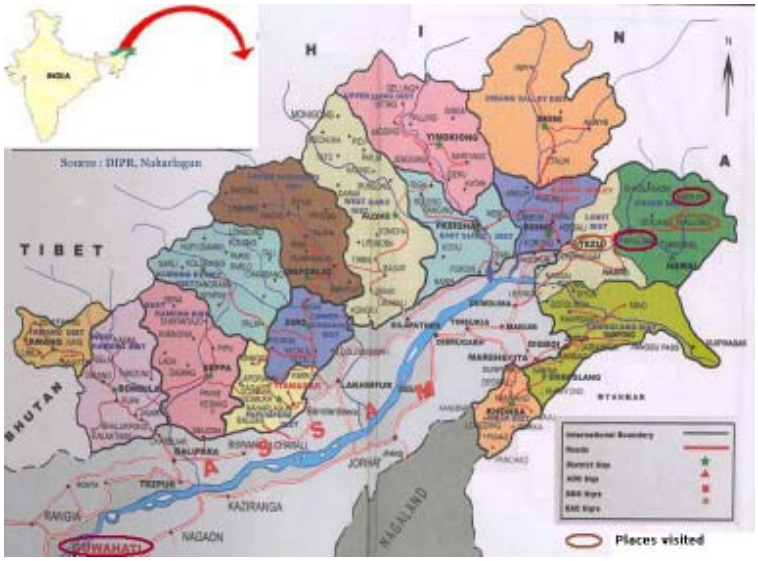
People and their Profile

Arunachal Pradesh is a happy home for scheduled tribes. About 64% of its people belong to one of the 26 STs and more than 100 subtribes. The Arunachalis speak Assamese, English and broken Hindi apart from their own dialect. They have no original script. Culturally, these tribes follow broadly one of the three religious cultural practices: Mahayana and Hinayana Buddhism prevalent among Monpas, Sherdukepens and Khamtis and Singphos respectively, Sun Moon God worships among Adis, Mishmis and Apatnis etc. and Vaishnavites among the Nochte. The tribals are distributed in the 15 districts the State is divided for administrative purposes (See Table 1).

Arunachal Pradesh has the largest population among the North Eastern States- 10,979,68. About 20.95% of population and 14% of the STs live in urban areas. West Kameng has the lowest and East Kameng and Lower Subansiri have the highest sex ratio. The child sex ratio (CSR), which is less likely to be affected by migration, has registered a sharp decline in the state from 982 in 1991 to 961 in 2001. Since many studies show that in predominant tribal societies, there is less gender discrimination, so this requires further investigation. Female literacy rate for Arunachal Pradesh, according to census 2001, was only 44.24 per cent, much lower than the national average of 54.03 per cent. (See Table 2)

The Total Fertility Rate of the State is 3.0. The Infant Mortality Rate is 37. The Sex Ratio in the State is 893 (as compared to 933 for India). (See Table 3)

Figure 2 (below): Map of Arunachal Pradesh



Public-Private Partnership with Karuna Trust

Karuna Trust , instituted in 1986, is a public charitable trust is located in BR Hills. Karnataka. The Trust began as a response to the prevalence of leprosy (21.4 per 1000 population) in Yelandur Taluk, Chamarajnagar district. Prevalence of leprosy dropped from 21.4/1000 population in 1987 to 0.28/1000 in 2005. From leprosy control, Karuna Trust diversified into epilepsy, mental health, tuberculosis and eventually, management of the PHC at Gumballi. Over the years, the scope of the trust's work has grown to include various other health aspects as well to integrated rural development.

Figure 3: The Mishmi

The Trust was handed over the management of Gumballi (Integrated Rural Development Project - Yelandur) PHC in 1996 in a unique and pioneering example of public-private partnership in primary health care. All national health programmes including Reproductive & Child Health (RCH) are important components of the activities. The success of Gumballi PHC and its impact as a 'model PHC' have strengthened the idea of PPP (see Table 4). Further, the following specialist care services have been integrated with primary care in the Gumballi PHC. Now, Karuna Trust runs 26 PHCs in all the districts Karnataka and 9 primary health centres in Arunachal Pradesh. The Government provides Rs 26 lakhs per PHC per year. In addition, the partner organization has to generate about Rs 2.5 lakh (10%).

Anjaw District: Some Facts

Anjaw district was carved out of Lohit District in 2003. It remains the Eastern most district of Arunachal Pradesh with an international border with Myanmar and the disputed line of control with Tibet-China (See Table 5).

Walong PHC

Walong is a small cantonment and administrative town. It lies on the west

bank of the Lohit River, approximately 20 kilometres south of the Chinese border. Just north of the border lies the Tibetan trading town of Rima. Walong is approximately 180 km by road from the neighbouring district headquarter town of Tezu and about 100 km from Hyaliang having the nearest First Referral Unit (FRU). The town is connected to Tezu by a thrice-weekly bus. Visiting Walong one follows the route: Tezu (Health HQ)- Hyaliang (CHC)-Walong (PHC) and its SCs at Yesong and Kibhutu. This route is also the lowest (1600 m at Kibhutu) trade route with Tibet-China. Walong PHC is situated in Anjaw district, which was a part of Lohit district till 2004 when it was carved out with Hawai as proposed district HQ.

Box 1: Staff and Coverage Area of Walong PHC and SC

	Staff	No of villages	Total Population	Distance of SC from PHC
Walong PHC	2M Os, 1GNM, 4 ANMs, 1 Lab Asstt., 1 Pharmacist 1 NA, 1 Driver, 1 Sanitary Asst	8	567	-
Yasong SC	2 ANMs, 1 Health Asst	8	428	24 km
Kibhutoo SC	2 ANMs, 1 Health Asst	8	483	20 km
		24	1478	

Infrastructure

- The PHC is situated almost opposite the GREF DET of Indian Army. It has been there since 1969. The PHC has been shifted just a week before my visit from the earlier wooden building to the concrete construction. Almost all staff, infrastructure, equipments and medicines as per IPHS standards were in place.
- An ambulance is available for outreach services, though very few villages are accessible. Walking or really, trekking is the only approach possible for 30 minutes to 2 hours. No two wheelers are available.
- The old building would be used as quarters for the staff because it is difficult to get it in the township.
- No OPD patients were available till 10:30 am. One patient with typhoid fever was admitted in the 5-bed ward.

Services

The table below gives the performance indicator justifying PPP, observations and gaps .

	Services and Performance Indicator	Observations, Gaps if any
1	Antenatal care 16	§ Registered Pregnant Women adequate. 8-9 women visited every month. However, more than one visits difficult because of household's location, communication and transport facilities & availability of women.
2	Deliveries Home deliveries 1 Instt deliveries 3	 § Home deliveries 1 per mt. § Instt deliveries 1-2 only per month.
3	Post natal care No indicator	§ Essential if home deliveries the main pattern, to reduce mother's and new born's morbidity and mortality § PNC coverage is low
4	Newborns and their care No indicator	§ Breast feeding within 1 hour but after bath. B/F erratic as mother very young – 16 year, also a working women.
5	Jan Swasthya Yojana§ All pregnant women	Have not received any JSY payments
6	At risk mothers and babies No indicator	§ No risks recorded in the past 3 yrs. According to staff, no pregnant women were anaemic.. Staff recalled anaemia, BP, urine albumin and /or sugar, convulsion, age of mother as risk factors for mothers. § Recalled only delayed and obstructed labour as risk factor. All considered primipara a risk factor both for baby and mother and referred to PHC/FRU.
7	Referral No indicator	§ As above but often delay in referral due to non availability of vehicles. § No other than ambulance at Walong available at Yasong, Kibhutu. ITDP/BSF or Army

		vehicles are not used for referral
8	Immunization 20	§ Coverage poor, reasons as above. Also mothers are resistant to OPV or injections for newborns.
9	Health education 51	§ Most sessions are at the SC or PHC as availability of community is not dependable at the community level.
10	OPD 50 per day (580 per month)	§ 20-30 OPD patients, common health problems fever, malaria (PF, PV) typhoid, jaundice, aches and pain, diarrhea, ARI in children, worms, injuries, skin infections. No specific problems from women reported. As per some sharing by the staff, women do suffer from manifestation of domestic violence but not yet on record.
11	IPD 10 per month	§ 5-6 per month mainly fever, injuries, jaundice and diarrhea, typhoid
12	Malaria test 30	§ Lab tests are routinely done. PV more common. (PF% lesser than state indicator?)
13	DOTS	§ Not yet recognized as a DOTS centre.
14	Birth Weight at Walong PHC in 2006-2009 period No indicator but 30% expected below 2.5 kg	§ Mean BW in Girl Child (n=27) 2.945 +/-0.503 & in boys (n=33) is 3.056 +/-0.436. There is no significant difference between BW of boys and girls. LBW seems to be uncommon here. However, ICDS data about malnutrition was not available
15	Medicines	§ All the medicines as per the EDL medicines were available at the PHC and SCs. § However, use of Cefotaxime for ARI etc in children and adults (if Amoxicillin not effective). Mefloquin and S-P, both were in stock and as per the MO i/c, it was in use. There is no guideline if the area is declared as a chloroquine/S-P resistant one. § It was not clear whether co-trimoxazole for severe bacterial infection (as per the IMNCI guideline) is effective or not because as per the MOs, only ceftoxime was preferred. Gentamicin was not used though recommended in IMNCI. § Pitocin was being used at the PHC and SC, during home delivery, too. This is not at all recommended even in at risk deliveries.
16	Other Observations	§ No target screening started yet for BP, Diabetes, mental health, malnourished children. § Data available only with ICDS for malnourished children. § Opium addiction among men and also women is a major public health issue. Illegal cultivation of opium is a challenging factor.

Yasong and Kibhutu SC

Yasong SC is situated on the bank of Lohit River but away from any habitation. The community raised this since they had no access to any medical services. Kibhutu SC is situated at the military camp at the end of the PHC coverage area. It is also about 3 km from the Indo Tibet/China existing LoC. All villages are toward the PHC.

§ All ANMs were present with the health assistants. All arrangements looked very new. All medicines were in place – very freshly stocked. The board and the concrete steps to climb up to the road, were new and also in place.

§ Its location may not be convenient because none of the villages are easily accessible from the SC.

§ 3-4 OPD per day and currently 16 pregnant women at Yasong. OPD about 10 per day at Kibhutu SC. Common illnesses: fever, cough, diarrhea, typhoid, injuries, malaria, white discharge, backache in women. Patients include soldiers at Kibhtu

§ Most deliveries at home. Most deliveries are conducted by local 'untrained' dais, family members. Sometime ANM is called. The staff are on call and accompanied by the Health Asst.. His presence has ensured that the calls have increased. Also, he is able to pay attention to other than clinical tasks.
§ Immunization coverage for children, ANC and PNC coverage low. Again accessibility and mobility a problem.
§ Sparse coverage, difficult accessibility, unavailability of mothers because of their engagement in farm labour, were clearly deterrent factors
§ Recall about symptoms of at risk mothers and fetus were limited
§ Medicines were available including Cefotaxime, Pitocin.
§ Infrequent visit by MO etc in past 2 months at Kibhutu, No communication system except PCO for a limited time. JSY not received or paid.

ASHAs at Walong PHC

There were 4 ASHAs present in the morning, about 5 joined later. They had accompanied the patients.

§ ASHA: Age range was between 20 – 28 years. They were mothers of 1 to 3 children. Average age of marriage was 14! Mothers when 16. They interacted in broken Hindi and even spelt their names in English.
§ They were 3-5th standard pass. The schools were quite far from where they lived.
§ Each ASHA had an apron but again new one. When asked when they were given the apron, they said just a few months back. No medicine kit was brought.
§ Selection: the villagers nominated them as mostly they were with some education and village's daughter-in-law. Belonged to various tribes.
§ Training: They had received all the ASHA training material. VHAI team trained them once.
§ Tasks: Ranking was done by all the four present - Escort patients and JSY
§ Other tasks were: Dressings, Headache, Pain in abdomen, Cleanliness and Condom distribution
§ Medicine Kits: No one had brought the kit, Kit contains DDK, First Aid, material, Condoms, paracetamol, cyclopam and chloroquine
§ Remuneration: None as coverage area very small and No institutional deliveries
§ Mobility and communication: No modern communication system, no mobility except on foot, But word reaches through traditional method of oral communication
§ VHC: Mostly not formed or not functional, No role clarity, No training/orientation
§ Flexifunds with VHC: Accounts opened or to be opened but bank quite far
§ Recordkeeping: No record keeping as not yet trained

Some Cutting Across Points

1. PHC Management

§ Remote PHC are in place. A printed guideline about PHC management available. Activity plan available.
§ HR management: Staff in place. A teamwork and good rapport with the technical and HR management staff. Rotation practice every 3 month. Quarters under consideration. Staff from different community and states. Staff still motivated.
§ Staff rotation can be implemented as an incentive with completion of certain outcome targets instead of time period. It can be used as a negative tool also.
§ A technical supervision can be added with a mobile medicine supply/indenting and on job training tasks can be model worth trying.
§ Routine mobility possible through vehicle. Mobility, communication and community mobilization can be emphasized for better ANC, immunization
§ A Primary Health Care Clinical Protocol can be prepared. Such a protocol manual is ready with the Government of Maharashtra.
§ Increased population coverage for SCs/PHC can be required.
§ Availability of a senior medical officer is a great advantage..
§ Low workload can be seen as an opportunity for creative work eg documentation/action research.
§ Involving local community to start simple activities like use of ORS, use of medichlor of stream water.
§ Regular power generation and temperature monitoring of ILR is again equally important for effectively maintained cold chain.
§ Enhanced communication system using military wireless facilities for emergencies can be explored.

2. Medicine supply

§ Regular medicine supply as new medicines were present at all the places
§ Inventory up dated. Indentation was from SC to PHC to HQ at Itanagar and then ordered.

§ All EDL medicines were available. No expiry date medicines at stock.

§ LOCOST stock with an NGO network at Itanagar and Tezu can add advantage for medicine distribution.

3. Training

§ ToT to existing PHC/SC staff regarding ASHA training, particularly for ASHA with lower education level may/would add value to their performance.

§ On job training as a role of MOs – to combine with field visit, should make their tasks easy.

§ CME to MOs/ ANMs/ASHAs regarding challenging public health issues incl MDGs, IMNCI etc. This should include rational drug therapy, updating diagnostic skills and management of important illnesses like ARI, snakebite, and identifying pregnant women with all high-risk indicators for mother and the baby etc.

§ ASHA should have a wider understanding about NRHM and their role as Activist.

4. Record Keeping

§ Computerized record keeping with in house training can get the staff, particularly younger ones more involved.

§ Using records for data analysis with a research attitude can make the MIS accurate.

5. ASHA Programme

§ ASHA were highly motivated. Clear role orientation, follow up training, field level supervision and continuous enhancement in their skills can make them effective interface with the community.

§ Financial rewards (regular+ task based) can ensure their motivation to act as an social activist.

6. Intersectoral Co-ordination

§ Coordination with ICDS (ICDS CDPO office was locked!) and information about malnutrition essential for an effective child health care.

§ Regular funds release from NRHM can ensure staff for motivation for innovative NRHM activities.

Hyaliang CHC

Hyaliang is situated on the way from Tezu to Walong. It is also quite close to Hawai – the District HQ. Hyaliang CHC is the First Referral Unit for PHCs in the area.

1. **IPHS standard:** Most of the standards for furniture, medicines were fulfilled. No blood storage facility available as yet. No experts were available as yet.
2. **No maternal deaths**: While discussing with Dr KK Singh, (MBBS) the Superintendent, Hyaliang CHC, it was surprising to note that in his 15 years of services he had not heard of a single case of maternal death due to pregnancy though fetal loss was recorded. According to him about 25% pregnant women are anaemic. This was contrary to what the PHC Walong staff felt.
3. **Reduction in IDD**: According to him IDD has reduced substantially. No goitre is seen now while earlier several cases were seen.
4. **Malnutrition**: Although he does not get many severe PCM patients, 25% of children below 3 are malnourished. Infant deaths are higher than Indian figure.
5. **AYUSH:** The CHC has a separate Homeopathy clinic. Mostly children are referred to thzere. About 10 patients a day is the daily OPD.
6. **PF Malaria** is quite common there.
7. **Medicine supply** is adequate and patients donot have to buy outside. There is no medical shop nearby.
8. **RKS** was not very active and oriented about its role. Also, no sources for donation available at such a town. Facilities like dharmashala was not available.
9. **NBCP** During the previous health camp about 20 cataract operations were carried out - the first such camp.

Conclusions

1. A good, promising practice of Public-Private Partnership with the spirit of NRHM. Promising only because several gaps are not easy to overcome, e.g., transportation, staff availability, etc. Also because human development, staff motivating and training is feasible with limited resources. Pressures from top may disregard innovative approaches and encourage 'showcasing' - a very detrimental outcome.
2. A difficult terrain, remote and isolated location has at least a full-fledged PHC in place with somewhat mobile team.
3. All management systems are in place, if operationalized regularly and vigorously can make this as an effective model.
4. A challenging area for action research programs in community health. This can be an advantage of a PPP model if it is encouraged.

My heartfelt thanks to everyone particularly to Ms Moushumi Gogoi, Dr Sonaval and the staff at Walong PHC for the help and hospitality provided during my visit. My personal thanks to Dr H Sudarshan for him to allow me to visit Karuna Trust, Arunachal Pradesh.

Table 1: District and the Main Tribes

District	Main tribes
Tawang, West and East Kameng, East Kameng Papum Pare	Monpas, Mijis, Khowas, Sherdukepens, Banginis
Lower and Upper Subansiri	Apatnis, Nyishis, Tagins, Hills Miris
West, Upper and Lower Siang	Adis, Galos including Mambas, Khambas
Dibang Valley, Lower Dibang Valley, Anjaw and Lohit	Mishmis, Khamtis and Singphos
Changlang, Tirap	Nocte, Wanchos, Tangsas

Table 2 Demographic profile of Arunachal Pradesh – District-wise (*Source: Census 2001)*

	Total Population	Sex Ratio	Literacy Rate female	% ST
Tawang	38924	963	31	75
West Kameng	74599	749	49	50
East Kameng	57179	985	29	87
Papum Pare	122003	899	62	57
Lower Subansiri	98244	985	36	90
Upper Subansiri	55346	973	43	90
West Siang	103918	913	53	82
Upper Siang	33363	858	39	78
East Siang	87397	937	53	69
Dibang Valley (New)	7342	840	43	44
Lower Dibang Valley	50378			66
Anjaw	18441	857	45	77
Lohit	125086			32
Changlang	125422	905	40	36
Tirap	100326	911	21	84
Total	1097968	901	38	64

Table 3: Health Indicators of Arunachal Pradesh and India

Sr. No.	Item	Arunachal Pradesh	India
1	Crude Birth Rate (SRS 2007)	22.2	23.1
2	Crude Death Rate (SRS 2007)	5.1	7.4
3	Total Fertility Rate (NFHS III)	3.0	2.7
	Neonatal Mortality Rate (NFHS 3)	34	39
4	Infant Mortality Rate (NFHS 3)	61	57
5	Maternal Mortality Ratio (SRS 2001 - 2003)		301
6	Population below Poverty line (%)	33.47	26.10
7	Annual Parasite Incidence (API) for Malaria per 1000 population)	37	1.67
	Slide positive rate (SPR)	13.98	
	Plasmodium Falciparum Rate (PFR)	3.64	
	High risks PHC for PF	71	
8	Annualised total case detection rate for TB (per lakh pop.)	230	
	Annualised total new smear positive detection rate for TB (per lakh pop.)	75	
	Cure rate %	86	
9	Institutional Deliveries	31.2	
	Safe Deliveries	33.4	
	Three more Antenatal check-up	36.4	
	Received 100 or more IFA tablets	56.3	
	PNC visit within 2 months	23.3	
	% children 13-24 months fully immunized	28.4	
	% children given ORS	33.5	
	% children given treatment for ARI	43.6	
	Prevalence of anemia	66	

Table 4: Unit Cost of a PHC under PPP

	Units	Amt	Total
Medicine and Health Care Consumable			**350000**
Medicines		300000	
Material and Supplies		30000	
Lab reagents etc		10000	
Surgical item		10000	
Maintenance, Furniture, Equipments			**550000**
Civil Works		100000	
Office Furniture		50000	
Hospital Furniture		100000	
Surgical Equipment		300000	
Administrative Charges			**100000**
Water and Electricity		10000	
TA		20000	
Ambulance Services		70000	
Personnel Cost			**1937000**
MO	2	366000	
Pharmacist	1	99000	
Staff Nurse	2	199000	
ANM(PHC)	2	162000	
ANM(SC)	6	486000	
LHV	1	90300	
Lab Tech	1	90300	
Driver	1	61524	
Health Assistants	2	180600	
Sanitary Assistants	4	201648	
TOTAL			**2937000**
From NGO source (10%)		less	**293700**
From Govt of ArP			**2643300**

Table 5: Some Facts about Anjaw District

1	Total Population	18, 428
2	Literacy Rate	31.32%
3	Female Literacy Rate	17.24%
4	Sex Ratio	816 females per 1000 males
5	Main Agricultural Products	Maize, Millet, Paddy, Beans
6	Main Horticulture Products	Cardamom, Orange, Pears, Plum, Apple
7	Total Population	18, 428

Table 1: *Source: A Development Profile of Arunachal Pradesh, Department of Planning, Government of Arunachal Pradesh, Itanagar*
Table 3: *Source: State Project Implementation Plan 2008-09, Department of Health and Family Welfare, Arunachal Pradesh, 2008*
Table 4: *Source: State Project Implementation Plan 2008-09 as Arunachal Pradesh in Arunachal_NPCC_08_09.ppt dated 25.03.08*
Table 5: *Source: <http://www.arunachalpradesh.nic.in>*

Hearing at the Raipur Sessions Court

March 17–20, 2009

- Mira Sadgopal[1]

At the 35th Annual Meet of MFC near Bongaigaon, Assam, in January 2009, we decided that at least two members of MFC should attend the monthly court hearing in support of Dr. Binayak Sen at Raipur."In January, Drs Anant Phadke and Sridhar attended the trial. In February 2009, Drs Vandana Prasad and Dhruv Mankad attended it."

In March, Sabu George and I were present at the hearing. Each time a report is given on the MFC egroup. The hearing's first day on 17th March followed the initial bout of the *'Raipur Satyagraha'* on March 16th, a planned demonstration of civil disobedience to continue every Monday in over coming months. Details can be found at <www.raipursatyagraha.wordpress.com>. A number of persons, who either supported or participated in the *satyagraha* and courted arrest for the release of Dr. Sen, also attended the court hearing on the 17th. These were Anand Patwardhan (film-maker, Mumbai), Ashim Roy and Rakhi Sehgal (New Trade Union Initiative, New Delhi), M.H. Gandhi (Ahmedabad), Sandeep Pande (Aasha Parivar, Lucknow), Satya Sivaraman (film-maker, New Delhi) and Sajjad Hussein (a Kashmiri student currently studying Human Rights at Jamia Milia Islamia, New Delhi). Ilina Sen was also present.

Prior to the start of the court proceedings there was an interesting occurrence. At exactly 11am, Judge Balwinder Singh Saluja came into the courtroom. Seeing all of us sitting there, he instructed the police inspector to take us out and record our names etc. Anyone about whom the police are suspicious might not be allowed in the court, he said. The inspector took us into a side room and asked us one by one for details (name, address, cell phone number), which he wrote in a diary. Then he said only close relatives of the accused are allowed inside the court. Sabu and Rakhi protested that this is an open court and there is no such rule for restricting the public. Only, as the judge had told us, if the police suspect any of us there could be a restriction. Then he said he suspects Gandhi and Sajjad as they are from Gujarat and Kashmir (and implying, obviously they are Muslims). We said we could vouch for them and asked him to let the judge pronounce on this. Back inside the court he complained to the judge. We insisted that Sajjad and Gandhi would stay with us. Given our persistence, the judge asked the inspector to give his objections in writing, which apparently ended the matter. At this time Ilina entered the court.

Binayak and co-accused Narayan Sanyal and Piyush Guha were brought into the court room around 12 noon along. It was a surprise to see him clean-shaven without his familiar long beard. He looked glad to see so many and varied supporters at the hearing. All three witnesses brought into the court on this day related to the allegations against Sanyal. Witness #1 was a police officer from Andhra Pradesh, #2 was an officer of the Chhattisgarh police and #3 a person named Gopanna. Just before closure, Binayak sought the judge's attention, saying, "You are not deciding on my plea for health care. I need urgent medical investigation... I am suffering from chest pain (angina) and hypertension. Last month I requested permission to be diagnosed and treated at a hospital of my choice." Thereupon the judge replied sharply, "On what basis are you saying that I am not doing anything about it? I passed an order on your plea." Binayak said he was unaware of any such response. After this the judge sharply remarked, "Whatever else you have to say, submit it in writing." He then closed the session at 2 pm.

On the 18th Sabu and I were joined by Jacob from Jan Swasthya Sahyog, Bilaspur. Before it began, Binayak apologised to the judge for his 'outburst' the day before, saying it was only because he is anxious about his health. This was acknowledged. Witness #1, a member of the Chhattisgarh police, again referred to Narayan Sanyal's case. In the following interval, the judge asked Binayak details about the doctor whom he wishes to see, etc. and proceeded to write out a fresh order. Then after a short while all three accused were taken back to the police van and we were told that the arrival of witness #2 was delayed. Outside each of us was able to talk with Binayak through the grilled window – for me it was the first time in four visits to Raipur since his arrest. He asked about the people who had come the day before and the *satyagraha* on the 16th. After a further lapse of time, Witness #2 arrived – I was surprised to recognise Shoma Sen, a senior lecturer in a women's college in Nagpur. Her train had been delayed. All returned to the courtroom, but as lunch hour was to begin we were told to come back by 2:45 pm. Meeting after more than a decade, Shoma and I found a quiet place to talk over a bite of lunch.

As Shoma occupied the witness stand, gross errors in her name (attached with an alias she never had) and age (38 years instead of 50) were found in the police statement. She was interrogated regarding a letter of hers found in her husband's possession when he was

[1] *Email:<miradakin@gmail.com>*

arrested in Patna in 2007 (as she had separately explained to me) on charges of Naxalite involvement from nearly thirty years ago. She acknowledged that this was in fact her letter. Writing it in 2005, along with news of herself and their daughter, she had mentioned Binayak's name and appreciated his role in the investigation of the Khairlanji incident (Bhandara Dt., Maharashtra) which she had organised on behalf of PUCL and the Nagpur-based Committee Against Violence On Women. She had also mentioned Binayak's concern at the time to investigate prison conditions in response to a letter from a prisoner reporting a particular unsafe and inhumane situation. The reception of the court – judge and each of the lawyers – was respectful and my impression is that, rather than implicating Dr. Sen as a naxalite colleague, the testimony has merely bolstered Binayak's role as a civil and human rights activist. The court was adjourned at about 4:25 pm as Sabu left to catch a flight back to Delhi.

On the 19th, I was alone in attending the hearing. There were only two witnesses. Interrogation of the first witness was largely complete before Binayak, Sanyal and Guha were brought into the court. This man was a police inspector from Rohtas (Patna Dt., Bihar) who described in great detail the circumstances around the arrest of Shoma Sen's husband (Tusharkanti Bhattacharjee) on 18th September 2007, alleging him to be a 'hard-core Maoist' and mentioning that in his possession was found the letter from his wife in which Dr. Sen is mentioned. The second witness was another police inspector from Bihar who had passed on the statements and photocopies of documents to the Chhattisgarh police. The testimony with the cross-examination appeared trivial to me. The court adjourned early at about 1 pm. Binayak's lawyer commented that the first witness was spurious, as Bhattacharjee's is a separate case and Shoma Sen has acknowledged that the letter is hers.

On the 20th, again I was the only outsider in the court. When Binayak and the other co-accused entered, the judge spoke briefly to him about the matter of getting his medical examination done soon. Regarding the witnesses, on this day I'm not sure if there was more than one, as I had to leave early to catch my train. This was Arun Kumar Dubey, an assistant bank manager in Raipur who had rented part of his house to a person who was visited by Narayan Sanyal several times in 2006. He claimed that Binayak had come there twice with Narayan Sanyal. He identified both persons and their photographs (Binayak with beard), and said it was only later when he saw NS's photo in the paper that he realised his mistake in renting the place to such people. It was interesting to see Binayak's lawyer set out to dismember the witness's testimony and I greatly regretted having to leave at 1 pm before this process was finished.

According to the count given by Binayak's lawyer Mahendra Dube, the last witness was #67 presented in court so far, of a total of 125 listed. About 20 of those have already been canceled. He expects that in all only around 80 witnesses may be interrogated before the trial goes for deliberation. The dates of the next hearing, re-adjusted to avoid Chhattisgarh's election dates, are *April 24th, 25th and 27th (Friday, Saturday and Monday).* Any MFC member who is able to be there on any or all of these dates should inform Dr. Anant Phadke <anant.phadke@gmail.com>. Keep in mind the *satyagraha* on that Monday.

Release Binayak Update

Fifth batch of Protesters

Dear friends,
The fifth batch of 99 protesters took part in the satyagraha for the release of jailed human rights and health activist Dr Binayak Sen, in Raipur today (April 13, 2009).

The programme began with protestors congregating at Budha Talab and holding a public meeting there.

99 protestors marched through the streets of Raipur and later courted arrest. The courting of arrest occurred after the satyagrahis were detained at Subhash Stadium by the Chhattisgarh authorities, following peaceful non-violent protest. They were all later released.

The satyagrahis who courted arrest included among others:

N. Vasudevan (Secretary, NTUI)
Manohar Kothekar (Jt. Secretary, NTUI)
5 Activists from Trade Union Solidarity Committee Mumbai
Workers from Pragatisheel Cement Shramik Sangh, Chattisgarh (associated with CMM-Mazdoor Karyakarta Committee)
Workers from Jan Adharit Engg Mazdoor Union, Chattisgarh (associated with CMM-Mazdoor Karyakarta Committee)
Workers from Mehnatkash Aavas Adhikar Sangathan, Chattisgarh (associated with CMM-Mazdoor Karyakarta Committee)
Satya Sivaraman from Delhi and Madhumita Dutta from Chennai (Corporate Accountability Desk).We thank Shahana from Delhi for sending protest costumes to be used in the Raipur Satyagraha.

Detailed updates and photos will follow from participants later today.

In solidarity,
Rakhi <releasebinayak@gmail.com>

Krishna Iyer's Plea on Behalf of Binayak Sen

The text of a letter written by Justice V.R. Krishna Iyer, former Supreme Court Judge, to Prime Minister Manmohan Singh, dated April 17, 2009:

I would like to bring to your attention a case of grave injustice which is a cause of much shame to Indian democracy: that of Dr. Binayak Sen, the well known paediatrician and defender of human rights.

This good doctor has been incarcerated in a Raipur jail for nearly two years now under the Chhattisgarh State Public Security Act, 2005. Among the charges against Dr. Sen, who is renowned worldwide for his public health work among the rural poor, are "treason and waging war against the state."

Chhattisgarh State prosecutors claim that Binayak, as part of an unproven conspiracy, passed on a set of letters from Narayan Sanyal, a senior Maoist leader who is in the Raipur jail, to Piyush Guha, a local businessman with allegedly close links to the left-wing extremists. He was supposed to have done this while visiting Sanyal in prison both in his capacity as a human rights activist and as a doctor treating him for various medical ailments.

The trial of Dr. Sen, which began in a Raipur Sessions Court late April 2008, has, however, not thrown up even a shred of evidence to justify any of these charges against him. By March 2009, of the 83 witnesses listed for deposition by the prosecution as part of the original charge-sheet, 16 were dropped by the prosecutors themselves and six declared 'hostile', while 61 others have deposed without corroborating any of the accusations against Dr. Sen. Irrespective of the merits of the case against Dr. Sen, there are very disturbing aspects to the way the trial process has been carried out so far.

As if all this were not enough, Dr. Sen has also been repeatedly denied bail by the Bilaspur High Court (in September 2007 and December 2008). And the Supreme Court of India rejected his special leave petition to have the bail application heard before it (in December 2007).

Given the paucity of evidence in the trial of Dr. Sen so far, in all fairness the Raipur court should have dismissed the case against him altogether by now. Certainly the weakness of the prosecution's position should entitle him to at least grant of bail. Dr. Sen is a person of international standing and reputation, with a record of impeccable behaviour throughout his distinguished career. In May 2008, in an unprecedented move 22 Nobel Prize winners even signed a public statement calling him a 'professional colleague' and asking for his release.

Normally bail is refused only in cases where courts believe an accused can tamper with evidence, prejudice witnesses or run away. In Dr. Sen's case none of these apply, as shown by the simple fact that at the time of his arrest he chose to come to the Chhattisgarh police voluntarily and made no attempt to abscond despite knowing about his possible detention.

Today Dr. Sen, a diabetic who is also hypertensive, is himself in urgent need of medical treatment for his deteriorating heart condition. In recent weeks his health has worsened and a doctor appointed by the court to examine him recommended that he be transferred to Vellore for an angiography and perhaps, if needed, an angioplasty or coronary artery bypass graft without further delay.

Instead of recognising their social contributions, the Indian state, by wrongly branding Dr. Sen and many other human rights defenders like him as 'terrorists', is making a complete mockery of not just democratic norms and fair governance but its entire anti-terrorist strategy and operations.

The repeated denial of bail which results in 'punishment by trial' constitutes an even graver threat to Indian society. The sheer injustice involved will only breed cynicism among ordinary citizens about the credibility and efficacy of Indian democracy itself.

Source: The Hindu, *April 19, 2009*

Dr. Wishvas Rane on 'Death'

- *Anant Phadke*[1]

As reported in the last *mfc bulletin*, Dr. Wishwas Rane, the seniormost and one of the most respected of the 'drug activists' in India passed away on December 13, 2008 in Pune at his residence. He was 75. Dr. Rane was involved in many pioneering initiatives in the Drug Action movement in India. Pioneering was part of Dr Rane's nature. Bapu as he was fondly called, will continue to inspire us, especially when we are faced with a challenge to launch a pioneering effort. This 'pioneering' attitude continued till his death, albeit in a poignant way. His approach to dealing with his advanced cancer of colon was exemplary. He did undergo surgery and chemotherapy. But when he realised that further very troublesome therapy would be of questionable value, he decided to stop all treatment and face his approaching death squarely. He remained calm and waited for nature to take its course. Perhaps due to this attitude he survived for two years after stopping all chemotherapy, when doctors had predicted that he would not survive for more than two to four months. These last two years were virtually free of troublesome symptoms. During the last months of his life he wrote a book in Marathi about his experience of 'living with cancer' and its treatment. There have been books in Marathi by cancer survivors who share their inspiring stories of overcoming cancer. Dr. Rane's book is different. Dr Rane, in his late 70s, describes his philosophy of facing death with equanimity, as a natural phenomenon. Here are a few paragraphs, that I have translated from the introductory chapter of this book, which reflect his attitude towards suffering and death during his terminal illness –

We have no idea about what death means to us. I too hardly had any idea about it till the age of 75 years. But now I know what death is. When my cancer was detected and when I was told that it has spread, I realised what death is. Yet I discovered a way to live happily. It is not important how I searched for it and how I discovered it. It is important that a way out has been discovered. Every moment of my remaining life is a priceless one and I want to realise its full value…. Being aware of impending death causes more fear than the deadly disease itself. The mind buckles down. It starts imagining various symptoms. Physical discomforts and complaints increase and this leads to despondency. Our sons and daughters, daughter-in-law, grandsons, all get demoralised. They also develop a negative attitude and start passively waiting for death. This is defeatism. We can score victory over it. If we keep control over our mind, the mind starts looking up; our protective powers get a boost. Our complaints get reduced. Family members are happy to see us contented and their outlook towards us becomes positive. They start telling others about our example of facing the disease. The attitude of visitors also changes and I feel convinced that I would not die of cancer. Once I get convinced that I can change my surroundings by my changed behaviour, every action arising out of this conviction gets a positive response from my body. I tell my self that pleasure and sufferings are both body sensations which my body has to deal with. I have to develop a positive attitude towards pain and suffering. One can face suffering by converting them into pleasures. If this can be done, suffering disappears. I have now reached this state. I am sure that I am going to die soon; and yet I am waiting for it with a smile. I am winning my battle against death, so long as my death gets postponed. And that constitutes my pleasure, my happiness….

[1]*Email:<anant.phadke@gmail.com>*

Mystery Shrouds Illegal Drug Trial at G G Hospital

Vadodara: Express News Service, Apr 05, 2009

A day after the illegal drug trial case was busted at the Guru Govind Singh Hospital in Jamnagar, the matter still remains shrouded in mystery.

Even as Dr Amul Bhattacharya, the main accused, said the trials were followed in a completely legal manner, the details with the ethical committee of the Jamnagar Civil Hospital reported of no record of any trials over the year.

On Friday, the Jamnagar police had registered a complaint against associate professor Dr Amul Bhattacharya, Nurse Aruna Bhatt, and two other unidentified persons for "illegal" drug trials. Though private drug companies are allowed to perform clinical research at government hospitals, the research is conducted only after initial permission and supervision from the Ethical Committee. The staff members of the G G Hospital and the M P Shah Medical College alleged that the working and the drug trial activities by Dr Bhattacharya were done under secrecy.

Dr Vikas Sinha, dean of M P Shah Medical College, who is also a member of the Ethical Committee of the college, said: "In the past nine months of my tenure in the college and as a member of Ethical Committee during that period, no record of any drug trial or drug testing in the name of Dr Bhattacharya was registered with the committee."

Dr Bhattacharya refused to comment over the allegations, but maintained that all trials were done with prior registration with the Ethical Committee and that the patients were well informed beforehand.

Half of Vibrant Gujarat Goes to Sleep Empty Stomach[1]

-Gaurav Sharma

Ahmedabad, Dec 21, 2008

Despite tall claims on paper, cases of malnutrition, anaemia, low body mass index abound in state

"It is with the core value of the Right to Food that the Gujarat government's Food, Civil Supplies and Consumer Affairs Department sets its mandate," this is the government's claim. But, according to various reports, the state's Public Distribution System (PDS) is in a shambles.

On paper, much hyped schemes like the Anand Smart Card Project, Roaming Ration Card, Food Fortification, Grahak Bhandar Yojana, Food Helpline and others may appear to be in place. Despite this, almost half of Gujarat's six crore population is hungry.

For its part, the state government has issued nearly 89.58 lakh Above Poverty Line (APL) cards and 35.51 lakh Below Poverty Line (BPL) cards. In the latter category, about 8.10 lakh cards fall under the Antyodaya Anna Yojna (AAY), which caters to the poorest of the poor. So, in all, nearly 1.33 crore ration cards have been issued in the state to ensure the availability of wheat, rice, sugar and kerosene to the poorer sections of society at highly subsidised rates.

This means that ideally, the system should work like this— the Food Corporation of India (FCI) issues the PDS quota to Gujarat at a subsidised rate, which in turn further subsidises it for BPL and AAY cardholders. APL citizens get no subsidy and have to pay the market price of their share of PDS. The food goes from the national warehouses to the state warehouses where it is checked, fortified and then distributed to Fair Price Shops (FPS). Ration cardholders then pick up their quota from there.

But, as the state government itself has admitted, the PDS in Gujarat have come to be known for hoarding, profiteering, poor quality, adulteration, overpricing and under weighing. The FCI allots less than the required PDS quota to Gujarat and the government doesn't even bother about it. It keeps itself busy converting more and more BPL cards to APL, apparently to showcase its efforts at improving the hunger situation in the state, at least on paper.

Also, bogus cards are made at will and the PDS quota is diverted to the open market using these. This happens at both the levels of the Civil Supplies Department and the Fair Price Shops. With absolutely no checks on the FPS, these functions as autonomous bodies and are the major source of resource diversions. Such is the situation now that numerous public hearings, suo motto cognizance by the Gujarat High Court and various RTI applications have failed to bring about any change.

Gujarat's Minister for Food and Civil Supplies Narattam Patel could not be contacted for comments.

Alarmingly Hungry

* According to International Food Policy Research Institute's 2008 Global Hunger Index, Gujarat is ranked 69th along with Haiti, the nation infamous for food riots. The state is placed in the 'alarming' category.
* The M S Swaminathan Research Foundation has identified urban Gujarat as 'moderately food secure' while rural Gujarat remains 'severely insecure.'
* The National Family Health Survey III (NFHS-III) conveys that 42.4 per cent of children in Gujarat are suffering from stunted growth due to malnutrition. Also, about 47.4 per cent of children are underweight in the state.
* NFHS-III also points out that more than half of Gujarat's population is Anaemic, with a percentage as high as 80.1 for children aged 6-35 months.
* NFHS-III further states that nearly one-third of adults in Gujarat have their Body Mass Index (BMI) below the normal, 32.3 per cent for women and 28.2 per cent for men.

System in Shambles but the Government is in Denial: SC overruled

* The Supreme Court had ordered on November 28, 2001 and January 10, 2008 to provide 35 kg food grains — 19 kg wheat flour and 16 kg rice — to the poorest of the poor under the Antyodaya Scheme. But the Gujarat government in its resolution dated March 24, 2008 decided to provide 16 kg rice and 16.7 kg wheat fortified flour
* The government deducts 2.3 kg from the entitlement of 19 kg and passes it on to the flour mills as the cost of fortification. So, flour mills get the benefit of 24,647 tons of wheat annually at the cost of poorest of the poor

[1] *Source: <http://www.expressindia.com/latest-news/half-of-vibrant-gujarat-goes-to-sleep-empty-stomach/401073/>*

Poor Distribution System

Public hearings in 2008 against injustices abounding in the PDS

* 900 people attend a hearing organised by the Lok Adhikar Manch (supported by Action Aid) on April 30 at Anjar, Kutch.
* 1,300 people attend a hearing organised by Lok Adhikar Manch on July 2 at Khavda in Kutch
* 1,150 people attend a hearing organised by Sarthi (supported by Action Aid) on November 21 at Panchmahals

Common Grievances Recorded

* Large scale diversion of PDS food grains
* Irregular identification and distribution of ration cards
* False and fake entries on ration cards
* Fair Price Shops (FPS) open for less than two weeks in a month against the stipulated 24 days

Sorry State of Affairs

* The National Council for Applied Economic Research (NCAER), New Delhi, finds in a survey that nearly 11, 53,000 ghost/fake BPL cards have been issued in Gujarat
* An ORG-Marg report commissioned by the Centre reveals that in Gujarat, about 41 per cent of rice slotted for the poor is being diverted
* According to the state government, the Centre allots food grains only for 21.20 lakh families as against the 35.51 lakh BPL families, a gap for nearly 14.31 lakh families. Still, the Ministry of Consumer Affairs, Food and Public Distribution confirms in reply to an RTI application that 'No representation is received from any MP, MLA, CM or Minister regarding the supply of food grains to Gujarat since the last one year.'
* An analysis report dated December 26, 2007 of the Public Health Laboratory, Ahmedabad Municipal Corporation, confirms live insects, high quantity of chaff in 18 samples of fortified wheat flour supplied by FPS at various districts in Rajkot, Panchmahals, Dahod, Dwarka and Jamnagar. It is deemed unfit for human consumption.
* The FCI admits in a reply to an application filed under the Right to Information Act that nearly 73,814 tons of food grains have been damaged in Gujarat and Maharashtra over the past decade.

Clinical Trials: Unfavourable Results Often go Unpublished

Trials showing a positive treatment effect, or those with important or striking findings were much more likely to be published in scientific journals than those with negative findings, a new review from The Cochrane Library has found. "This publication bias has important implications for healthcare. Unless both positive and negative findings from clinical trials are made available, it is impossible to make a fair assessment of a drug's safety and efficacy," says lead researcher, Sally Hopewell of the UK Cochrane Centre in Oxford, UK. The international team of researchers carried out a systematic review of all the existing research in this area. In addition to showing that negative results were published less often, they found that if these results were eventually published, they would take between one and four more years to appear in journals than studies showing positive results. Results from one of the five studies in the review indicated that investigators and not editors might be to blame. The reasons most commonly given for not publishing were that investigators thought their findings were not interesting enough or did not have time. "The registration of all clinical trial protocols before they start should make it easier to identify where we are missing results," says Kay Dickersin from Johns Hopkins University in Baltimore, USA, another of the researchers on this project. One of the other researchers, Kirsty Loudon, based in Scotland, adds, "Registration of trials and their results would help people conducting systematic reviews to look at both published and unpublished evidence, to reach reliable conclusions."

The researchers say their study also highlights the need for a worldwide commitment to the disclosure of the findings of clinical trials. Mike Clarke of Trinity College Dublin in Ireland, says, "The World Health Organisation recently found widespread support for the development of such a process." Andy Oxman from the Norwegian Knowledge Centre for Health Services concludes, "Healthcare decisions need to be based on all the evidence, not just the most exciting results."

Hopewell S, Loudon K, Clarke MJ, Oxman AD, Dickersin K. Publication bias in clinical trials due to statistical significance or direction of trial results. Cochrane Database of Systematic Reviews *2009, Issue 1. Art. No.: MR000006. DOI: 10.1002/ 14651858.MR000006.pub3.*

WHO to Blame for Dangerous Child Vaccine?

- *Dr. Jacob M Puliyel*[1]

The World Health Organisation (WHO) is facing a crisis of transparency and accountability over the perverse decision it has made to ignore its own advice and promote a children's vaccine for pneumococcal disease, which does not significantly decrease the incidence of pneumonia but doubles the number of children with asthma, which can last a lifetime.

The WHO cannot claim ignorance about the dangers of the vaccine because they published the startling facts in their own bulletin. The statistics show that for every 2000 infants vaccinated, only seven cases of the uncommon pneumonia will be prevented. Furthermore, for every five cases of pneumonia avoided, two children will develop asthma as a direct consequence of the vaccine.

Pneumonia is a one-off illness that is usually cured with simple (inexpensive) antibiotics. Asthma on the other hand can be a lifelong disability, requiring treatment with inhaled drugs and steroids, and sometimes hospitalisations. The benefit of the vaccine in terms of pneumonia prevented, pales into insignificance in the face of this risk of asthma.

To add insult to injury, the pneumococcal-vaccine is one of the most expensive vaccines on the Indian market. The three doses required to immunise one child costs a whopping Rs. 12,000. In contrast the treatment of an episode of pneumonia using Septran (as recommended by the WHO protocol) costs Rs. 10 per child. The vaccine is therefore exorbitantly expensive and it does more harm than good.

All these facts were documented in studies and known to the experts. However, in a sinister move by the WHO, the results were cleverly shielded from the public for 5 years before being finally exposed in the October 2008 WHO Bulletin. It is crucial that the public are informed as to how such a vaccine came to be advocated by trusted advisors - the WHO, the expert body of the Government of India (the department of biotechnology (DBT)) and by individual doctors. This is crucial for accountability and for trust to be slowly rebuilt.

There is currently an unhealthy nexus between the WHO, the GOI agencies and the drug industry. These unhelpful relationships need to be exposed and corrective actions put in place to avoid such risks in the future. The influence of drug manufacturers on professional medical advice has been discussed widely in journals like the British Medical Journal, the New England Journal of Medicine and the Canadian Medical Journal. Such discussions in professional circles are sterile unless the lay press also takes it up and demands a change in standards of behaviour.

Perhaps what has led to this dangerous vaccine being given to our children is the way the WHO has recently lost its independence by getting into bed with pharmaceutical companies. The 19 January 2008 issue of the British Medical Journal details how the WHO Expert Group Meetings are now sponsored by pharmaceutical companies and manufacturers now have access and can influence the decisions made by Expert Committees. With such obvious conflicts of interests, how can the WHO possibly be trusted as an honest broker between the needs of public health and the pharmaceutical industry?

In the case of vaccines the WHO has joined forces with vaccine manufacturers in the Global Alliance for Vaccines and Immunization (GAVI) to promote vaccines in third world countries. Shamefully, this promotion is done without regard to the costs, the lack of benefits in countries with a low incidence of the problem and the imperatives of more pressing public health needs.

GAVI has entered an Advance Market Commitment (AMC) with manufacturers. Through the AMC, donors commit money to guarantee the price of vaccines once they are developed. In 2007, GAVI began working with partners on a US$1.5 billion AMC pilot to fund the introduction of pneumococcal vaccines in poor countries. This fund will ensure that manufacturers receive their high guaranteed rate. Poor countries are enticed to introduce the vaccine with huge subsidies. For example, the asthma causing

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pneumococcal vaccine, which costing Rs. 12,000 per child was being provided for Rs. 50. The subsidy and co-financing schemes prevent nations from doing a proper cost benefit evaluation.

Like all introductory offers, it is for a limited time only. Countries are forced to pay full market rates after the offer is withdrawn. The AMC having promised manufacturers a guaranteed market for their vaccine at the rate of Rs. 4000/dose (Rs 12,000 per child), led to both the GAVI and the WHO glossing over the lack of efficacy and the obvious harms of the vaccine when marketing the vaccine to poor countries.

In April of this year, experts of the Government of India recommended the introduction of the vaccine in the country's routine immunization, 'if the vaccine covered 70% of the strains of the bacteria in the country'! It must be clarified here that the lack of efficacy reported in the WHO Bulletin relate to countries where up to 80% of the local strains were covered in the vaccine! The risks in terms of asthma were available in the literature but do not seem to have caught the attention of these experts.

The price of a vaccine is inversely proportional to its usefulness. The less useful the vaccine, the higher the inducements needed to encourage reluctant doctors to use it. On one end of the spectrum we have the highly effective DPT (diphtheria tetanus pertusis) vaccine which costs just a few paisa and on the other end we have the pneumococcal vaccine which costs thousands of rupees. Out of the Rs 4000 the public pay for one dose of pneumococcal vaccine Rs 1000 goes directly to the doctor or dispensary that sells the vaccine. This is a fail-safe marketing strategy by the pharmaceuticals. Indeed, with these types of incentives it is a win-win situation for everyone, aside from the child patients who have an increased chance of getting asthma and having their health impacted for the rest of their life.

India cannot afford such costly public health mistakes like the pneumococcal vaccine. Currently, we only have around 50% coverage of the basic vaccines and it is crucial that all the resources available be used to improve this coverage in the interest of public health for all. Spending money on newer vaccines of doubtful utility will ensure that even less is available for the rural poor. Perversely, those parents who don't have access to immunize their children against pneumococcus may however be relieved that their child avoided asthma. We can only hope that the pneumococcal faux pas will prompt the policy makers into developing a more coherent policy for public health and equity in services.

The WHO website reads that "It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends." For this reason, the WHO and the GOI need to ask searching questions as to how they came to promote a vaccine that does more harm than good. Further to this, by trying to hide the vaccine's health risks and ignoring requests from civil society organisations as to the reasons why this decision was made, the WHO has shown an astonishing lack of both transparency and accountability, which poses serious questions about the legitimacy, authority and judgment of the organisation.

Recently the All India Drug Action Network wrote to the Director General Margaret Chan asking her why she was promoting this vaccine that does more harm than good. She has replied through her personal assistant that she looks forward to creating a **world where no person should die of a vaccine-preventable disease**. So 12 million rupees will be spent to reduce 3.6 cases of pneumonia with this vaccine while millions die of malnutrition. The letter suggests that the WHO plans to siphon off millions of dollars contributed by member countries for the Millennium Development Goals to pay pharmaceutical companies through Advance Market Commitments.

To repair its reputation and to protect people's health rights, both the WHO and the GOI need to purge the people who have allowed this catastrophe to take place and safeguards must be put in place to never again allow people's health rights to be comprised. Furthermore, the WHO and GOI should issue a full and prompt apology to the children and families who have been adversely affected by their mismanagement.

A Medical Satyam Scam: Anesthesiologist Faked Data in 21 Studies Atleast

Pioneering Anesthesiologist Implicated in a Massive Research Fraud

- Brendan Borrell

[This article originally titled "A Medical Madoff: Anesthesiologist Faked Data in 21 Studies" is reproduced from Scientific American *in public interest (Source: http://www.sciam.com/article.cfm?id=a-medical-madoff-anesthestesiologist-faked-data&print=true). See also: "Prominent celecoxib researcher admits fabricating data in 21 articles" in* BMJ *2009; 338: b966, published 9 March 2009; and "Celecoxib: a big research fraud stands exposed" in* The Hindu*, March 19, 2009. The news will not, however, have any effect on the drugs' regulatory status because Reuben's studies were not apparently submitted to the U.S. Food and Drug Administration or to European authorities. A Pfizer spokesperson was quoted as saying in the* British Medical Journal *that the retraction of papers "does not change the risk-benefit profile" of the drug]*

March 10, 2009: Over the past 12 years, anesthesiologist Scott Reuben revolutionized the way physicians provide pain relief to patients undergoing orthopedic surgery for everything from torn ligaments to worn-out hips. Now, the profession is in shambles after an investigation revealed that at least 21 of Reuben's papers were pure fiction, and that the pain drugs he touted in them may have slowed postoperative healing.

"We are talking about millions of patients worldwide, where postoperative pain management has been affected by the research findings of Dr. Reuben," says Steven Shafer, editor in chief of the journal *Anesthesia & Analgesia*, which published 10 of Reuben's fraudulent papers.

Paul White, another editor at the journal, estimates that Reuben's studies led to the sale of billions of dollars worth of the potentially dangerous drugs known as COX2 inhibitors, Pfizer's Celebrex (celecoxib) and Merck's Vioxx (rofecoxib), for applications whose therapeutic benefits are now in question. Reuben was a member of Pfizer's speaker's bureau and received five independent research grants from the company. The editors do not believe patients were significantly harmed by the short-term use of these COX2 inhibitors for pain management but they say it's possible the therapy may have prolonged recovery periods. Baystate Medical Center in Springfield, Mass., began investigating Reuben's findings last May after its chief academic officer, Hal Jenson, discovered during a routine audit that Reuben had not received approval from the hospital's review board to conduct two of his studies. Reuben "violated the trust of Baystate, the community and science," Jenson says. The story of the investigation was first reported by *Anesthesiology News* late last month.

Reuben, 50, has been stripped of his research and educational duties and has been on medical leave since May. He received his medical degree from the State University of New York at Buffalo School of Medicine & Biomedical Sciences in 1985 and did his residency at the Mount Sinai Medical Center in New York City. In 1991, he joined Baystate, which serves as the western campus for Tufts University School of Medicine, and has worked as a staff anesthesiologist and the director of acute pain management.

His lawyer, Ingrid Martin of Dwyer & Collora, LLP, in Boston, told *ScientificAmerican.com* that Reuben has cooperated with the investigation and that he "deeply regrets that all of this happened." She added that "with the [investigating] committee's guidance, he is taking steps to ensure this never happens again." She declined to answer any further questions, and Reuben did not respond to an e-mail request for comment.

Beginning in 2000, Reuben, in his now-discredited research, attempted to convince orthopedic surgeons to shift from the first generation of nonsteroidal anti-inflammatory drugs (NSAIDs) to the newer, proprietary COX2 inhibitors, such as Vioxx, Celebrex, and Pfizer's Bextra (valdecoxib). He claimed that using such drugs in combination with the Pfizer anticonvulsant Neurontin (gabapentin), and later Lyrica (pregabalin), prior to and during surgery could be effective in decreasing postoperative pain and reduce the use of addictive painkillers, such as morphine, during recovery. A 2007 editorial in *Anesthesia & Analgesia* stated that Reuben had been at the "forefront of redesigning pain management protocols" through his "carefully planned" and

"meticulously documented" studies.

Any orthopedic surgeons, however, were slow to adopt COX2 inhibitors due to animal studies that showed short-term use might hinder bone healing. Then, in 2004, Vioxx and Bextra were pulled from the market because of their link to an increased risk of heart attacks and strokes, leaving Pfizer's Celebrex as the only COX2 inhibitor available. Celebrex sales plunged 40 percent after a study that same year suggesting that it, too, posed a heart attack risk. Despite this, Reuben continued to present "findings" in research funded by Pfizer that trumpeted Celebrex's alleged benefits and downplayed its potential negative side effects.

He apparently hoped to erase doubts by persuading orthopedic surgeons to co-author papers with him based on his bogus data. In 2005 he and Evan Ekman, an orthopedic surgeon at Southern Orthopaedic Sports Medicine in Columbia, S.C., published a study on the use of Celebrex to control pain in back surgery patients. "The short-term administration of celecoxib," they wrote in the paper published in *The Journal of Bone and Joint Surgery*, "results in no significant deleterious effect on bone or ligament healing or cardiovascular outcomes."

Three years later, Reuben's career would begin to unravel as Ekman began to suspect foul play. In addition to collaborating with Reuben on the now-retracted Celebrex study, Ekman agreed to review a Reuben manuscript on surgery on the anterior cruciate ligament (ACL) in the knee. But when he asked the anesthesiologist for the name of the orthopedic surgeon on the study, Reuben ceased communication with him.

Then, last year, Ekman was invited by Pfizer to give a talk. While there, he was handed a version of the very manuscript Reuben had asked him to review, which had subsequently been published in *Anesthesia & Analgesia*. To his surprise, and horror, he was listed as a co-author: Reuben had forged his signature on the submission form, Ekman says.

By then, Editor in Chief Shafer had already put several Reuben manuscripts on hold after learning that Baystate had initiated a probe into the validity of his research. The investigation later identified 21 articles based on patient data that had been partially or completely doctored. Although Pfizer funded Reuben's research between 2002 and 2007, Baystate has no records of those payments and says that the research funds could have been paid directly to Reuben. Such an arrangement would be "highly unusual," Shafer notes. "It's just a little frustrating," Baystate spokesperson Jane Albert says. "I don't know how many dollars went to Dr. Reuben or his group."

Pfizer spokesperson Sally Beatty insists the grants were properly disbursed to Baystate in accordance with Pfizer policy. "Pfizer is not familiar with the records retention policies of Baystate Medical Center," she says, "However, independent investigator-initiated research grant agreements were executed between Pfizer and Baystate Medical Center." Beatty was unable to provide information on the dollar amount of the grants, but editor White says they typically range between $10,000 to $100,000.

The question is: Why did it take 12 years before a "routine audit" revealed Reuben's widespread data fabrication? "Baystate publishes about 200 [studies] every year, and of those [articles], the audit rate might only be 5 percent," Baystate's Jenson says, acknowledging that ultimately "Baystate is responsible" for making sure that research done there is properly conducted and reported. He says that the hospital has been trying to strengthen its oversight program over "the past few years" and that it is in the process of applying for accreditation from the Association for the Accreditation of Human Research Protection Programs (AAHRPP) in Washington, D.C., which provides an independent evaluation of an organization's ethical standards and oversight. The lack of accreditation is not unusual because the nonprofit program was not established until 2001 and only recently has grown to include 159 hospitals, academic institutions and other organizations.

In hindsight, *Anesthesia & Analgesia* editors Shafer and White admit that it should have been a "red flag" that Reuben's studies were consistently favorable to the drugs he studied. White, who has also received drug company educational grants, says that such funding comes with "subtle pressure" to give the companies the results they want. For now, at least, neither the drug companies nor Reuben's co-authors are officially sharing in the blame, but that's expected to change. "There's a lot of responsibility to pass around," White says, "It's all being focused on Scott Reuben, but the reality is there are many other responsible parties."

Medical Studies Authored/Fabricated by the Shamed Dr. Scott Reuben

[*Please note the number of Indian sounding co-authors. Are they too indicted? –Editor, mfc b*]

1. Preventing the development of chronic pain after thoracic surgery.
Reuben SS, Yalavarthy L.
J Cardiothorac Vasc Anesth. 2008 Dec;22(6):890-903. Epub 2008 May 7. No abstract available. PMID: 18834790

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Anesth Analg. 2008 Apr;106(4):1258-64, table of contents. PMID: 18349203

3. Update on the role of nonsteroidal anti-inflammatory drugs and coxibs in the management of acute pain.
Reuben SS.
Curr Opin Anaesthesiol. 2007 Oct;20(5):440-50. Review. PMID: 17873597

4. The effect of initiating a preventive multimodal analgesic regimen on long-term patient outcomes for outpatient anterior cruciate ligament reconstruction surgery.
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5. Evaluating the analgesic efficacy of administering celecoxib as a component of multimodal analgesia for outpatient anterior cruciate ligament reconstruction surgery.
Reuben SS, Ekman EF, Charron D.
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Illegal Drug Trials Cast a Shadow on Cancer Institute

Hiral Dave Rajkot: Apr 07, 2009

This is the second medical institution in Saurashtra where charges of illegal drug trials have been levelled in barely a week's time

After the government hospital in Jamnagar, it is the Rajkot-based V R Desai Cancer Research Institute (VRDCRI), which is mired in allegations of illegal drug trials for private international drug companies.

Following a complaint by a trustee, Kishore Ghia, the Rajkot Cancer Society (RCS) run institute now faces an inquiry by the state medical services department.

Incidentally, this is the second medical institution in Saurashtra where charges of illegal drug trials have been levelled in barely a week's time.

Now, the Human Research Ethics Committee, an umbrella under which clinical research was being conducted at the institute, has also been dissolved. Formed three years ago, VRDCEI Director Dr V K Gupta, against whom allegations have been made, had dissolved HREC a month ago.

Dr Gupta said: "Due to too much of unwanted queries in connection with clinical research, the activity has been stopped for a month now. The HRES also stands dissolved." He, however, maintained that the entire exercise was legal and ethical. "The HRES is answerable to the department of drug control in India. The research and details of volunteers cannot be shared with any other body," he said.

Ghia, who has been associated with the RCS since its inception two decades ago, said details of the HREC functioning in isolation, the clinical researches and the accounts, have not been shared even with the trustees.

Source: <http://www.indianexpress.com/news/illegal-drug-trials-cast-a-shadow-on-cancer-institute/443905/>

Research Integrity in the Media Articles by Date[1]

Date	Source	Title & Summary
March 9, 2009	*BMJ*	"Prominent celecoxib researcher admits fabricating data in 21 articles" by Jeanne Lenzer - Scott S. Reuben, Associate Professor at Tufts University and chief of the acute pain service at Bayview Medical Center admitted to fabricating patient data in 21 of his 72 published articles. He received research grants from Pfizer and studied drugs such as Celebrex and Lyrica and their use in pain management. Reuben has since gone on medical leave at Bayview Medical Center, resigned from his associate professor position and will not be permitted to participate in research.
December 3, 2008	*The Scientist.com*	Peili Gu, a postdoc at Baylor College of Medicine in Houston, Texas, was found to have falsified images which appeared in three published manuscripts. Gu apparently used Photoshop to alter the images. One paper was retracted from Molecular and Cellular Biology. Gu was fired but has since been hired as a senior research assistant at the MD Anderson Cancer Center in Houston.
November 11, 2008	*The Scientist.com*	Jusan Yang, a former molecular biologist at the University of Iowa, was found to have falsified figures which he used in two scientific meetings and an unpublished manuscript. Though this does not represent a major misconduct case, Yang resigned and is now volunteering with a health care facility in California.
October 6, 2008	*Scientific American*	"Montagnier, Barré-Sinoussi, and zur Hausen Share Nobe" by Jordan Lite - Three scientists have been awarded the Nobel Prize for Medicine for their discoveries of the Human Papillomavirus (HPV) and Human Immunodeficiency Virus (HIV). French Professors Luc Montagnier and François Barré-Sinoussi were recognized for their discovery of HIV, caps a long controversy between the two French Professors and American Professor Robert Gallo. Gallo claimed to have identified HIV independently of Montagnier and Barré-Sinoussi although his work was published a year after theirs. A 1992 review panel at the National Academy of Sciences found evidence of research misconduct in Gallo's samples.
September 23, 2008	*The Wall Street Journal: Health Blog*	"Most Drug Studies Remain Unpublished" by Jacob Goldstein Researchers looking at pharmaceutical drugs passed by the Food and Drug Administration (FDA) between 1998 and 2000 found that 394 out of 909 total studies were published. Studies that included blind or double-blind trials (with the drug and placebo) were more likely to be published, especially those with favorable results. This raises concerns over FDA practices in approving drugs, since new FDA rules will make it mandatory for drug companies to release the results of clinical trials on an online registry.
September 10, 2008	*The New York Times*	"Scientific Error Reignites Debate About Armstrong" by Ian Austen - Lance Armstrong preparing to return to the

[1] *Source: <http://www.hopkinsmedicine.org/Research/OPC/riArticlesByDate.html>*

		professional cycling tour has resurrected old controversy about allegations of performance enhancing drugs. Edward F. Coyle, an expert on human performance at the University of Texas in Austin, admitted a "minor miscalculation" in his long-term study of Armstrong's muscle efficiency. That study had been repeatedly used by Armstrong to shoot down doping allegations of the 7-time Tour de France winner. Three Australian scientists and one mathematician have now pursued allegations of scientific misconduct against Coyle with the University of Texas. Robert Peterson, the vice president of research at the university, noted that there are deficiencies in the research, but none that rise to the level of scientific misconduct.
June 19, 2008	*The Financial Post*	"Researcher fired over faked data; Ottawa institute discovers past misconduct" by Margaret Munro - The case of Kristin Roovers of Ottawa Health Research Institute is discussed. She was found to have falsified and manipulated data and images in several publications.
May 7, 2008	*The Australian*	"Minister eyes watchdog" by Bernard Lane - A cabinet minister in the Australian government raises concerns about the ad hoc handling of research misconduct cases by Australian universities. The Australian government is considering some sort of review mechanism which would be "cost effective and have scientific and legal authority".
February 7, 2008	*Sydney Morning Herald*	"Rats in the ranks" by Deborah Smith and Leonie Lamont - The article explores some research misconduct cases from the Monash University in Australia, and weighs in on a few issues related to reporting and investigation of scientific misconduct. The authors briefly explore the tension produced by the tough competition for funds, the demand to publish, and increased commercialization of research. These factors have not only increased the opportunities for scientists to behave badly but also to an increase in the number of "rats in the ranks".
January 23, 2007	*The Gazette*	"Science watchdog urged: To combat fraud. Research misconduct rarely reported" by Margaret Munro - The article mentions the Chandra case from Newfoundland's Memorial University. The researcher made up babies for his studies on infant formula and to have inflated results of breast-feeding studies. The piece reports on calls for a national agency to monitor allegations of research misconduct in Canada. March 2007 The Lancet "Reforming research in China" - An editorial in the Lancet mentions plans for the establishment of a commission for scientific integrity by the Chinese Academy of Sciences and the Ministry of Science and Technology in China.
May 15, 2007	*The Guardian*	"Education: Higher: Whistleblowing in the wind?: A new hotline for those who suspect malpractice in medical research has not been universally welcomed" by Jessica Shepherd - The piece talks about the recent establishment of a Research Integrity Office in the UK. They have also introduced a hotline/helpline for reporting suspected research misconduct. The article also deals with some of the pros and cons of providing such a facility.

June 6, 2007	*The Australian*	"Work so nice, they use it twice" by Brendan O'Keefe - The article briefly explores "self-plagiarism" in the research community.
December 15, 2007	*The Globe and Mail*	"A Hippocratic Oath for science; In the wake of faked data and ghosted research, Britain's chief science adviser is calling for a new code of ethics for scientists. But is a seven-point vow the answer to such problems - or could it create new ones?" by Anne McIlroy - The article reports on arguments for and against a universal code of research ethics, similar to the Hippocratic Oath. A universal code is being advocated in light of some of the high profile cases of research misconduct involving American EricPoehlman and Southern Korean stem-cell researcher Hwang Woo Suk.
November 28, 2007	*The Seattle Times*	"UW: Researcher faked AIDS data, altered images" by Nick Perry and Carol M. Ostrom - Scott Brodie, a former University of Washington AIDS researcher, was found to have committed scientific misconduct by altering images and fabricating data in 15 separate instances. The investigation began when a rival researcher, who was reviewing a paper Brodie submitted for publication, noticed some anomalies and notified the federal Office of Research Integrity, which, in turn, notified the UW in August 2002. Not only did it cast doubt on Brodie's own work, but it also created problems for many other researchers who relied on his data.
October 20, 2006	*The Philadelphia Inquirer*	"Casting wide net for peers' review; Some academic journals are replacing the secret-evaluation part of the process with online critiques for research authors" by Dawn Fallik - The article reports an experiment by some academic journals, like Nature, to open the peer-review process by posting the papers online for review by a wider pool, as compared to the standard review process. Journal editors hope that by putting more research online, problems that escape a few select reviewers would be caught by a larger community.
October 17, 2006	*The Guardian*	"The Moral Laboratory: Should the world try to agree on a code of research ethics? Two academics confront the arguments" by Jonathan Wolff and Niall Scott - This is a very interesting article with two specialists exchanging emails arguing whether the world should attempt to agree on a code of international ethics. Professor Jonathan Wolff is head of philosophy at University College London, while Niall Scott is a lecturer in ethics at the Centre for Professional Ethics, University of Central Lancashire, Preston.
October 10, 2006	*The Guardian*	"World at one?" by Linda Nordling - Linda Nordling reports on efforts to ensure ethical standards are maintained in labs across the globe. Conditions in some of the developing countries may not meet the acceptable scientific standards of the more developed countries. This situation has prompted some experts to suggest a global code of research ethics to ensure compliance with western research standards and prevent abuse of cheaper facilities in developing countries.

Health Sector in Gujarat: What is the Policy Thrust?

Statement by Civil Society Participants on April 7, 2009 on the State Medical Tourism Policy

Since 2006, the Health and Family Welfare Department of Gujarat has been supporting an initiative to develop a Public Health Act for the state. This Act is visionary and progressive. It guarantees essential health services to its citizens especially the vulnerable groups and makes right to health care justiciable. The Act makes it mandatory that standards for health care be specified and both the public and the private facilities be required to follow these standards. Monitoring structures, which include participation of user groups, elected representatives and health care providers – are specified to ensure quality of care and redressal of grievances. The Act includes in its purview not only health care services, but also determinants of health like access to safe drinking water, sanitation, food security and safe living condition for both the rural and urban population, in the state. In short, as mentioned above, the Act is radical in its commitment to improving the health status of its citizens, especially the poor, and the disenfranchised.

Simultaneously, the Department of Health, Government of Gujarat has formulated a Gujarat Medical Tourism Policy in 2006. The policy is based on a report by CII- McKinsey that suggests that medical tourism could fetch as much as $2 billion by 2012 compared to an estimated $333 million. The report states that there is also an unexplored potential for what is called 'Health Tourism' – Yoga, Medication, Ayurveda, Art of Living and so on. Based on this purely and economic market analysis, the Gujarat Medical Tourism Policy, lays out the following objectives (among others):

1. Encourage medical tourism as an important engine of economic growth of health care industry in the state.
2. Promote and plan Indian systems of Medicine to integrate their services, at the appropriate levels in medical tourism business, within specified auras of responsibility and functioning in the over al health care deliver systems, specially in regard to the preventive and curative health objectives.
3. To build an enduring brand – name for the state based on clinical excellence as synonymous with trust, safety and excellence and to attract a high inflow of foreign patients.
4. To enable health providers in the state in collaboration with tourism industry to prepare comprehensive package deal that includes flights, transfers, hotels, medical treatment and where appropriate a post-treatment vacation.
5. To acknowledge the critical role of private sector and individual medical skill with government working as a pro-active facilitator and catalyst.
6. To develop an intensive IEC campaign so as to reach all country and their embassies on the various medical tourism packages available in Gujarat.
7. To develop a state-of-the-art "Medicity", which would be a health care complex fully operationalized by the private health sector and facilitated by the Government in Gujarat.

There appears to be a clear contradiction between the goals of the Public Health Act and the Gujarat Medical Tourism Policy. In a state, starved of qualified doctors and specialists in the public health sector to deal with the shamefully high Maternal Mortality Ratio [136 per 100000 live births compared to 13.7 of Thailand in 2003, 27 (1992) of Srilanka and 20 (1990) of Malaysia], what is the justification of promoting private medical sector for the needs of tourists?

Should the state be putting its energies and resources to improving the malnutrition amongst children (which has worsened in the last seven years since the National Family Health Survey 2), improving tribal women's malnutrition status, increasing access to quality services at the primary level through fully staffed and functioning sub centers, or creating 'Medicities' with state-of-the-art specialist services for the rich medical and health tourists from across the world?

Should the state be concentrating on regulating the profiteering private medical sector, which is engaged in among other things, unethical clinical research on unsuspecting poor patients in the state, or on boosting the private medical sector to further profiteer through medical tourism?

What is the justification for the government to propose a Medical Tourism Policy?

On World Health Day, we want a commitment from the Government of Gujarat that health and nutrition needs of its poorest sections of society will be addressed through concerned, focused action.

Only when health equity within the state is achieved, can governments be justified in thinking about increasing revenues through Medical Tourism!!

Second Common Review Mission, Nov-Dec 2008

Executive Summary: Extracts of Findings

The Second Common Review Mission of the National Rural Health Mission was held in November-December of 2008. Eighteen officials of the central and state government, 19 public health professionals from academic and technical institutions and 17 public health activists from civil society and 13 representatives of development partners, a total of 67 persons, participated in the mission. The Mission divided into 13 teams, which visited over ten facilities in a minimum of two districts in 13 states. And at each of these sites, the Mission interacted extensively with community representatives, service providers, and officials and then after discussion with state officials submitted their state reports. These state reports have been summarized in this national report along with an analysis of general trends across states.

Key Findings of the Mission

1. The most important finding is a general increase in utilization of public health services, reflected in increased outpatients, increased in-patients and a sharp increase in institutional deliveries and greater utilization of ancillary services like diagnostics, referral transport etc.

2. All states have seen substantial increase in numbers of service providers deployed. Some states have substantially revised and improved on key dimensions of their workforce management policies. One important development is a range of incentives across states to improve availability of the workforce in hitherto underserved areas. There is concern that the major parts of the increases are contractual and sustainability beyond the sanctioned NRHM period would be a problem.

3. Expansion of paramedical, nursing and medical education is occurring in all states and there are plans for a major acceleration of this. Lack of faculty, lack of institutions and lack of resources seriously hamper this expansion. In many states almost all recruitable staff available on the open market have been taken in- and unless the pool of new recruits is sharply increased further improvements even in service delivery would become critical.

4. Quality of care and preparedness of facilities have improved. However states with better baselines like Kerala, Tamil Nadu and Maharashtra have been in a position to make quicker use of untied funds and the state and district planning procees for addressing these issues.

5. Induction of management skills, IT skills and accounting skills in a major way into every state and district level has improved the management of programme significantly. Fund flows have increased with computerization of accounting and bank transfers of funds at most levels. However states have shown very varied progress in setting up institutions that are needed to improve management and drive the process of architectural correction.

6. ASHA programme has expanded on the ground to cover all the high focus states except Himachal Pradesh and Jammu and Kashmir, and is now being expanded to cover the entire nation. The ASHA has emerged as an enthusiastic community health worker whose effectiveness has live contact with the public health system is sustained through the JSY and her role in the village health and nutrition day/immunization session. Most other dimensions of community participation- the village health and sanitation committee, the community monitoring programme, the public participation in *rogi kalyan samiti* and district health societies are showing good potential but in many states it is too early to comment as they are only in the take-off stage. There is scope to increase NGO participation in the ASHA programme and in strengthening other community processes.

7. Systematic inadequacies are affecting all vertical programmes, the most important of these being the poor densities of functional health facilities and consequent low human resource densities in the low performing states. Immunization continues to be affected by poor logistics. The efforts at integration, especially by using the district plan process to address systems-programme linkages could be strengthened.

8. Most planning for fully functional facilities or achieving IPHS norms focus on the RCH components. Other health care needs like management of acute illness, trauma, and of non communicable disease are not as yet getting the importance due to them in planning, resource allocation, human resource planning or in monitoring. There is a need for states to develop models of integration of these concerns that could represent upto 80% of morbidities, into the district plan.

9. Hospital Development Societies are in place in all district, divisional and block hospitals and in most PHCs. These societies are functional and are an effective vehicle for untied funds and to some extent of improved facility level management and this has substantially contributed to improving quality of services. Much needs to be done to make them more conscious of their role in safeguarding equity, along with quality of services, and to reduce their image as merely being a vehicle for user fees.

10. Decentralisation in terms of devolution of governance powers to *panchayats* continues to be a challenge.

11. A wide variety of non-governmental partners have been involved in provision of services or strengthening of the programmes. For the large part they are not-for-profit agencies who are reaching out to underserved areas through different contracting arrangements. Though these are all useful supplements to the public health system there is no generally replicable model that has been seen in the states visited. In all cases of partnership, even where it is a reputable not-for-profit group involved, there is a need to have an independent monitoring mechanism in place.

New Releases

§ *The Losers Shall Inherit the World*. A Collection of Essays by T.Vijayendra. April 2009. Rs 60/-.

Co-published by Sangatya Sahitya Bhandar, Udipi; Sahitya Chayana, New Delhi; Bal Sahiti, Chandigarh; and SAHAJ-Shishu Milap, Vadodara. For copies email: <t.vijayendra@gmail.com> or <sahajbrc@youtele.com>, or <sahityachayana@hotmail.com> or <vhapunjab@gmail.com>.

§ *Medicine Prices and Affordability*. A Policy Brief

Published by All-India Drug Action Network (AIDAN), A Campaign Group for Rational Drug Therapy and Policy, April 2009. Rs 20/. Also at <http://aidanindia.wordpress.com/>.

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