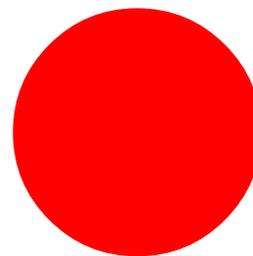


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Health System Challenges and Elements for the Further Right to Health Campaign

- *Abhay Shukla**

This article attempts to briefly review some developments related to the health care system, which are impinging on health rights of people in India today. It is argued that especially in an era of growing 'PPPs' the traditional conceptual separation between 'public health system' and 'private medical sector' needs re-thinking and we need to address the entire health care system as a larger entity. Some key challenges related to social determinants of health are briefly discussed, with the suggestion that health activists need to play a role in critically influencing the broader developmental paradigm. This is followed by suggestions of some directions towards furthering the Right to Health Campaign, which could be taken by the health movement to address this situation.

1. **Developments Related to Health Care since 2003-04 and the Current Situation**

On September 6, 2003, during a national public consultation on Right to Health Care at Mumbai, Jan Swasthya Abhiyan (JSA) launched its Right to Health Care campaign. Such a campaign was considered necessary due to the serious deterioration in public health services, stagnant health budgets and overall inaccessibility of quality health care to people across the country. Major activities by JSA constituents during 2003-04 included documentation of cases of denial of health care in public health facilities, organisation of local or district level Jan Sunwais on health rights in some states, and organisation of regional and national public hearings on Right to Health Care in collaboration with NHRC.

The focus of this campaign was on improving public

health services, with a concentration on rural areas, while trying to make these services accountable so that people could effectively claim their health rights. The process of public hearings mobilised health activists on a significant scale, enabled the documentation of hundreds of cases of denial of health care across the country, demanded accountability from state health authorities on the NHRC platform and helped to highlight the crisis of the public health system. With this context it will be useful to review developments since 2004, to take stock of where we stand today and how we need to move ahead for a next stage campaign on the Right to Health.

Launching and Implementation of NRHM

The most significant official response to the health system crisis has of course been the launching of the National Rural Health Mission (NRHM) in April 2005. The electoral mandate of the 2004 general elections was obviously the major factor responsible for this. Jan Swasthya Abhiyan members were involved in some of the initial NRHM task groups and consultations, and tried to shape the Mission in a pro-people direction, although their suggestions were often accepted only in part and there were significant differences within JSA on certain issues. JSA launched the People's Rural Health Watch (PRHW) in 2006 to assess the evolving status of the Public health system in rural areas, to 'watch' and thus build pressure for ground level fulfilment of the positive promises of the Mission, and to critique various negative tendencies. Community-based monitoring of health services was launched in mid-2007 in selected districts of nine states, and along with providing a space for people to demand accountability, has provided another source of information about the status of delivery of services related to NRHM.

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This brief article is of course not the place to analyse NRHM in detail (which has been done by many others in various documents), rather the purpose here is only to trace the role of a health rights approach in the current situation. Of course there are various positions within JSA and the health movement about the design of NRHM and the degree to which it is having an impact on health services. However based on the PRHW reports and Community monitoring experiences from various states, it would probably not be inappropriate to conclude that although certain positive health system changes have been initiated, there is still a very long way to go before quality public health services become available in an assured manner, as a right to all people in rural areas across the country. Guaranteed health services remain a positive goal, but are yet to be operationalised as an assured reality. Continued implementation of detrimental programmes like the Pulse Polio eradication strategy has been joined by new problematic schemes like Janani Suraksha Yojana. Untied funds have proved a mixed blessing, with the potential to improve peripheral health facilities combined with the frequent reality of problematic 'directed from above' utilisation and enhanced corruption.

Elements on the 'input' side of NRHM such as increased public health budgets are a definite step forward, compared to the 'lost' decade of the 1990s. However despite service improvements in some areas in certain states, it is debatable as to what extent there is qualitative improvement on the 'output' side, in terms of assured, accountable quality health services being made available to all in rural areas across the country. Until such substantial improvements lead to ensured health care entitlements, for activists the health rights approach will remain relevant in the context of the rural public health system. This may consist of three strands of action – community-based monitoring of health services demanding services as rights within the NRHM framework; beyond this framework also demanding health rights at grassroots level and protesting against problematic aspects of implementation and programmes in various areas; and carrying on a larger critique and dialogue at the policy level.

However, we cannot understand and address the current state of the health care system without also looking at the 'Big Brother', the private medical sector.

Private Medical Sector Continues to Proliferate without Regulation

While public health system reform in some form, in

the shape of NRHM has been underway since over four years, the private medical sector remains unregulated in any effective form in most states of the country. In the section "Role of the Private sector", the National Health Policy 2002 had promised:

... the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions by 2003. Also, statutory guidelines for the conduct of clinical practice and delivery of medical services are targeted to be developed over the same period.

Even till mid-2009 such 'suitable legislation' is yet to see the light of the day.

NRHM documents, despite aiming at 'architectural correction' of the Health system have been low-keyed in their statements about the private medical sector; NRHM as well as the broader health sector reform process have failed to initiate much-needed regulation of this sector until now.

A much belated draft legislation for clinical establishments was circulated in November 2007, which largely restricted its scope to registration of clinical establishments, made only a brief mention of standards, and was completely silent about patients rights, emergency medical care or public health obligations related to private medical establishments. The fate of even this limited legislation remains uncertain since it has not yet been presented in a final form for adoption by the Parliament.

In a state like Maharashtra, where processes for regulation of the private medical sector have been underway since over a decade, there has been little concrete progress so far. Draft legislation for regulation of Clinical establishments (to be achieved through modification of the Bombay Nursing Homes Registration Act) was developed through wide ranging discussions and consensus among representatives of the Health department, private medical professionals and health activists in 2001-02. Then after over three years of unexplained official paralysis, a tokenistic modification was made to the Act in end-2005. Subsequently a set of draft rules were developed through wide-ranging discussion in the first half of 2006. However the draft rules which were put on the Maharashtra Health Department's website in mid-2006 are yet to be operationalised, despite continuous follow up by Jan Arogya Abhiyan (JSA-Maharashtra) over the last three years. It is widely believed that this second bout of 'paralysis' is due to the private medical lobby stalling effective regulation.

The continued, *tremendous reluctance of governments, at both the Central level and in most states, to effectively regulate the large private medical sector* in any form is a matter of serious concern. This of course fits in with the current approach of globalisation with a human face, rather mask. The government may be willing to make some increases in social sector expenditure and provide some public services to the poorest in a targeted manner, but continues to aggressively promote neoliberal globalisation-privatisation and hence *will not intervene in the core processes of profit accumulation by the private sector*, and will not support any social regulation which may even minimally reduce the margins of profit for capital. Regulation, even when it finally does come through, is likely to be of the minimal variety and may not go beyond registration and some very basic physical standards. This approach, in other words, amounts to ‘deliver some basic public services for the poorest, but do not even touch the exploitative profiteering of the private sector.’ In this context, it is high time that the issue of often exploitative and irrational nature of the expanding private medical sector and its frequent violation of patients’ rights, necessitating effective public and social regulation, is turned into a major campaign issue.

Dominant Model of Privatisation-Oriented PPPs - An Emerging Problem

Linked to the government’s attitude to the private sector is the emerging, dominant model of so-called Public-Private Partnerships (PPPs). Since the early stages of the evolution of NRHM, one aspect which has appeared particularly problematic has been the dominant form of PPPs being proposed. In general, most of the interactions between public and private health systems being suggested are in the direction of outsourcing, weak public control, lack of control on quality or rationality, and dilution of public responsibility, rather than strong public regulation and harnessing of rationalised private medical sector resources. Bihar is one of the states which led the way in introducing such PPPs on a significant scale, which have often collapsed under their own weight of incompetence. The multi-hundred crore EMRI episode, where disproportionately large resources have been poured in by governments for an ambulance service, is another example of problems emerging from inadequately regulated PPPs. (The EMRI scheme has been evaluated by NHSRC and the report is available on their website. This report shows that above and beyond all operational costs, from ambulance drivers to state managers, there are massive ‘leadership costs’. This constitutes about 200 ‘leaders’ with average

salaries of Rs. 18 lakhs per year, i.e., Rs. 36 crore annually. This seems quite excessive and unjustified. It is also well known that the EMRI scheme has not been particularly transparent and there has been no open tendering at any stage.) The much celebrated Chiranjeevi scheme in Gujarat has also been revealed to be problematic, with cases of private providers charging patients for services supposed to be free, and decline in utilisation of public health facilities in some areas. The entire gamut of ‘partnerships’ is taking place in a situation of complete non-regulation of the private medical sector, opening the way to a wide range of ‘public funding, private profiteering’ scenarios. There are no clear national guidelines or criteria about which kind of processes must be prevented or allowed under PPPs, leaving State Health departments free to ‘improvise’ with often questionable consequences. Although PPP services are funded and organised by the state, there are no clear provisions of citizen’s health rights regarding such services.

Contrary to this trend, we need to think of systemic options where along with significant strengthening of the public health system, a public mechanism regulates, rationalises and utilizes certain private/non-profit medical providers to provide specific health services to people, ensuring that these services are free at point of service. In effect, along with increasing its own capacity, the public system needs to progressively control, ‘socialise’ and ‘take over’ rationalised sections of the private medical sector to form a larger system of publicly managed health care provision. There are numerous examples from other countries (e.g. U.K., Canada, Brazil) where this has been done effectively. However, under NHRM in certain states, and as likely part of the emerging National Urban Health Mission (NUHM), we are seeing the emergence of a variety of PPPs *where the reverse is being promoted*; in fact private providers may be enabled to ‘take over’ public resources by the medium of various forms of outsourcing to an unregulated and often irrational private sector. If NUHM is implemented in its ‘privatisation variant’ we might now see further rapid evolution of privatisation oriented PPPs sweeping through our already highly privatized health care system. There is *need for clear criteria to help analyse and assess the PPPs being currently implemented*, and to highlight the dangers of many of the current PPPs which might lead in the direction of loss of control and weakening of responsibility by the Public health system. Wherever services are being outsourced and now people are being required to pay for services delivered by private providers, there is an obvious violation of health rights.

Similarly PPPs which lead to regular decline in utilisation of public health facilities need to be questioned. Today JSA needs to discuss the specific types of PPPs being implemented and these need to be analysed, critiqued, and as relevant opposed from a strong health rights perspective.

2. Public Health System Crisis and Private Medical Sector Dominance - Two Faces of the Same Coin

In discussions about NRHM and strengthening of the public health system, we have often treated 'public' and 'private' as two isolated and opposed systems, while ignoring the key role of the much larger and dominant private medical sector in shaping the public health system. The public health system is effectively treated like a stand-alone system which can be transformed and strengthened in isolation. However *we need to squarely address the health system crisis in an integrated manner* - the public health system cannot be transformed in isolation beyond a point because *private sector dynamics dominating the entire health care system decisively influences and shapes the public health system*. The existing public health system thus often functions as a 'semi-privatised' system. This can be seen on several fronts:

- ***Flourishing of both 'legal' and illegal private practice:*** It is long established that the existing public health system in many places is actually informally quite 'privatised'. Doctors are mostly allowed private practice outside duty hours, which strongly induces them to 'direct' patients to their private clinics, to remain absent during part of duty hours since they are busy in their clinics, and to maintain differential standards of care and attention in the public facility compared to their private practice – which often induces and pressurises even poor patients to seek care in their private clinics. Added to this is frequent illegal private practice within the walls of the public institution, including charging for operations and other services. Without decisively tackling this existing large scale 'semi-privatisation' resulting from private sector dynamics operating within the public health system, it will be difficult to ensure quality care for patients in this system.
- ***Systematic linkages with private facilities:*** It is common knowledge that patients approaching public facilities often have to get investigations (Pathology, X-ray, Ultrasound, etc.) performed in those private facilities which give a 'cut' to the referring public doctors. It is also not

uncommon for a doctor sitting in a PHC or CHC to refer an 'affording' patient, not to the next higher public facility, but rather to a 'preferred' private hospital. In effect, public facilities become a gateway for patients to be channelled to the private sector.

- ***Hidden hand of the drug industry: irrational treatment practices:*** Even when essential medicines are available in the public facility, patients may be asked to buy irrational and expensive 'non-essential' medicines from medical stores which give commissions to prescribing public doctors. The treatment practices of doctors in both public and private health facilities are today strongly influenced by the drug industry, and effectively the irrationalities of the private sector become the 'benchmark' even for public health system doctors. Rational treatment protocols and norms need to be applied across the board, in both public and private sector, to change this trend.
- ***Non-availability of doctors: result of market failure:*** The non-availability of doctors for the public health system, especially in rural areas has of course been identified as a key barrier to improving services. However, the fact is that the total availability of doctors per population in India is better than in many other developing countries. In fact the majority of doctors being produced are from publicly funded medical colleges - however the massively proliferating private sector 'captures' most of the newly graduating doctors who have been educated at significant public expense. This is a typical case of 'market failure' where just 'leaving it to the market' does not meet the social need. On the other hand if further growth of the private medical sector were to be subjected to effective 'certificate of need' regulation, the irrational proliferation of private hospitals in major cities could be checked, and more doctors could be induced to work in the public health system in smaller towns and peripheral areas. Further, the distorted dynamics of private, capitation medical colleges (where each student may pay Rs 30 lakh plus to become a doctor), and now paramedical colleges too, and the effect of such privatised medical education on the career path of new doctors and paramedicals needs to be assertively checked; and to influence which sector doctors prefer to work in after graduating.

Further moves such as introduction of user fees and

the idea of turning public health institutions into 'autonomous' bodies required to earn part of their revenue through various such measures, would only strengthen semi-privatisation. In short, while working to strengthen various aspects of public health system, *it will not do to ignore the massively dominant private sector and its malign influence on the public system.* Combined with internal reforms and strengthening of the public system, decisive and effective regulation of the private medical sector including checks on its irrational proliferation, and tackling of all-pervasive *private sector dynamics within the public health system* must be taken up in an integrated manner. If public processes do not reshape the private sector, then the private sector will continue to reshape the public health system in its own image. It will not be sufficient to focus exclusively on the public health system in isolation, while strong winds of private sector dynamics are sweeping through the entire health system.

Health System at Crossroads: What Will Be in Command, Public Health or Private Profits?

Today private interests influence and distort many bodies which are supposed to promote the public interest. One glaring example are the instances of medical professional associations such as IMA publicly endorsing particular private brands of consumer products.

Such trends have also made inroads into the ideology of public bodies. Today, as we take stock of NRHM four years down the line and look forward, we can see that health system development is reaching a crossroad. There is one influential school of thought – championed by those like Montek Ahluwalia, the Deputy Chairperson of the Planning Commission – who point to the sub-optimal improvements due to NRHM and use this as a pretext for much greater emphasis on outsourcing, PPPs and privatisation of services. This approach is reflected in one version of the various NUHM drafts and is likely to be strongly supported by BJP-led state governments. On the other hand, there is a strong social argument for comprehensive regulation of the private medical sector, establishment of patients' rights, and moving towards a system for Universal Access to Health Care based on a combination of strengthened and accountable public services along with certain publicly regulated, rationalised private services. While the larger political scenario will play an important role in deciding which choices are made, it is our duty to place the issues before the people and mobilise public opinion to the maximum extent possible, in

favour of the latter option. This would necessitate a very effective national campaign strategy, about which some ideas are outlined in the last section.

3. Health Determinants under the Shadow of Neo-liberal Globalisation

While the scenario on the health care front appears quite problematic, when we look at trends related to key social determinants of health, the situation looks even grimmer. Although analysing each of these major areas would require separate detailed documents, a few points may be briefly noted here –

□ ***Deteriorating food security and nutrition:*** It has now been widely documented how per capita food grain availability has actually declined over the last two decades. The deepening agrarian crisis has led to stagnant or uncertain incomes for the rural poor with obvious implications for their ability to purchase basic food items. Combined with this has been conversion of PDS to a targeted form, with a highly problematic 'poverty line' leading to exclusion of large numbers of the food-insecure and overall weakening of the public distribution system. We have a situation that would be considered ridiculous if it were not so tragic, where 77% people earn less than Rs. 20 per day, about 65% of the population are unable to access their full complement of calories (NSS 61st round) but only 27.5% is officially 'Below Poverty Line'. Large scale undernutrition and anaemia persist (NFHS-3) and the consequences these are having for public health, including lowering of resistance to various communicable diseases, are obvious. Unfortunately we have hardly ever heard of public health authorities championing food security or nutrition as a key intersectoral issue related to health. Health activists need to intervene in the drafting of the Food Security Act to ensure that entitlements are in keeping with actual requirements of the people, and that BPL-style targeting does not continue to deny access to large sections of the deserving population.

□ ***Privatisation of water:*** As part of implementing the neo-liberal mantra, there have been various initial moves towards privatisation of water supply in both rural and urban areas. Some such moves have been effectively resisted due to citizens' mobilisation, especially in cities like Delhi and Bangalore. However, moves to offload maintenance costs onto communities in rural areas through schemes like Jal Swarajya and efforts to privatise water supply and introduce user charges in certain cities, continue to loom on the horizon. If water availability becomes further restricted due to privatisation and user charges, then the consequences for public health have already been

documented in other developing countries, especially in Africa. A similar dreary future lies in store for us unless such moves are effectively exposed and defeated.

□ ***Environmental and occupational impacts on health:***

As the Indian capitalist class seeks to become increasingly globally competitive, costs have to be cut to protect and expand profit margins. While manufacturing and extractive industries seek ‘double digit growth rates’, there are two major victims of such cost cutting – the environment and workers. Industrial estates and specific hazardous industries blatantly violate environmental norms and release hazardous wastes, contaminating air, water and soil. Communities living in proximity with these industries suffer the adverse health effects of such toxicity, while regulatory authorities conveniently look the other way. Health departments – which should be in the forefront of documenting and monitoring such health effects and activating environmental regulatory bodies – are nowhere to be seen.

A parallel situation prevails on the occupational health front. As working hours are prolonged, extended overtime becomes the norm, and safety provisions are downsized as part of cost-cutting measures, accidents at work are bound to increase. Contract workers are cheaply available and are considered ‘disposable’, so they are forced to work in unhealthy conditions, in regular contact with toxic materials and unsafe conditions. An extreme example of this is the silicosis epidemic in certain districts of Western M.P., generated by stone crushing industries in neighbouring Gujarat. These crushers employ young migrant workers without protection in extremely dusty and hazardous conditions which give rise to ‘acute silicosis’ within a year or two. Once these young workers develop the relentlessly progressing and invariably fatal disease, they are ‘free’ to go back to their villages and die, many of them barely in their late twenties or early thirties. Needless to repeat, while the main role of ESI has been to deny the need for compensation, Health departments in either Gujarat or M.P. have done next to nothing either to document this major health problem, or to prompt related departments to address working conditions in the deathly units, which not only crush stones but also crush the life out of their own workers.

While a much more detailed discussion on each of the health determinants is required, even a cursory overview may prompt us to rethink about our positions and strategies to struggle for people’s health in the

era of neoliberal globalisation. It is obvious, and has often been discussed in JSA and other forums, that health activists need to take a proactive role in addressing health determinants. This needs to be done as part of a larger social process of rejecting and replacing neo-liberal globalised-privatised development, which is eroding a spectrum of social rights. It also needs to be recognised that in related sectors such as food security, environment or education there exist parallel movements with their own leadership and area specific capacities. Hence the role of health activists is not to replace the efforts or supplant the leadership of these ongoing initiatives, but rather to support and strengthen them with health arguments and participation.

Further, can the dominant privatisation-oriented PPPs in the health sector, irrationality and exploitation by the unregulated private medical sector, growing medical tourism and ‘internal brain drain’ be separated from the larger model of neoliberal ‘development’? Today we dialogue, negotiate, in some forms even collaborate with one arm of the State – the public health system – concerning improvement of public health services. But can we ignore *what the same neo-liberal, corporate dominated state is doing in other sectors of the economy, which also impact on health* – forcible land acquisition through SEZs, deliberately weak implementation of labour laws which increases the profits of capitalists but damages the lives of workers, privatisation in multiple sectors and promotion of exclusionary ‘predatory’ development on all fronts? As health activists, do we not have a role of participating in the critique of a socio-economic model which produces a GDP growth rate of 7-8% but fails to reduce large scale malnutrition, fails to protect food security leading to hunger-related deaths, massively promotes migration with its share of adverse health impacts, sharply increases inequities and violence with their health consequences? Can we confine ourselves to ‘engaging’ with the public health system while ignoring the larger political-economic agenda of the state and the corporate class which stands behind it?

4. Some Points for Campaigning on the Right to Health

□ The Right to Health Care, demanded in 2003-04 has to some extent come on to the agenda but is far from being realised. In the context of NRHM, the health rights approach acquires a new significance – to press for actual delivery (and progressive expansion) of the full range of ‘guaranteed services’ at the ground level.

Key issues like availability of essential medicines, problematic user fees and corruption at various levels of the public health system need to be addressed from a strong right- based framework. Community-based monitoring (from ‘within the system’) offers one channel – but this needs to be combined with popular mobilisation and generating much stronger political will for public health at various levels.

□ We are faced with the overdue task of squarely addressing regulation of the private medical sector – however there is the challenge of developing an effective popular campaign strategy regarding the private sector. One way forward is to begin posing *demands for patient rights in the private sector*, which have a strong popular appeal. This may focus on so-called Trust hospitals to start with; they have certain public obligations and accountability since they have availed of public subsidies and are registered with the Charity Commissioner. We need to emphasise that promotion of the private sector is not the solution to the public health system crisis, rather the private sector itself needs to be publicly regulated and rationalised.

□ We need to sharply oppose forms of privatisation being pushed through the dominant PPP model – and highlight the dangers and failures of such strategies. However in a situation where 60-80% care is given by the private sector and over three-fourths of doctors are in this sector, any comprehensive alternate solution will have to build in a component of *bringing private medical resources under public management*. One good place to start might be to demand ensured provision of compulsory free beds for poor patients in Trust hospitals, and to move towards a publicly-managed mechanism for allocation of such beds.

□ A series of regional and national public hearings on health rights has been proposed by JSA to NHRC, which could provide a useful forum to highlight violations of patients’ rights in the private medical sector as well as continued, outstanding health rights issues related to the public health system. Highlighting rights violations in the private medical sector with publicity in the media may be accompanied by raising issues concerning some of the ongoing PPPs which have aspects of rights denial (e.g. patients having to formally/informally pay for services in various outsourcing arrangements).

□ The draft National Health Bill provides an important instrument to push for Health rights in both the public health system and the private medical sector, as well

as for key social determinants of health. As JSA we need to take the draft to large numbers of activists, to give inputs to refine the current draft and to generate large social consensus and pressure for this to be passed as the National Health Act.

□ With this entire context in mind, we need to start working on models for Universal Access to Health Care, which would emerge through a publicly regulated system which ensures services which are free for all at point of service. This would require examination of models in other developing countries like Thailand and Brazil, and looking at various workable options in the Indian context. Key issues would be funding (significantly increased tax-based funding, perhaps combined with comprehensive social health insurance for the organised sector), provision of services (strengthened public health facilities combined with regulated, rationalised private providers) and participatory regulation and community monitoring.

□ Given the positive experience of health activists allying with the Right to Food campaign, the health movement may think of helping to build and participating in an alliance with partner movements working on various other social rights, towards building ‘**social sector alliances**’. Such alliances could transcend the current fragmentation of movements, and could move towards more effectively challenging the model of neo-liberal globalisation while strengthening a broader socio-political struggle for people’s rights.

There is obviously need for wide ranging debate on all these issues within the health movement. Yet this debate has now acquired certain urgency and needs to be oriented towards concrete campaigns and action. Today in a rapidly evolving scenario the health system stands at a crossroads, with both danger and opportunity lying ahead. Broad based social mobilisation for health rights in both public and private health sectors, opposition to privatisation including dominant PPPs needs to be combined with concrete proposals for publicly organised universal access to health care. This should be done in tandem with alliances to strengthen access to key determinants of health such as food security and nutrition, access to safe water and healthy occupational and environmental conditions.

Such is the difficult but exciting road ahead, as we face the challenge of the struggle to achieve the Right to Health for All.

The Myth of Regulation:

A Critique of the 2008 Draft ART (Regulation) Bill and Rules

- Sama - Resource Group for Women and Health¹

Introduction

Assisted Reproductive Technologies or ARTs are a group of technologies, which assist in conception and pregnancy. They encompass various procedures ranging from the relatively simple Intra-Uterine Insemination (IUI) to other variants of *In-Vitro* Fertilization (IVF), more commonly known as “test-tube baby technology”. Surrogacy, which is not a technique, but an arrangement, is also included under the umbrella term of ARTs.

In India, there has been an unprecedented and unregulated growth of ART clinics providing IVF procedures over the years. Within the framework of medical tourism, ARTs are the latest addition to the long list of medical services being offered. Low costs, easy access to the otherwise highly regulated technologies and easy availability of surrogate mothers and gamete donors have made India a favored destination for these procedures. The resulting surge of the ART ‘industry’ in the country has posed a number of ethical, legal and social dilemmas, including amongst other things the increasing commodification and commercialization of women’s reproductive tissues.

In such a context, stringent regulatory and monitoring mechanisms are the need of the hour. Laws and guidelines on Assisted Reproductive Technologies (ARTs) have been developed by many countries across the world to regulate the practice of ARTs, especially to check unethical practices and prevent the proliferation of unsafe techniques. The recent Draft Assisted Reproductive Technology (Regulation) Bill and Rules-2008 by the Ministry of Health and Family Welfare (MOHFW) and the Indian Council of Medical

Research (ICMR) is an important and welcome step in this direction. Although the Draft Bill attempts to incorporate many issues related to Assisted Reproductive Technologies, it unfortunately carries on the vestiges of the drawbacks present in the National Guidelines on Accreditation, Regulation and Supervision of ART clinics in India (2005). The purpose of this fact sheet is to highlight the concerns with regard to the Draft Bill amongst parliamentarians

ARTs as Practised in India Today, Some Features

- Rampant use of unethical practices in the use of ARTs
- Women’s health and well-being severely compromised
- Women’s bodies treated like commodities
- No accountability of providers practising ARTs
- No standardisation of the procedures and drugs used, no proper documentation,
- Non-transparency and insufficient information provided to patients
- Misinformation about success rates (a “successful cycle” need not lead to a baby being born)
- No rights to patients/users of ARTs
- Providers fleecing patients of huge amounts of illegal money by cashing on their desperation for a child and the stigma around infertility
- India fast becoming a destination for foreign health tourist shopping for ARTs, especially for surrogate mothers, who can be commissioned for much less price
- Large-scale exploitation of surrogate mothers
- A whole range of research activities around and arising out of ARTs, especially those using embryonic stem cells remain unregulated

Assisted Reproductive Technologies

- Are highly invasive procedures
- Have low success rates
- Have serious risks and side effects
- Are very expensive
- Do not treat infertility, only assist in reproduction

¹This paper is part of the Fact Sheet prepared by Sama-Resource Group for Women and Health towards the Orientation for Parliamentarians. Fact Sheet is an attempt to bring forth some of the important concerns in the Draft Bill so that they can be rectified towards a pro-people and pro-women legislation. A detailed description of the concerns and limitation is not within the scope of this particular document. For the full length critique of the Draft ART Regulation Bill and any further information please contact: Sarojini N.B/Preeti Nayak, c/o Sama-Resource Group for Women and Health, B-45 2nd Floor, Shivalik Main Road, Malviya Nagar, New Delhi 110017, Ph. No.: 26692730, 65637632. Email: <sama.womenshealth@gmail.com>; Website: <www.samawomenshealth.org>

and policy makers, and to engage with them towards a more effective and comprehensive legislation. The fact sheet tries to highlight only certain concerns. However, there are many issues in the entire document which are not in the interest of women's rights, child rights and promote the interest of ART industry.

Contradictions within the Proposed Draft ART Bill

The document lacks clarity at many levels and uses ambiguous language, which makes the effective implementation of the Draft Bill challenging. Moreover, different parts of the Draft Bill contradict each-other leaving certain critical questions unanswered.

For example, regarding the issue of making payment to the surrogate, Clause 26 (6) of the Draft Bill states that *"A semen bank may advertise for gamete donors and surrogates, who may be compensated financially by the bank."*

But according to Clause 34(2) *"... the surrogate mother may also receive monetary compensation from the couple or individual, as the case may be, for agreeing to act as such surrogate."*

Further, the Form of Contract between the Semen Bank and the Surrogate [Form- R2 (4)] mentions that:

...the consideration for the surrogacy is to be paid by the parent(s) and the Bank will not be responsible for any demand by the surrogate in the form of compensation. The Bank shall not be responsible for payment to the surrogate for any other expenses incurred during the surrogacy period.

It is interesting to ponder upon how the law would perceive these contradictory clauses and the way their implementation would be brought about. In case of such contradictions, which clause would be given precedence?

Eligibility

Though the Bill claims to be liberal by using the phrase married or unmarried couple as eligible for ARTs, it does not include within its ambit people who are not heterosexual and their accessibility to ARTs. The Bill clearly defines "Unmarried Couple" as a man and a woman, both of marriageable age, living together with mutual consent but without getting married [Clause 2(w)] and "Couple", as persons living together and having a sexual relationship that is legal in the country/countries of which they are citizens or they are living in. [Clause 2(e)]. Therefore, Indians who openly identify as homosexuals are not eligible. As per both the above-mentioned definitions, only heterosexuals, irrespective of their marital status, are

eligible to access these technologies in India.

Age

The Draft Bill has left a substantial void in the regulation process by not specifying the maximum permissible age of women for undergoing ART procedures. Considering the serious health implications, the magnitude of which may increase with age, this lacuna needs to be addressed. There have been cases where women as old as 60 years or above have conceived through ARTs with serious implications to their health. Providers are glad to undertake such 'challenging' cases without analyzing the repercussions. It is important that this should be monitored by the MOHFW/ICMR, rather than be left to the discretion of the providers. The number of embryo transfer and oocyte retrievals should also be specified corresponding to the age of the woman.

Women's Agency

The Bill has no consideration for the status of a woman: to describe a woman who may not be able to have a biological child, as a 'patient' is extremely offensive, regressive and anti-women. The Bill also uses the term 'client' for persons accessing these technologies. Words such as Patient has also been used in the sense of categorizing them in specified groups for referral to different levels of infertility/ART clinics. In the case of only male factor infertility, the couple is referred to as patient. The Contract between the Semen Bank and the Patient defines Patient as *"an individual/ couple who has approached the bank for availing the services of a sperm/oocyte donor or as surrogate"* [Form-S (2)]. This would mean that only those individuals/couples requiring donor gametes or surrogate for conception would fall under the category of 'Patient'.

The various consent forms, specially the agreement on surrogacy, stress on spousal consent. Such requirements of 'consent' formally establish the heteronormative principle of the 'husband's right to control the 'wife's' body. This requirement is unreasonable as it takes away the right of the surrogate over her own body. This should be reconsidered by the MOHFW/ICMR.

The law, when it comes to the right to have a child, a woman's agency must necessarily be subject to that of her 'husband's'. This has something to do with an inherent understanding that a pregnancy outside of 'wedlock' is something that needs to be avoided so as to maintain the 'legitimacy of reproduction' only within marriage.

Health Risks and Side-Effects

The Draft Bill states that “ARTs carry *small risks both to the mother and the offspring*” (Rules 6.13) and at the same time mentions that the risks for women include health implications such as multiple gestation, ectopic pregnancy, spontaneous abortion and Ovarian Hyper Stimulation Syndrome (OHSS). These risks are not only serious by themselves which is not reflected in the Bill, they further entail serious implications, which also have not been mentioned in the Draft Bill. It is appalling how the MOHFW/ICMR have described life-threatening risks as ‘*small risks*’. It only reflects the extent of their concern for women’s well-being in a document that actually seeks to regulate these technologies and ensure their safe delivery.

Risks Associated with Intra Cytoplasmic Sperm Injection (ICSI)

- i) possible inheritance of genetic and chromosomal abnormalities including
 - (a) inheritance of cystic fibrosis gene mutations
 - (b) sex chromosome defects and the inheritance of sub-fertility
- ii) abnormal numbers or structures of chromosomes
- iii) novel chromosomal abnormalities
- iv) possible developmental and birth defects
- v) possible risks during pregnancy such as miscarriage

Source: Human Fertilization and Embryology Authority’s Code of Practice (6th Edition, Part 16)

Further, while the document at least mentions risks for the women, risks to the *offspring or children* born of ARTs are not mentioned at all, even though they are really substantial as revealed through studies (see box below).

Surrogacy

Although the Draft Bill has specific clauses regarding the surrogacy arrangement, the rights and health of the surrogate are still compromised to a large extent. MOHFW/ICMR should take special measures for safeguarding the rights and health of the surrogates, especially those commissioned by foreigners. Further, the Draft Bill prohibits the surrogate from being the egg donor, thereby only permitting gestational surrogacy. This also indicates that the surrogate would have to undergo IVF even though her oocytes are viable and she can conceive through the much simpler procedure of IUI.

In addition to the broad concerns there are also specific

concerns which have been left unaddressed or inadequately addressed in the Bill, some of which are:

- o Eligibility and age for becoming a surrogate,
- o Contract between the surrogate and the couple,
- o Exploitative role played by ‘middle-men’ and intermediaries in surrogacy agreements,
- o Special safeguards and special terms of agreement, for surrogates commissioned by foreigners
- o Role of the semen bank in the payments made to the surrogate,
- o Number of cycles or attempts for surrogacy,
- o Other health risks that surrogates are vulnerable to,
- o Health insurance and Legal Aid for the surrogate,
- o Other rights of the surrogate and guardianship,
- o Screening of the intended couples

Inadequate Coverage through Registration and Monitoring

The Draft Bill in its present form focuses only on IVF clinics and semen banks, but ignores gynaecologists offering infertility ‘treatments’ and IUI procedures. Further, the Draft Bill does not take into consideration other consultancies, organizations, agents, private agencies and travel agencies involved in promoting IVF/ART techniques, egg donation and surrogacy. It is important that any piece of regulation should take into consideration the increasing numbers of ‘players’ and take measures to specify their roles and status. Further, the Draft Bill is limited in the sense that it does not extend to the public hospitals offering these technologies.

Age of Women Undergoing ARTs

The Draft Bill treats women’s bodies and wombs merely as sites of reproduction, without any concern for other aspects of her life and well-being. It has left a substantial void in the regulation process by not specifying the maximum permissible age of women for undergoing ART procedures. Considering the serious health implications, the magnitude of which may increase with age, this lacuna needs to be addressed. There have been cases where women as old as 60 years or above have conceived through ARTs with serious implications to their health. Providers are glad to undertake such ‘challenging’ cases without analyzing the repercussions. It is important that this should be monitored by the MOHFW/ICMR, rather than left to the discretion of the providers. The number of embryo transfer and oocyte retrievals should also

be specified corresponding to the age of the woman.

Role and Regulation of Semen Banks

The Draft Bill in its current form hands over a substantial part of managing and running of the ART process to the semen banks without providing any rationale. According to Clause 26(1): “*The collection, screening, storage and handling of gamete will be done by a semen bank.*”

Without clear directions regarding mandatory equipment and personnel in the semen bank, the Draft Bill is not clear on how they are going to equip themselves for these responsibilities. The Draft Bill also does not lay down any clause specifying who can open and run a semen bank – the qualifications and background of the person and the team necessary to run a semen bank, as has been specified for ART clinics. There needs to be a clear-cut demarcation of roles of the ART clinic and the semen bank, which at present, is one of the weakest points in this Draft Bill. In the present scenario left unchecked, there is a greater risk of manipulation, entry of intermediaries and breach of anonymity of donors and surrogates making them vulnerable to exploitation.

New and Emerging ART Procedures, and Embryonic Stem Cell and other Researches around ARTs not Covered

The Draft Bill appears narrow in its approach by trying to regulate only a specified number of procedures. However, with the everyday advancement of these technologies, a number of new procedures have also been introduced in some of the IVF clinics. The Draft Bill does not mention any of the new procedures in the entire draft. By not doing so, the legislation is limiting itself to only the ART procedures the aspects of which are so far well understood.

Further, having included a chapter on research on embryos, it is surprising that the Draft Bill does not mention human embryonic stem cell research or issued any regulations related to it. Considering the fact that the source of embryonic stem cells is generally the spare embryos developed during IVF, the document should make efforts to regulate this aspect. In lieu of the rapid pace of advancement being made in this field, scope should be left in the legislation for the inclusion of new technologies, researches, and the possible debates resulting from their potential use.

Exploitative Practices by Other Players

The Draft Bill allows couples to advertise for surrogates without mentioning ‘*details relating to the caste, ethnic identity or descent of any of the parties*’

and prohibits ART clinics from seeking surrogates for its clients [Clause 34(7)]. However, advertisements for egg donors or surrogates by advertisement agencies, tourism departments, surrogacy agents, women’s magazines, medical tours and travel agencies are not covered in the Draft Bill at all. Advertisements from couples looking for surrogates and women intending to be surrogates can be found regularly in newspapers and magazines like *Sarita* and *Woman’s Era* mentioning the desired age, religion, caste and even the skin colour of the donors. Similarly, there are many advertisements by women wanting to become surrogates. The Draft Bill only prohibits the clinics from advertising but does not foresee the establishment of newer enterprises that may undertake such advertising. Further, the contents of the advertisements should be monitored and regulated and the Draft Bill should have specific provisions for this.

Promoting Eugenics through Donor Matching

According to Clause 20(4),

Either of the parties seeking assisted reproductive technology treatment or procedures shall be entitled to specific information in respect of donor of gametes including, but not restricted to, height, weight, ethnicity, skin colour, educational qualifications, medical history of the donor, provided that the identity, name and address of the donor is not made known.

Similarly, couples are entitled to know the ethnicity and educational qualifications of the donor and details like religion, education and monthly income of the donor must be recorded in Form M [Information on Semen Donor (4, 6, 7)].

Form M2 [Information on Surrogate (8, 9)] requires education and occupation of the surrogate and her spouse (if any), religion and monthly income. Moreover, current practices indicate that surrogate mothers and donors are chosen based on their caste, religion, skin colour and attractive physical features. A recent article in *Outlook* stated that “Traits such as Fair skin, Lighter hair, Blue/green or light eyes and High IQ levels are greatly in demand by the Indian couples coming to the fertility clinics.” (Amba Batra Bakshi, ‘This Sperm Counts’, *Outlook*, November 3, 2008.)

Unfortunately, the Bill too supports these trends by asking for the surrogate’s colour of skin, hair, eyes [Form M2 (34, 35, 36)], which is completely pointless since her oocytes would not be used in the procedures. As she only gestates the child, it is unnecessary to record her genetic characteristics. Giving significance to these characteristics is unnecessary since they do

not have a bearing on the genetic composition of a person at all. Revealing particular characteristics of the donor to the intended parents and allowing them to choose donors based on those characteristics ushers in a number of debates. They only encourage eugenic tendencies and lead to discrimination against people belonging to particular religions, castes and with low educational and economic status.

These may promote creation of designer babies and can definitely not be allowed through a national legislation. It must be distinguished whether particular characteristics are being chosen because they match with those of the parents or because they are socially prized. Monitoring of such selection, which has been ignored in the legislation, must be strictly undertaken.

Rights and Welfare of the Child

The Draft ART Bill states that, “A child born to a married couple through the use of assisted reproductive technology shall be presumed to be the legitimate child of the couple, having been born in wedlock, with the consent of both the spouses, and shall have identical legal rights as a legitimate child born through sexual intercourse.” [Clause 35 (1)]

It is unclear as to why there is a separate listing of the legitimacy of a child born through ARTs to married, unmarried and single men and women. Moreover, the definition of legitimacy is premised on the assumption that only children born within wedlock are legitimate. This essentially violates the right of a child to live a life of dignity and respect.

The document also falls short of the measures to ensure the well-being as well as the welfare of children born through ARTs.

Adoption Not Suitably Emphasized or Endorsed

“...Further treatment for the unresponsive couples will then consist of counseling and an in-depth investigation, leading to the use of ART – failing which, adoption may be the only alternative...”

The Draft Bill does not adequately emphasize on adoption. Rather, it mentions adoption as the only option if and when ARTs fail for a particular couple, further demonstrating the endorsement of the desire for a ‘biological’ child or ‘genetic make’ in an official document. This shows the medical-technical bias of the Bill to the issue of infertility as also the fact that it presents ARTs as a perfect solution to the problem of infertility which actually they are not at all. The making of informed choice by the user is compromised in the process.

Conclusion

Apart from these inconsistencies in the document, a larger concern emerges from the outlook with which different issues have been approached. The medical approach to address a problem rooted in the social context creates a narrow and limited perspective of the issue. The Draft Bill is retrograde in its intent because it reiterates patriarchal values, and it reinforces eugenics. The Draft Bill seems to have been prepared mostly by individuals from medical fraternity who are practicing ARTs. It tends to promote the interest of the private sector providers of these technologies rather than regulate them and compromises on women’s health and the rights of women and children in many ways.

Recommendations

- The Draft Bill in its present form is completely unacceptable, and there is an urgent need for **regulation** of present practices of ARTs, **NOT just regularization and promotion which seem to be its main thrust in the current form.**
- There is a need to locate the current legislation on ARTs within the framework of the country’s health policy, population policy and other relevant policies. This is important in order to understand the perspective and the motivation with which these technologies are being regulated.
- A clear preamble outlining the purpose/framework/fundamental approach to the Bill emerging from the government’s own perspective within the context of pre-existing policies on population and health is seriously lacking in the Bill.
- There should be clearer articulation and dealing with health risks borne by the patients, especially women and surrogates mothers, and the children born through ARTs.
- In case of surrogacy arrangements, the Draft Bill should make an effort to safeguard the rights and health of the surrogate and of the child born thereby, especially in the case where the commissioning couple is out of the country. There has to be some sort of follow up or reporting back by the couple/individual regarding the child.
- When a woman gives birth to a child, the birth must be officially documented and that women must be the natural parent of the child born to her.
- Considering the fact that these technologies do

- not 'treat' or cure infertility, and keeping the potential risks for the mother and child in mind, a responsible legislation regarding infertility and ARTs must encourage adoption and present it as a course of action as significant as ARTs.
- Various procedures and the steps involved, including the drugs being used, standard dosage, appropriate monitoring need to be laid down in detail.
- The Draft Bill must ensure that the commissioning parents understand and agree to the fact that the surrogate has a right to physical integrity and bodily autonomy, i.e. she cannot be forced to abort the foetus, go through foetal reduction or made to follow a certain diet.
- A clear demarcation between mandatory information to be provided to the users and counseling is necessary, and the two should not be clubbed as one. The former should include all the information regarding side effects, systematic break down of costs and essential details of the procedures. Counseling should be customized for the particular couple /women according to their age, number of years married, cause of infertility, and other specific details.
- The central database as mentioned in the Draft Bill should also keep a record of, live birth rate/ take home baby rate, number of implantation Rate, number of still births, number of health IVF children born etc.
- The requirements of a semen bank in terms of the facilities needed, kind of personnel and qualification to run a semen bank must be clearly spelt out and explained in the Draft Bill. It should make adequate provision for the inspection, monitoring and regulation of semen banks.
- The Draft Bill must ensure that the act of taking 'informed consent' should be a continuous process of explanation and interaction over a period of time and not merely restricted to taking a signature of the concerned person.
- The MOHFW and ICMR should not rush into finalizing it until a wider debate across the country, at various levels and regions has been conducted and their responses incorporated.
- The ICMR and MOHFW should organize public hearings in different parts of the country with active involvement of women's and health movements, and other sections of the civil society.
- The ICMR as a premiere medical research body should undertake research on the health of the women and children born through ARTs to understand all the implications of these technologies in the long run, for patients, especially women and children.

Can you believe what you read in the papers?

- Mike Clarke

Trials 2009, 10:55 doi:10.1186/1745-6215-10-55, Published 16 July 2009

Abstract (provisional)

The number of reports of clinical trials grows by hundreds every week. However, this does not mean that people making decisions about health care are finding it easier to obtain reliable knowledge for these decisions. Some of the information is unreliable. Systematic reviews are helping to resolve this by bringing together the research on a topic, appraising and summarising it. But the quality of these reviews depends greatly on the quality of the studies, and this usually means the quality of their reports. If there are fundamental flaws within a study, such as the use of inappropriate 'randomisation' techniques in the context of reviews of the effects of interventions, the reviewers will not be able to fix these. Worse still, if they are not aware of underlying flaws, they might make incorrect judgements about the quality of the research in their review. A study by Wu and colleagues of 'randomised trials' from China provides a reminder of the cautious approach needed by users of scientific articles. They contacted the authors of more than 2000 research articles, which purported to be reports of randomised trials; and concluded that ten of every 11 studies claiming to be a randomised trial probably did not use random allocation. Better education of researchers, peer reviewers and editors about what is, and is not, a properly randomised trial is needed; along with better reporting of the details for how participants were allocated to the different interventions. Systematic reviewers must be cautious in making assumptions about the conduct of trials based on simple phrases about the trial methodology, rather than a full description of the methods actually used. It's not that you can't believe anything that you read in the papers, just that you cannot believe everything.

The complete article is available as provisional pdf at <<http://www.trialsjournal.com/content/pdf/1745-6215-10-55.pdf>>

Locally Relevant, Affordable Diagnostics in a Close to Patient Context: Changing the Equation in the Developing Nation Context

-Anand Sivaraman¹

The cost of BAYCIP, a typhoid medication in India: Rs.10

The cost of diagnosing Typhoid in India: Rs 50

This inequity is a key barrier in the creation of a paradigm for evidence based clinical management in developing countries like India. Unlike in the west, where third party re-imbursement may exist for testing, this is not the case in India. The presence of a strong generic pharmaceutical industry has ensured the local production of many key medicines resulting in these being within the reach of the average patient. However, many diagnostic solutions are still parachuted from the West, resulting in them being expensive and in many cases having features not always relevant to the Indian context. For example most parachuted diagnostic solutions require the aggregation of samples in pathology labs to ensure advantage of economy of scale- this results in the generation of the diagnostic information farther away from the doctor-patient interaction context. This in turn leads to delays in the generation and utilization of diagnostic information, and increased costs due to multiple margins. This has often led to practices such as reflex antibiotic prescription, empiricism in clinical diagnosis and an overall lack of an evidence-based approach in patient management.

Diagnostics is a tool for generating clinical information. Amassed experience in different parts of the globe has shown that this process of generating and utilizing clinical information is not only different among various countries but also different in microenvironments within the same country. The development of affordable diagnostics requires consideration not only of the component costs such as hardware and consumables but also other related costs that contribute to the generation and delivery of that information. It is important to recognize that these costs associated with public health in resource-poor settings cannot remain at the mercy of charitable contributions from western nations. Therefore, the challenge of technological innovation is to create solutions that are locally affordable and sustainable

in the long run within the local macroeconomic constraints. The objective of this paper is to provide a wider view of diagnostic cost components and to show how solutions developed and delivered locally may result in economically affordable as well as sustainable products.

Affordable HIV/AIDS Patient Monitoring Diagnostics: A Case Study

Frequent monitoring of CD4 counts is critical to insuring effective management of HIV patients. CD4 counting is critical in determining the course a physician takes during the treatment regimen. The most widely used methodology of accurate CD4 counting is using a technology called flow cytometry. Flow cytometry reagents, which mainly comprise fluorescently labeled antibodies, are still prepared using protocols developed almost 25 years ago. Because the costs of the reagent raw materials constitute a very small portion of the overall COGS in resource-rich settings, there has been little incentive to optimize either the process yield efficiency or the minimum amount of reagents required to robustly label the target cells. When the same process is implemented in a resource-poor setting, however, the material cost of the reagent suddenly becomes a significant component of the COGS. There is now ample incentive to optimize both the process yield and the amount of reagents used per assay. This optimization process demands the development of a highly stable and repeatable manufacturing operations protocol (MOP). Standardized MOP can then lead to a significant improvement in the total material yield by addressing the loss of material at each step in the process. Once a stable and repeatable methodology of producing reagents has been established, it is possible to define the complex matrix of relationship between assay parameters in order to arrive at the minimum amount of reagents required per assay. Because of the robust and repeatable reagent MOP, it is possible to zero in on the optimum selection of the right dye molecules, the preferred antibody clone with the highest affinity, the right Dye to Protein ratio for that antibody, and the right combination of antibody concentrations required to achieve saturated labeling for the cell count range in the sample. ReaMetrix has been able to beat its own internal cost target of

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Rs.80 for fully formulated reagents and is able to provide these reagents in the market for Rs 125 (nearly 5 fold below the average cost of imported reagents), demonstrating that this is not just an academic exercise. The whole optimization procedure was accomplished by leveraging the “cost arbitrage” opportunity of talented local labor. This process is now ingrained locally, allowing its application to new set of reagents relating to a set of diagnostic tests. This is a perfect example of using unique local resources to create sustainable local solutions.

Incorporating Locally Relevant Features in the Design of the Diagnostic Solution

Flow reagents are typically delivered as liquid reagents, and they require cold chain during shipment and refrigeration for cold storage. In resource-poor settings, these costs turned out to be significant relative to the cost of the reagents. Even when there is cold storage, because the reagents are kept outside during sample processing, the high room temperature conditions can significantly degrade the reagents even over the course of the day. Additionally, in most of these settings, it is common to transport blood samples from remote areas through collection centers to centralized testing laboratories. Depending how far-flung these areas are, the stability of the blood samples over the transportation period is a concern due to both temperature and duration. All these factors lead to unreliable or inaccurate CD4 counts. These issues necessitated the development of dry reagents that are stable, do not require cold chain shipment and storage and allow staining of the blood sample even at the point-of-sample collection. ReaMetrix has developed a robust cost-effective dry-down process (using a standard drying oven) that provides the reagent in a dry unitized format. In the current healthcare infrastructure, in many instances, blood samples collected in rural areas need to be transported to centralized testing facilities in metropolitan cities. This can take up to several days, during which the CD3+ expressions on the membrane of the T-cell undergo a change, making population analysis cumbersome and inaccurate. The dried reagents are stable at ambient temperatures, they can be shipped to the point of sample collection with minimal effort, where the blood samples can be stained and fixed. After fixing, the samples can be shipped to centralized labs for analysis. The advantages are two-fold: (i) the samples at this stage are rendered non-infectious. (ii) The fixed

samples are stable for up to 8 days at ambient temperatures. Whereas the presence of superior logistics in the Western world may not warrant the innovation of dried reagents, in India, dried reagents offer significant benefit. In addition, dried reagents remove the need for cold chain and refrigeration, again resulting in decreased cost of testing.

Extending the Innovation and Affordability to Instrumentation Design

There are many economic factors that are hardware platform related that constrain the full impact of advancements in diagnostic reagents. Current installed systems are often so large that they are forced to reside in centralized laboratories far away from where the test needs originate. The absence of affordable transportation hindering efficient sample aggregation, coupled with high maintenance and service costs, make these systems highly cost inefficient. Smaller systems do try to address some of these problems. In practice, because of the absence of the ability to perform a critical mass of tests needed to effectively manage the patient, they sit idle in many cases. From an economic perspective, the development of point of care systems should be driven by a combination of the need to deliver the clinical information closer to the patient and the synergistic grouping of tests needed to not only leverage but to monetize the cost savings. The hardware platform or a combination of platforms must be smaller, more robust, and more luggable if not portable. They must be able to perform at extended ranges of temperature and humidity and must be easily serviced by locally available talent. Such an exercise has a higher probability of success - the point of care system platforms will become economically sustainable in only when development is carried out within the economic environment of resource-poor settings. ReaMetrix is currently working on designing a hardware platform system that meets the above key design criteria, within the developing nation context. We have realized that this cannot be a CD4 enumeration instrument alone – but the instrument development economics dictates that this needs to be an instrument that is versatile enough to do a variety of tests in a close to patient context.

Affordability does not Imply Cheap or Low Quality Reagents: FDA Clearance for the Affordable CD4 Enumeration Reagents

In India, oftentimes, affordable alternatives may be

misconstrued as being cheap in quality. We did face a significant mindset in the market that refused to accept that the quality of a 5-fold more affordable reagent could be anywhere near the same as the expensive imported alternative. The “dried-reagent” concept would never be seen as a useful innovation, unless we were able to show that affordable reagents did not mean low quality reagents. This necessitated the need for us to ensure that a credible regulatory authority could attest to the quality and performance of the reagents. We submitted an enormous amount of validation data that eventually resulted in an FDA clearance for the dried-reagents for CD4 enumeration – demonstrating that indeed, it is possible for us to produce reagents that are significantly more affordable, but still adhere to the highest standards of quality and performance.

In conclusion, we hope that our attempt at creating

a sustainable model for the locally relevant design of affordable diagnostic solutions can help usher in the paradigm of evidence-based clinical management of patients. The creation of a successful model necessitates the close partnership of clinicians, engineers, scientists, and the patient. We hope that this article helps us connect with clinicians and other stakeholders, with a vision similar to ours, who would like to partner with us in the realization of a shared vision.

Our experience has shown that the way to bring affordable and accessible diagnostic solutions to reality in a sustainable manner is to develop them locally with local resources, with features of local relevance, rather than parachute a solution from the West that may have been sub-optimally designed for use in the local context.

Govt Crosses Sword with UNICEF over Serving Packaged Food

- Rema Nagarajan , TNN 3 August 2009

The debate over hot-cooked meals versus nutrient enriched supplements has reached a new level with the ministry for woman and child development (WCD) saying that the government may need to re-examine whether international bodies like the UNICEF should be allowed to operate in India if they do not abide by its guidelines.

The escalation comes as a result of UNICEF going ahead distributing packaged imported food last year for severely malnourished children in several states. This despite the fact that the Prime Minister’s Office, the National Advisory Council, the Planning Commission, SC, nutrition experts and even the President in her recent speech have all strongly advocated locally prepared hot cooked meals through anganwadis to fight malnutrition.

The government’s charge is that disregarding this policy, UNICEF imported and distributed packaged food in an unauthorized manner without the knowledge of the government. Hence, the government has now asked UNICEF to ship the imported commercially produced packaged food out of the country and to restore to the country programme, the \$2.4 million spent on the supply.

According to the WCD ministry, UNICEF has apologized for its unilateral decision and has offered to ship the emergency stock of imported nutrients to other countries. However, when contacted, UNICEF justified its intervention with ready-to-use therapeutic food in Bihar and Madhya Pradesh saying it was a proven, life-saving intervention according to WHO’s globally recommended protocols and products.

Joint secretary of WCD ministry, Shreerajan, insisted that the ministry’s displeasure has been communicated firmly. “We are examining whether there is a need to re-examine

the agreement which exists between us and agencies such as UNICEF, making it conditional to their following our guidelines. We have already informed the relevant section of the ministry of external affairs that looks after international agencies such as UNICEF,” explained Shreerajan.

The debate over locally available and locally produced products versus imported products is not new internationally, but it has acquired steam in India with UNICEF introducing Plumpy Nut, a product of Nutriset, a company in France.

Is this just an ego clash between the government and UNICEF? Not really. The decision to not depend on imported nutritional supplements has solid academic backing. A paper by nutrition and public health experts Dr Vandana Prasad, Radha Holla and Dr Arun Gupta, for instance, advocated developing community-based treatment rooted in locally available foods for addressing severe malnutrition. Such an approach would promote local agricultural practices, as it would use locally available foods and promote local livelihood, thus conferring more than food supplementation: an opportunity to raise economic status, argued the paper.

The paper gives examples of various mixes used to treat acute malnutrition in different states for many decades by institutions such as the Jodhpur Medical College, Medical College Davangere in Karnataka and the Direct Nutrition Programme of Tamil Nadu. It is hard to explain why it has been permitted for a somewhat alien product (Plumpy Nut) to be introduced at such large scale without investigating the relative merits and demerits of the ready to use foods that we have been using, says the paper.

Source: <<http://timesofindia.indiatimes.com/NEWS/India/Govt-crosses-sword-with-Unicef-over-serving-packaged-food/articleshow/4850130.cms>>

The Gravest Displacement of Our Time – Part 2

-Sudha Bharadwaj¹

An Imperialist Military Strategy

The following excerpt of the letter written by a group of environmentalists, scholars and activists to Chief Minister Raman Singh in early 2008 regarding the implementation of the Forest Rights Act in the state describes the extent and gravity of the forced displacement that was caused by Salwa Judum:

However, we are particularly concerned about the rights of those villagers in Dantewada and Bijapur districts who have been compelled to leave their villages due to the ongoing Salwa Judum campaign against naxalites. The total population of about 1200 villages in the two districts is 7.19 lakhs, of which 78.5% is tribal. About 50% of these villages, with an approximate population of 3.5 lakhs, is currently displaced from their villages. While about 47,000 are living in roadside camps set up by the state government, another 40,000 or so have fled to the forest areas of Andhra Pradesh to escape the ongoing violence between Salwa Judum and naxalites. The whereabouts of the remaining 2,63,000 villagers from the abandoned villages is unknown.

In at least 644 abandoned villages in the two districts, no gram sabha meetings required under the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act for initiating the process of recognition of rights can be organised under present circumstances. At a meeting organised by the Department of Tribal Welfare of Andhra Pradesh, it was decided that the Gutti Koyas who have sought shelter in AP's forests from the naxal -Salwa Judum violence in Chhattisgarh will not be eligible for recognition of land and forest rights in Andhra. However, due to being displaced from their own villages, they will not be able to claim their rights even in their original villages in Chhattisgarh. Their being deprived of rights in both Chhattisgarh and Andhra Pradesh will be a terrible subversion of justice.

Consequently, we appeal to you to suspend implementation of the Act in the affected areas while facilitating speedy return of the villagers to their own villages. In the meantime, no land should be allocated to outsiders and no leases or prospecting licenses for minor minerals should be given in these villages as under PESA. These also require Gram Sabha permission, which is not possible under present circumstances.

Yours sincerely,

Madhu Sarin, Environmentalist and Scholar; Nagaraj Adve, People's Union for Democratic Rights; Rohit Jain, Society for Rural, Urban and Tribal Initiative; C.R.Bijoy, People's Union for Civil Liberties (Tamil Nadu & Pondicherry); Naga Peoples' Movement for Human Rights; Shankar Gopalakrishnan, Campaign for Survival and Dignity; Gautam Kumar Bandyopadhyay, People's Alliance for Livelihood Rights, Chhattisgarh; Dr. Nandini Sundar, Delhi University;

¹ Email: <advsudhacmm@yahoo.co.in>. Part 1 of the article was published in the previous issue of the mfc bulletin.

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The fact that about 644 villages, some estimates put it even higher at around 700 villages, were emptied out and a population of about 3.5 lakhs had been displaced from the Bijapur and Dantewada districts during the heyday of the Salwa Judum operations is undisputed. The Government would like us to believe that this happened voluntarily because all these adivasis fled from Naxalite violence. The Salwa Judum camps, 24 in number were, according to them, set up to shelter those fleeing from such violence. Time and again surveys of the camps have shown otherwise, that people were usually brought to the camps forcibly or against their will and often brought back if they tried to escape. Besides plain arithmetic shows that, even if we are to believe this, there were 47,000 in the government camps which accounts for only 13% of the displaced population. 75% of that displaced population, or about 2.6 lakhs, chose not to go to the camps, and preferred to live in and out of the jungle; even if it meant being treated as outlaws.

The theory that such a huge and absolute displacement could have occurred spontaneously, is on the very face of it untenable. Let us look at the following facts:

That ground clearing for mining and other companies was an important motive and in fact provided the driving force is clear from the MOUs with Tata, Essar, Texas Power Generation, Arcelor Mittal, BHP Biiton, DeBeers, Rio Tinto, Godavari Ispat, Prakash Industries etc and the around 96 mining leases with various companies in the Bailadila area. A bare perusal of the MOUs show that they were being practically handed out high quality iron ore deposits, coal blocks, water from the Indravati River, etc. Apart from this, a large number of mining and prospecting licenses were also distributed (sold?) to come into effect if "all went well", which remain undisclosed to this day. The corporate

vested interest is also apparent from the fact that it was the Essar Company that provided funds for setting up of the first Salwa Judum camps. It is reported that a foreign company called "Crest" has been given a contract to survey mineral deposits in the South Bastar, Dantewada and Bijapur districts. This company had said that it could undertake this mammoth survey only once the land was cleared.

It is now also widely recognised that the ground clearing operation that was attempted to be carried out through Salwa Judum is a military strategy referred to as "strategic hamletting". This involves clearing out villages and bringing them to roadside camps. This strategy was used by the Americans in Vietnam and the Indian State in Mizoram, Nagaland, Tripura, and Manipur.

In Bastar this strategy has been closely overseen by the Counter Terrorism and Jungle Warfare College, Kanker headed by Retd. Brigadier BK Ponwar. Brigadier Ponwar earlier headed the Warrangte Counter-Insurgency and Jungle Warfare School of the Indian Army at Mizoram.

In the year 2006 left political parties as also the Chhattisgarh Mukti Morcha had protested against the statements of two officers of the American Consulate - one heading its Commerce Wing and the other a Regional Security Advisor, who had visited Kanker and Raipur and offered the Chief Minister American assistance in dealing with the state's insurgency problem. We had condemned this as undue interference in the internal affairs of a sovereign nation. A few months ago I came to know that the current Chief of Economic and Political Affairs - Michael Neville and a Regional Security Officer - William Inman had visited Kanker and Raipur again. As an advocate familiar with Dr Binayak Sen's case I had been requested to brief these officers by a staff member of their Mumbai Consulate. I had declined stating that I believed that human rights could not be separated from the policies of globalization and militarization which their country government was supporting. It is pertinent that putting Indian Maoists on the American terror list, gives a handle to the Americans to interfere in the affairs of our country ostensibly for protecting American interests (read companies!).

The third factor is the heavy military deployment - 19 battalions of CRPF and 2 Naga and Mizo IRB battalions - which were used with ruthlessness to commit all manner of barbarities to cow the adivasi people into submission. The presence of the Salwa Judum, who also no doubt used brutal force themselves, added a factor of unaccountability and spontaneity.

Their role was also as informers and guides.

In the past three years the incidents of such barbarism have appeared many times in the press, only to be quickly covered up. Some brave journalists notably Shubranshu Choudhary in his column "Basi Ma Uphan" in the evening daily paper Chhattisgarh has reported scores of such cases. We are giving here only a few instances:

On 13th March 2007 when the Naga Battalion and the Salwa Judum entered the Nendra village of Gaganpali panchayat, everyone ran away. But the children of the village were bathing at a hand pump. When the Naga jawans could not find anyone else in the village they shot these 11 children between the ages of 2 and 16 and one young man dead. We are giving their names not because it would make a difference to the reader but to remind them that 12 is not a statistic but represents human beings (their ages are in brackets) - Soyam Raju (2), Madvi Ganga (5), Midium Nagaiyya (5), Podium Adma (7), Vetti Raju (9), Vanjam Raja (11), Soyam Raju (12), Sodi Adma (12), Madkam Aite (13), Madkam Budraiyya (14), Soyam Rama (16), Soyam Narya (20).

280 persons of Gangrajpadu village were taken by the Salwa Judum to the camp, but 175 of them were murdered, killed in sacking and thrown in the river, because they were protesting against going to the camp.

A CRPF jawan of the 119 Battalion, G company told a journalist that they had been given orders that if they saw anyone in those villages after 15 March 2007, he/she would be a Naxalite and if he ran away we could shoot them.

On 7th April 2007 a jawan of the Chhattisgarh Armed Force told a journalist that he had been posted there since the 15th of January 2007 and since then his unit alone had killed at least 60 persons. He said that as soon as they would reach a village with the Salwa Judum, people would start running. "We cannot understand the language of the adivasis here. Whoever we could catch, we would kill like a chicken or a goat, on the say so of the Salwa Judum. All this is happening because of our orders from above, and I am very unhappy about it."

The other significant aspect of this strategy was the outlawing and cordoning off of those adivasi people who refused to come to the camps, the total withdrawal of health services, ration shops and local markets. In other words starving out or "sanctions". This is described in the accompanying excerpts from news items.

Because of Judum the Haat Markets Were Closed Down

In the Naxal stronghold areas of the Konta area, after the start of Salwa Judum, the weekly markets had closed down, then the Naxals had started holding a market at Gachanpalli for their so-called people.

After the attack of the force (paramilitary) on this market, the Naxalites have changed the venue of the market. The weekly markets are the most important part of a forest products based economy. It is from these markets that Naxalites also get the articles for their daily needs. After the start of the Salwa Judum campaign in 2004 (sic) the villages around the main centers were depopulated. The markets of these centers were also closed down and the economy of South Bastar crumbled. In the interior areas where the Naxals had a stronger base, the villagers left their villages and shifted to the mountains and jungles. Owing to this problem, the markets of Jagargunda, Bhejji, Basaguda, Golapalli, Kankerlanka etc. were closed down. Markets that were operating in the interior like Bhejji were brought to the roadside. The villagers who did not join Salwa Judum were debarred from coming to these market places on the roadsides. The villagers who came to the markets carrying mahua, imli, tora and other forest products began to be victimized as Naxals. Looking to this problem the Naxals started a new market in Gachanpalli. The traders of Cherala, Andhra Pradesh used to come in bullock carts with their wares. The Naxalites had directed that essential items be provided at reasonable prices. But the news of this reached the Salwa Judum supporters of Dornapal. So much forest produce used to come into the market, that the traders couldn't transport all of it back.

- Nai Dunia, *January 3, 2009*

Like everything else, "Counter-Insurgency" has also become an industry in Chhattisgarh. Crores of rupees come in for defence expenditure and security costs. Huge undisclosed budgets exist for this purpose. And allegations of siphoning off are traded publically. (Even otherwise, out of the 1654 crores sanctioned for modernization of the police force by the Central government for the 13 Naxal affected states, only 2 to 13% have been used for improving weaponry. The lion's share has gone into building bungalows and offices!) Besides, running the Salwa Judum camps itself is a lucrative proposition for the contractors and Judum leaders, many of whom have built houses and purchased vehicles in this period. From makeshift tents, tin roof structures have been constructed in the camps. All government schemes have been transferred there from the villages. Ration shops, anganwadis, schools, hostels, literacy and health missions.....all funds designated for the villages now come to the camps. Foodstuffs, medicines, relief materials including those sent by international agencies, intended for lakhs of people are claimed to be distributed to a few thousands. And even those are distributed on paper, for now the majority of people, having neither employment nor food have run away.

No wonder that the journalists who were trying to expose this scam were beaten up by Salwa Judum goons in the police station. The news item Patwari suspended in rice case gives us an idea.

The Story of the Other Side of Indravati

...Quite a few people were already sitting there (in Village Niram) when we arrived. The people respectfully asked us to be seated. When we asked them about the facilities provided by the government they told us that upto two years ago the school and anganwadi centres were functioning here, though not regularly. Similarly the health workers also used to come sometimes, so at least we and our children could get some kind of relief. But as soon as Salwa Judum started, all these facilities were stopped by the government. The villagers said they couldn't understand why all these facilities were stopped by the government. Whereas no one had ever objected to their functioning. The villagers said that when Salwa Judum started, the entire populations of the villages of Chinger, Ehkeli, Satwa, Bangoli, etc. were forcibly taken away by the Salwa Judum leaders and the force (paramilitary). But we thought that if we go away, we would neither be able to do our farming nor collect forest produce which is the basic source of our livelihood. All of us will simply die of starvation there. The peasants also stated that they are facing a shortage of grain, salt, oil, chillies, clothes etc, because if they cross the river and go to the Geedam or Tumnar market, the Salwa Judum and force catch them and beat them up badly and take them and throw them in the camp or else murder them. So they don't go to the market at all. If they require these necessities of life they go walking to another market 80 km away, they have to spend three days doing so.

-Shubranshu Choudhari, *June 11, 2007, Chhattisgarh*

This corruption has been acknowledged at the highest levels. Once the present DGP Vishwaranjan was asked to comment on the statement made by the outgoing security advisor to the government of Chhattisgarh, K.P.S. Gill that the police of Chhattisgarh was so corrupt that the police officers posted at Bastar extort bribes for transfers and postings from jawans. He replied, "Had I been there I would have asked how is it that in Punjab, where you finished off terrorism so efficiently, 3/4ths of the officers have houses in England and America, though they have no relatives there?" It might appear that the DGP is exposing corruption very frankly. But on studying his statement more closely we realise that its real meaning is "Gill Sahab, better not speak too much about corruption, if you do, we can expose you as well!"

But the issue of graver concern is that the American state has a powerful influence over the top echelons of the police today. This is even more so for Chhattisgarh, from where police officers are regularly sent to America for training. In the Punjab period,

officers did not make frequent trips abroad, as they are doing today, yet many houses got built. How many houses are being built now is anybody's guess!

Patwari Suspended in Rice Case

The administration has finally taken stern action in the case of blackmarketing of rice brought for distribution to the inmates of the Salwa Judum Relief camps, and suspended the Patwari of Dornapal....

On the one hand various kinds of questions are being raised against Salwa Judum by NGOs and political parties, on the other this kind of incident raises doubts about the functioning of the administration.

On 15 December the police had raided and seized 100 sacks of rice intended for the inmates of the Dornapal Relief Camp which had been kept for backmarketing in the house of Md Ahmed at Nadi Road. He was found prima facie to be guilty.

There is consternation among the employees at this action taken for the first time since the start of the Salwa Judum. Complaints of this nature had been made several times earlier in the Salwa Judum camps. Such irregularities are not a new thing. There has been blackmarketing of all materials which come here for the past two years. ...Most of the camp inmates have gone back to their respective villages, but despite this the materials are shown to be distributed on the basis on the old figures. If the administration carries out an impartial enquiry, several startling facts will be uncovered."

- Haribhoomi, December 19, 2008

In his statement of 6th May 2008 in the daily Deshbandhu, Mr Vishwaranjan also admits, "In the Bijapur-Dantewada areas, they (the Naxalites) started raking up the old discontent of the adivasis. Actually adivasis consider the jungle to be their own; they do not accept that it belongs to the government. In 1910 a revolt took place against the local raja because he tried to implement the Forest Act. He had to call in the British army for help. Ever since then this discontent has taken root. Later on the National Forest Act was implemented. The adivasis could not emotionally accept this."

Recently DGP Vishwaranjan stated that there are at present about 10,000 hard core Maoists and 40,000 people's militia in Dantewada out of which 15,000 are women. In other words we are back to the magic figure of 50,000 given by DGP Rathore before Salwa Judum started. In that case, what has been achieved by the past 3 years of forcible displacement, detention of thousands in camps, and hundreds of killings?

The Story of a Village

What has Salwa Judum meant for the adivasi people? This is poignantly described in the following narrative of the speech given by an adivasi in a meeting organised at New Delhi by the "Citizens for Peace and Justice in Chhattisgarh":

"After some hesitation he (Chamru) started speaking, 'It was in the December of 2005, the Sarpanch of Mirtur sent a letter to our village (Vechapal). In that it was written that now in Bastar some man-eating people are coming, so if we want to save ourselves from them we should go to the Mirtur camp.

The adivasi translating said that man-eating people meant Nagas. Chamru continued, "We got scared. We got together and decided that first all the men would go and stay in the camp and then we would decide what to do afterwards.

In the Mirtur camp there were some old Sangham members who had now become SPOs. Every morning they would first beat us. They would say, "When we went to these peoples' village with the Naxalites, they had fed us food". After this they used to take us to other villages and tell us to set fire to houses in those villages.

After some days some people of our village ran away from the camp. Even then most of the people used to stay in the camps in the night but mostly come back home in the day time.

To scare those people who had run away from the camp, 8 days later, the Salwa Judum and the police went to our village. The others ran away, but Joga Aayami fell into their hands and the Salwa Judum and police together killed him. They took away the 17 year-old daughter Rukni of Sannu Oyami. As far as we know, Rukni is still imprisoned in Jagdalpur jail today.

After staying in the camp for two or three months, all of us from our village decided one day that we should run away. In February-March we ran away from the camp and came back to our village.

After this Salwa Judum started coming to our village regularly. As soon as they came, we would run away to the jungle. After our running away they set fire to 60-70 houses in our village and took our cattle away.

One day in April when I had gone to pick mahua, suddenly the Salwa Judum people came there. I hid behind a tree and they caught hold of 4 women who were picking mahua. They raped the 16 year old daughter Kumari of Sannu Oyami and the 27 year old wife Kamli of Bande Kadi in front of my eyes. I kept watching from behind the tree. They let the two older ladies go.

After that they made the young girls wear Naxal uniforms, which they had brought with them. They cut their hair, put a gun on their shoulder and took them away with them. These two girls are still in Jagdalpur jail accused in Naxalite cases. We have already paid 12,000 to the lawyer but he says he can only get them out if we give him 20,000 more.

After that we started living in the jungle only, and Salwa Judum started coming very frequently to our village. Each time we would run away, but somebody or the other would get caught. In this way six people of our village have got caught.....Two of them were father and son, They were caught together when they were cutting wood. They were hacked to death and thrown in the river.....None of these 6 was a Sangham member.

The Salwa Judum people have burnt my house three times till now. Now there is not a single house in the village which has not been burnt. There are only walls left in the village. Whenever we make a house they come and burn it. This has happened about 10 times. Now we make houses of plastic sheets and are living in the jungle.

Jaganath (32), son of Aytu from our village, used to tell people to go the camp and we suspect that he used to spy about our village to the SPOs. The dadas (Naxalites) came to know about this and one day during this period the dadas killed him.

There was a school in our village. Now the administration has transferred the school to the

Mirtur camp. Not a single person from our village stays in the camp now. That's why no child of our village goes to school.

There is no hospital in our village. We used to go to Mirtur for the market and hospital but now we cannot go to Mirtur for fear of the Salwa Judum. Now we only send old ladies and children to the market to buy salt and oil. They have to walk one full day and after that spend the night somewhere to reach the market

in the morning." Chamru requested me not to write the name of that market.

"Earlier in our village there were 5 Sangham members and the dadas (Naxals) used to come from time to time. They used to take meetings and tell us to do agriculture well and not drink. They never did any harm to us, Sahab".

Chamru told me that this is not only the story of his village. The neighbouring villages like Timenar, Hurepal, Phoolgatta, Dorguda, Kondapal, Pittepal, Neelavaya, Madpal, Indri, Kokur, Tamud, Orvada, Paralnar, Kudalka, Peddapal...in all these villages the story is more or less the same. All of them are living in the jungle. The people of all these villages cannot come out and neither can anyone except Salwa Judum and the police come to our villages.

There was no one from the dalam in our village earlier, now one has joined. From my neighbouring villages, 15-20 from some and 30-40 from others have joined the dalam. Before Salwa Judum there were only 1-2 persons from these villages in the dalam." Chamru also told the names of the villages where all the youth had gone with the Naxalites but he requested me not to write the names of those villages for reasons of security.

Chamru can be called a Naxalite. This meeting can be called Naxalite sponsored. But when Chamru was speaking there was pindrop silence in the whole hall and I saw tears in the eyes of many people sitting in the chairs around me.

The population of those 644 villages like Vechapal is about three and a half lakhs. According to government statistics about 50 thousand of them are in camps and the remaining 3 lakhs like Chamru have gone closer to the Naxalites.

This is the success of Salwa Judum.

- Shubranshu Choudhari, Chhattisgarh, Sep 19, 2007

Every day newspapers of Chhattisgarh carry disturbing news of killings, most of these are attributed to Maoists. As peace-loving people, far removed from the villages of Bastar, we shudder on reading these. We wish that there were some solution to end this seemingly endless cycle of violence and counter-violence. But we must remember that it is difficult to find the stories of the "Chamrus" in those reports. We have to read between the lines. If the newspaper says "commanders were felled" and shows a photograph of several young men in lungis what does it mean? If we are told the Maoists ruthlessly murdered "a villager" who also was an SPO what does that mean? And if we are told nothing at all what does that mean? Though we are often told that "the Maoists threw

pamphlets", it is rarely that a statement of the CPI (Maoist) finds its way to the press, and if so to confirm its authenticity. On 22.12.2007 a statement was published in the name of Gudsa Usendi, Spokesperson of the Dandakaranya Special Zonal Committee in the daily Chhattisgarh in response to an article of journalist Asha Shukla. This is how it concludes:

Whatever is being broadcast in the TV channels and newspapers is almost all one-sided. If we make only this storm of one-sided propaganda our source of information we shall make serious mistakes. Ashaji has rightly said that our Chhattisgarh is looked upon as a backward region; otherwise people would have shown the same interest in exposing the frightening

and most brutal violence which is going on in the name of Salwa Judum as they have in exposing the Gujarat riots or the killings in Nandigram. Without writing or speaking anything about these women (rape victims described earlier in the article), and hundreds of other men and women, or even trying to find out about them, to try to blame us, or abuse us in very emotionally and literary style as Ashaji has done, shows only dishonesty towards this problem....

Here on the one hand the violence of the Salwa Judum is on ... On the other hand is the retaliatory violence on behalf of a historically defeated people who have been struggling for their water, land and forest for the past 27 years. It is the violence of those who have nothing left to lose. Everything has already been looted from them.....They have only two ways left: to surrender and live like slaves in the "relief camps" or to resist even at the cost of their life. I am not trying to give an argument to justify our violence; I am only repeating that the people were forced to make this choice. Sitting in Delhi or Raipur or even remaining confined to the roads of Bastar and shouting "you are killing innocent and helpless people" is very easy, but to touch the hearts and feel the pain of those whose tears have dried up is very difficult. Finally I want to say that in these last two and a half years if despite this barbaric repression there are still people alive in south and West Bastar it is only and only because of our resistance struggle. If our party had not led this people's resistance history would perhaps not forgiven us. You may callus violent or abuse us, but this is the reality and it is our conviction that history will vindicate us.

Knocking on the Doors of the Democratic State: Do Adivasis of Bastar have any Civil Liberties?

The silence about Bastar is not "natural". There are many brave journalists, lawyers, social activists in Bastar and Chhattigarh. And many of them have been trying to speak. But journalists have been harassed, beaten, arrested; their homes and jobs taken away from them. False cases, transfers, income tax raids, defamation - the state has a myriad ways to silence social activists. Even a lawyer, Shri Girjaram Kashyap, who was preparing affidavits of villagers against the fake gram sabhas at Lohandiguda was picked up. The politically motivated and criminal incarceration of Dr Binayak Sen - which continues even after 19 months despite the lack of legally admissible evidence and the widespread protest, nationally and internationally - is also to "teach a lesson" and brutally enforce this silence.

Salwa Judum began in June 2005, and by December the blood had started trickling out from under "the

wall of silence" – the hushed reports of repeated attacks on villages under massive paramilitary cover, the rounding up of entire villages into camps - houses razed to the ground, meager belongings looted, crops ruined and livestock slaughtered, hundreds of ostensible "Sanghams" killed, and all those who refused to come to the camps and preferred to flee to the jungles labelled 'Maoists'.

It was Dr Binayak Sen who took the first brave step of organising a joint All-India fact-finding team of human rights organizations to investigate these disturbing rumours. The team was obstructed, harassed and threatened, but it nevertheless let the nation know what was happening in Dantewada. The report was aptly entitled "When the State makes War on its People". After this many fact finding teams notably the Independent Citizens Initiative, various governmental commissions such as the National Commission of Women, international human rights organizations like the International Association of Peoples Lawyers and Human Rights Watch, journalists' and doctors' associations (Reporters Without Borders and Jan Swasthya Abhiyan), and teams of various political parties like those of the CPI and the Congress have also repeatedly documented atrocities, lawlessness, forcible displacement, pitiful conditions in camps, cases of sexual harassment etc. Letter petitions of the Vanvasi Chet ana Ashram have been taken up suo moto by the Chhattisgarh High Court, and the Forum for Fact Finding and Documentation has filed numerous petitions before the State Human Rights Commission. Finally two petitions questioning the legitimacy and violent modus operandi of Salwa Judum have been taken into cognizance by our apex judicial forum - the Supreme Court – one filed by Nandini Sundar, Ramchandra Guha & EAS Sharma, and the other by Kartam Joga, Manish Kunjam and other residents of Dantewada belonging to the Adivasi Mahasabha. What has been the response of our democratic institutions?

Take the Ponjer fake encounter case. Not only the CPI, the Forum for Factfinding and Documentation, and the PUCL, but even a 5 member team of Congress MPs including Moolchand Meena and Jamuna Devi had conducted an investigation and declared that 12 innocent villagers had been murdered by the police in March 2007.

8 bodies were exhumed and a magisterial enquiry was ordered. But the police finally registered an FIR in the name of "unknown uniformed persons."

The BJP MLA of Keshkal and Parliamentary Secretary Mahesh Baghel had gone public stating that the 79

persons who were paraded before the press in Raipur as surrendered Naxalites in January 2007, were innocent peasants. He had claimed that not only were they not even Sangham members, but most of them were BJP cadres and he knew them personally. But only a few of these persons could be released. Presumably the rest are still rotting in jail.

The gang rape of an adivasi woman by the Mizo jawans had enraged the people of the Nakulnar area in February 2007, and they continuously agitated under the leadership of the Adivasi Mahasabha for the punishment of the jawans and the withdrawal of the Mizo batallion. Those jawans had also threatened and beaten the local adivasi police who had tried to register a case. Thanedar Khalko told an ETV reporter that, "The Mizo jawans beat up anybody. If they are not withdrawn from here, the situation can become explosive. We are only 7 and they are 117. We are helpless before them." The Dantewada police however colluded to save these jawans. The woman was made to identify the rapists in an identification parade of Mizos with identical Mongoloid features, which was well nigh impossible for her.

Apart from this denial and cover-up mode, the other official response has been offensive - to declare every person who opposes the brutalities of Salwa Judum as a "Naxalite supporter".

The extreme example of this was when, in November 2007, the Dantewada collector KR Pisda wrote to the State Government that the Y category security given to Congress MLA Kawasi Lakhma be withdrawn as he was a "Naxalite spokesperson." The "proof" given for this was, "He has not issued any statement opposing Naxalites. He has not participated in the Salwa Judum. In fact he has demanded that it should be stopped."

Even in the petitions in the Supreme Court, the reply of the Chhattisgarh government was that all the petitioners are "Naxalite supporters!"

After the recent elections, as usual, an adivasi MLA, this time Nankiram Kanwar has been adorned with the crown of thorns, namely the post of home minister. It is pertinent that in the previous cabinet he had been Forest Minister, which ministry was taken away from him when he had tried to prosecute the Jindal and Sterlite companies for their illegal encroachment on forest land and felling of thousands of trees. This time he has immediately towed the line. After being made home minister, Mr Kanwar's first visit was to the RSS office, after which he told the press that all those who oppose Salwa Judum are "anti adivasi", "Naxalite supporters" and shall be "dealt with sternly."

In which case the list of Naxal supporters is rather daunting: Sandeep Pandey, Justice Srikrishna, EAS Sharma, Nandini Sundar, BD Sharma, D.Raja, Medha Patkar, Kanak Tiwari, D. Bandhopadhyay, Hira Singh Markam and of course the inimitable Ajit Jogi. The latest addition could be our Union Home Minister P.Chidambaram who stated during question hour in Rajya Sabha on 16 December 2008 that "We are not in favour of non-state actors taking law enforcement in their hands."

The CMM, which has been consistently agitating for the release of Dr. Binayak Sen, much-loved doctor of the miners and industrial workers of Chhattisgarh, has equally been a strong opponent of the brutal and forcible displacement in Bastar taking place in the name of Salwa Judum and has repeatedly demonstrated against it, for it believes that: "Injustice anywhere is a threat to Justice everywhere". No wonder that CMM is therefore very much also in the "firing line", as DGP Vishwaranjan made clear by his veiled threat that "Niyogi was the first Naxalite."

Chief Minister Raman Singh and DGP Vishwaranjan are literally crowing over the results of the recent assembly elections of November 2008 in Bastar and interpreting them as a mandate in support of Salwa Judum. Is it so?

Most of the times nowadays elections are not fought on issues, how else can one explain campaigns using naïve if not outright dumb star celebrities and results determined by crates of liquor. In Chhattisgarh, the burning issues faced by a region reeling under imperialist onslaught were totally absent from the electoral discourse. What to say of poor contract labour or peasants facing displacement, even the issue of the small industrialists did not figure in the manifestos of the "mainstream" political parties. They were only vying with each other in throwing crumbs to the people from the high table of loot - luring them with 'three rupee rice', 'two rupee rice', and finally even 'one rupee rice'!

But any one who visited the Dantewada or Kont a constituencies in the buildup to the elections could see that the election there was being fought like a referendum on Salwa Judum and land acquisition for companies. I quote from the newspaper Nai Dunia of November 7, 2008:

Shri Karma has not been able to start his campaign in the Naxal stronghold areas of Katekalyan and Kuakonda, even the BJP candidate Bhimram Mandavi has not plucked up the courage to go there. On the contrary, under the banner of the Adivasi Mahasabha,

Shri Kunjam has been successful in reaching his message. He is the national President of the Adivasi Mahasabha and by going to jail in the matter of giving land to the Tata industrial group, he has earned considerable sympathy. Famed as “Bastar Tiger”, Mahendra Karma, though he is an adivasi, is considered a leader of the non-advasis. But some incidents of the recent past have spoiled this image of his. Similarly his efforts to persuade the adivasis of Bhansi and Dhurli to give their lands to the Essar industrial group may cost him dear.

The defeat of the powerful sitting MLA Mahendra Karma does of course signal the unpopularity of the Salwa Judum he headed and also the land acquisitions of Tata and Essar which he personally tried to push through. And this was despite not only muscle power but even money power. He was caught on camera bribing an adivasi woman, and had quickly signalled to a man carrying a sack of cash to scoot! But how then, did the BJP candidate, who was nowhere in the running, defeat such an obviously popular candidate as Manish Kunjam?

The Citizens for Peace and Justice in Chhattisgarh had expressed apprehensions in their letter to the Election Commission of India regarding electoral rolls being prepared in camps and therefore the possibility of fraudulent voting:

According to recent media reports Government of Chhattisgarh claims that more than 57,000 people are living in these camps and their names are getting included in the electoral rolls for the camps.

As per reports we have received from local civil society members and fact findings done by CPJC members, majority of people who were living in the relief camps have gone back to their homes in the irrespective villages. According to our information the number of residents in camps is not more than 10,000.

We are also aware of several other discrepancies existing in the preparation of Electoral rolls: many names from the voter's list have been dropped and in some cases names of children aged 13-16 have been included in the names. Moreover, names of several people who have fled to Andhra Pradesh and other neighbouring states have been added or maintained in the electoral rolls of Salwa Judum camps when they never lived there.

We are afraid that this will inevitably result in fraud voting while the citizens themselves are deprived of their right to vote.

According to media reports Communist Party of India has also raised their objection with you on similar points. They have informed that 50 polling booths

in Bijapur and 92 polling booths in Dantewada has not been inspected by Election Commission. They feel the inspection staff have refused to do their duty, probably due to threats from Salwa Judum.

Recently Advocate Pratap Narayan Agrawal preferred a letter petition in the High Court of Chhattisgarh alleging that the election was “neither free nor fair”:

9. From the preparation of voters' list, photo-identity card and polling in booth is a story of abuse of power and connivance of public servants with money-muscle-mafia candidates. The election commission abused its' power in firstly declaring that in absence of photo-identity- card the voters will be allowed to cast their votes if they have any of the other 29 proof of their identity, but suddenly the election commission debarred the voters of Dantewada and Kanta-Sukma constituency who had no voters'-identity card. The commission's agency failed to update and issue voters' identity- card to each of the Indian citizen voter. Thus, the conduct of election was neither free nor fair nor constitutional.

10. The commission failed to make arrangements for security of voters from naxals and other anti-law; is clear from the incident of voting thrice in village Gogunda in Kanta constituency. The fear and insecurity amongst voter is proofed by the fact that only 10 voters cast their vote against the roll of 711 voters. The election-party many a times did not go the booth and made false documents of voting. The election-machinery cared and busy only to protect the election-party, they did not care to secure the voters. Thus, the election in Kanta, Dantewada, Kanker, Keshkal, Narayanpur constituency were neither free nor fair nor secure nor constitutionally achieved.

11. The very fact that Collector and District Returning officer with superintendent police Dantewada having reported against the election- observer; and the observer having reported against them for corrupt practices is a proof of conduct of illegal elections.

12. The very fact that the Chief Election Officer of Chhattisgarh election commission Dr.Alok Shukla reported of non-cooperation by Director General Police and his subordinates and the District Returning officers, is a proof of conduct of elections in unfair and unfree and illegal and insecure manner.

13. The very fact that Commissioner of Bastar Ganesh Shankar Mishra, Collector of Raipur Sonmani Bora and collector of Kanker Pinda were transferred for free and fair elections, indicates unfree and unfair involvement of public-servants.

14. The fact that many of the officers were not relieved from duty despite instructions of election commission and some of them relieved on my notice, is a proof of unfair and unfree and corrupt and abusive-power involvement of public servants in conduct of elections. None of the erring public-servant is punished is the prove of their criminal conspiracy with political parties.

In fact, some poll parties and security parties have already been prosecuted for election malpractices by the Election Commission in Rajnandgaon and Kanker districts. 11 persons are in jail in Rajnandgaon pending trial. This poll party had never gone to the booth but had sat in the fields and pressed the EVM buttons, all for the BJP! The Congress candidate from Bhanupratappur - Manturam Pawar has filed an election petition alleging that goons of the BJP candidate (now Minister) Vikram Usendi had terrorized and chased away all the voters at one of the booths and pressed the EVM buttons 504 times in favour of the BJP. There have been dozens of cases of more than 100% voting and even more where votes were cast only for the BJP. Besides when we recall that the votes in the camps could hardly have been cast freely and that votes of government servants were ostensibly "cast by post", it is not difficult to understand how the BJP might have won.

Recently the papers in Chhattisgarh were blazing headlines – "NHRC gives a clean chit to Salwa Judum", referring to the enquiry made on the directions of the Supreme Court. Of course the NHRC had acted in a typical "police" fashion, traveled to villages in anti-land mine vehicles with SJ leaders and alleged perpetrators as translators and guides, and could not even protect the few villagers who were brave enough to depose before it.

Yet the recommendatory chapter of its report begins by noting that the Salwa Judum movement has now lost its momentum, and suggests that efforts should be made to rehabilitate the remaining camp inmates. It recommends that village wise lists of missing persons be made, atrocities be investigated and villagers be encouraged to lodge FIRs, that all losses due to loot and arson be compensated irrespective of perpetrators (read "even if non-naxalites"), that paramilitary forces stop using school buildings, that corruption in camps be strictly checked, that security forces be trained to avoid human rights violations, that a more humane transfer policy be put in place to relieve them, and that rather than a security-centric approach efforts be made to address socio-economic deprivation.

Dilute as they may be, could these recommendations,

which are practically a vindication of the allegations of human rights groups, be described as a "clean chit"? Well, so thinks the Public Relations Department of the Government! And so that is the Truth (with a capital T) in current vogue in Chhattisgarh.

In other words, after all that effort, we are back to square one.

Not recognising the people's brave resistance Missing the forest for the trees. For the State in Chhattisgarh, there are no adivasi people, it only recognises "Maoists" or "victims of Naxal violence".

People have been Speaking. But has Anyone been Listening?

On 5 November 2007, about 2 lakh adivasis gathered at Jagdalpur in a rally organized under the aegis of the Adivasi Mahasabha. When we went as a team of the CMM we saw that at the venue – the huge Jagdalpur stadium - there was not a single matador, truck or bus. All the participants had come walking, some had left their villages 3-4 days before the event, carrying rice and their own fuel wood. Their slogans - "Stop Salwa Judum", "Stop giving adivasi lands to companies", "Down with Mahendra Karma." Huge winding rallies poured into the city from all directions. We were surprised to see an Air Force plane hovering sinisterly overhead, making an airborne survey?

A similar rally at Dantewada on 14 November 2006 had been denied permission by the Collector Dantewada in the name of a by- election taking place in the Bilaspur district more than 500 kilometres away! The High Court had struck down the order of the Collector and permitted the rally. Despite all-out efforts by the Salwa Judum leaders and the police and para-military to obstruct and threaten, the participants of the rally did arrive at Dantewada, 50,000 of them, to oppose the land acquisition by Tata and Essar, and to oppose the massive displacement of adivasis in the name of Salwa Judum. It is interesting that despite all the government support, Salwa Judum has never been able to muster such mobilisations.

And that is not all. Six months ago hundreds of tribals had demonstrated at the district headquarters of Bijapur, protesting that CRPF jawans posted at a relief camp in the interior village of Cherpal had fired at camp residents, killing a two-year-old boy, Raju, and a woman, Ram Bai, 25. They had demanded the recall of CRPF from the village.

And at Nakulnar... At Bhansi.....At Kondagaon..... At Lohandiguda.....At Santoshpur.....At Singhavaram...

Yet unfortunately, for the civil society too, the adivasi people are only victims, “ground between two stones”, “caught in the crossfire”, “those whose only crime is to be neutral.” We have been appealing to the democratic institutions – the Executive headed by the Collector and the Governor in the Scheduled Areas; the Judiciary headed by the Chief Justices of the Supreme Court and High Court; the National and State Human Rights Commissions, and the special committees set up to monitor the status of the scheduled tribes and the scheduled areas; the national and local media; political parties of all hues. After many undaunted efforts, not to be belittled in the least, there has been a small stir. But small, far too small, in comparison with the dimensions of the human tragedy.

But the NHRC is right about the fact that the Salwa Judum has lost its momentum. Now the operations are clearly police-CRPF-IRB operations. A large number of the “pakka” SJ recruits have been absorbed as “Special Police Officers” - the lowly paid (yet by local standards getting a royal sum of Rs. 1500 a month) youth who serve as the spy network, guide the police parties in the jungles and literally form the physical shield around the CRPF in each of the thanas. Recently the DGP Mr. Vishwaranjan stated that more than 1500 SPOs were discharged on grounds of indiscipline (euphemism for atrocities).

The SP of Dantewada candidly admitted to the press in November 2008 that 80% of the inmates of the camps have returned to their villages and the newspapers of 19 January 2009 state that 11,000 more returned enmasse. When one recalls that there are 19 battalions of CRPF, not to mention Naga and Mizo IRBs, in Bastar and Dantewada, today, and that these security forces have been treating all those who refused to come to the camps as “Naxalites” and in fact forcibly bringing them back if they ran away, how did this happen?

How has Salwa Judum been Pushed back?

The live telecasts of happenings in Singur and Nandigram have shown us what happens when people of 11-12 villages refuse to part with their lands. Now multiply this by 50. Think of the enormity of it - 644 villages, 3.5 lakh adivasis. The government figures say 50,000 are in the camps. Human rights organizations say another 50,000 have fled to Andhra Pradesh. Let us add another 50,000 for good measure. Even so, our arithmetic has failed. Where have 2 lakh adivasis vanished? Obviously into the jungle. And therefore by the government logic – they are Maoists?

It is these adivasis who have been declared outlaw, who are being cordoned off by the security forces, who are being deliberately starved of food and medicines by the withdrawal of health services and ration shops. These adivasis, whose crops are repeatedly burnt when they try to sow them in the abandoned villages. These adivasis who have to walk kilometers and kilometers to a local bazaar to avoid being “identified” as a Naxal by the Salwa Judum (or now the local SPO) and beaten, arrested or even killed. They who are swelling the overcrowded jails of Dantewada, Jagdalpur and Kanker, accused of “offences by unknown Maoists” – serving a sentence even before trial, for the word “bail” is unknown in the legal lexicon of Dantewada. Trials from which everyone knows they can only be acquitted for there are no witnesses, and no complainants, and most of time no co-accused either.

But it is also these adivasis who have refused to go the camps, who have repeatedly tried to return to their villages, who have sown their crops knowing that they might be destroyed by the Salwa Judum and CRPF, who have also been fighting to save their fields, their homes, their villages.

And yes, how can we deny it, they have resisted the Salwa Judum, the police, the CRPF physically with their traditional weapons. And again, it is undeniable, that the Maoists have supported them.

It is these adivasi people who have bravely created the conditions for those held in virtual detention in the camps to return home. It is they who are refusing to hand over their lands, their forests, to the rich global mining interests who are waiting in the wings. It is they who have pushed back a brutal campaign like Salwa Judum. Can we refuse to recognize this brave resistance only because we may be ‘labelled’?

Today’s imperialist onslaught is a desperate attempt to overcome crisis. And the masses of people refuse to be the sacrificial goat. The ferocious aggression of imperialist capital, especially from the US, has to be seen in the light of the economic crisis impending since the 1990’s that has erupted now in 2008. This final economic meltdown has exploded many a myth about the illusory ‘free market economy’ and we are seeing the naked collusion between finance capital and their imperialist governments. The ‘free market’ is for the devastation of lakhs of peasants, and the ‘bail-outs and subsidies’ are for the big capital.

Even the mainstream economists like Joseph Stiglitz and Paul Krugman and many others have been demonstrating that, especially in the last decade, the

US has been consuming vast resources at the expense of the developing countries such as China, India and Russia etc. This has been done largely through its unique position by way of issuing dollars to reduce its mega-deficit and making the poor countries pay for its consumerist extravaganza. According to a New York Times article, since 2001, the US debt has grown by \$1.7 trillion. Foreigners financed 75 percent - about \$1.3 trillion - of this, China alone bears one-fourth the burden. So, we see that the plight of the Indian peasants or that of the small industries is not a natural phenomenon, but a direct consequence of ruthless loot by the desperate imperialists. But with all this loot, they could only postpone the collapse of their economy, and finally by 2008, the crisis caught up with them.

A word of caution. By economic analysis alone, without an all sided study of our times we can never get to the whole of the truth, more importantly to that truth, which guides us to work to change the wretched conditions of our world, beyond mere interpretations.

If we carefully think over the whole sequence of the events, we can figure out that had George Bush succeeded in taming the Iraqi people in a time period of three to six months, then he could have proceeded to conquer Iran and could have got hold of vast oil resources cheaply. In that situation the imperialists could have postponed the crash for another decade. This is what they had calculated.

The people of the oppressed world thought otherwise. At the cost of untold sufferings and sacrifices, the march of the armed might of US imperialism has been brought to a grinding halt. After Korea and Vietnam, the people of Iraq have shown that imperialism is indeed a paper tiger. The moral of the story is that we have to go beyond interpretation, work for change, come out and organize the struggle to defeat the plunderer imperialists.

At this historic juncture of world wide economic crisis, what is the state of affairs in our country? What are the politicians of every major political party and the ruling bureaucrats doing? Of course they are working to save the country, to save the economy from the crisis. The country is - Tata, Ambani, Jindal, Jaiprakash, DLF, Indiabull, Essar, Birla, Holcim, Lafarge, ITC etc. etc. and the vast people are their subjects. More than 60,000 crores have been injected. More may be needed. After all the country has to be saved from the economic crisis.

The crisis is of the demand side. So demand has to be boosted. Excise duty has been cut across the board.

Mobikes are cheaper by 4000, cars by 20-40,000. Banks have been instructed to disburse loans to boost the consumer market. Come on citizens, the country has to be saved, the economy has to be saved, tighten your belts.

How can they give bonus, there is an economic slowdown. Wages less than half the legal minimum? You should understand, it is a crisis. Everyone has to do their bit. The country is taking upon itself the burden of carrying package after package, the citizens should chip in with a bit of overtime and a bit of unemployment.

And peasants, yesterday, you were to contribute your land for development, today to save the country from economic crisis. Are you not to be expected to make that contribution at the altar of country? You see, we are all one. The government of economists is leading us. We are in safe hands.

Just a minute. The crisis is of the demand side. Then, can't the demand be boosted by paying bonus to the workers, by paying full wages and even giving a raise, by providing employment to all with a living wage (and not a starvation wage as under NREGA)? Imagine the boost to the demand when 77% of our people earning less than Rs. 20 a day start earning a minimum wage of say Rs 100 a day? By constructing decent hospitals for the 80% of population that doesn't have them? By providing for construction of houses with toilets for every family? To boost the demand and save the economy, isn't it logical to have a moratorium on the constructions of malls and all other extravaganza before the whole population is provided with these essentials? Or is it that only when malls and flyovers are constructed, the demand for the steel and cement industries is boosted and when hospitals and houses and toilets are constructed, it is not?

The logic of economics is absolutely clear in this matter. That in fact demand can only be boosted in this manner. But how can finance capital allow you to even think this, leave alone propose action on this line? Ah! There is this political side to our economy. And our economist rulers are the agents of the supreme imperialists. Indeed the whole ruling class, the politicians, the big bureaucrats! It has recently been reported in the mainstream media that the black money stashed away by this ruling class in Swiss Banks was Rs. 1300 crore in 1984, it increased to Rs. 28,000 crores in 1997 and this amount had soared to a whopping Rs. 72, 80,000 crores by the end of 2006. This amount is hundred times more than the much worshipped FII investments in the Indian stock market.

In its crisis-ridden state, imperialist capital has become ferocious, like a real tiger in its old age. It has been waging an all out attack on the lives and livelihood of people. The crisis-ridden imperialists and its pliant state have been particularly aggressive in carrying out land grab and easing out the peasants from their land, lives and livelihood at an unprecedented scale. Kalinganagar, Singur, Nandigram, Midnapur, Koelkaro, Netrahat, Raigarh, Jashpur, Posco in Jagatsingpur, Tata in Lohandiguda & Essar in Bhansi in Bastar, and so many other places in Chhattisgarh and all over India. Displacement under Salwa Judum, as relocation under military strategy is the one of the most brutal instances. Imperialists consider the Maoist forces to be the most serious obstacle in the way of unbridled exploitation in Bastar and many other adivasi areas. To fight them, the state does not hesitate to carry out genocidal campaigns among the adivasi peoples. But the adivasi people are refusing to quietly surrender their lands, forests and resources to the imperialist loot machine and are bringing it to a grinding halt. So the representatives of the US imperialists have to be frequently present to see if the state is doing enough to protect their "long term

interests" in the mineral rich hinterland of India. This interference in the affairs of our country cannot be allowed. The dalaal political class should be exposed before the whole people. True, the foundation of capitalism was laid on clearing indigenous population through genocides in many continents, on blood and sweat labor of African slaves, on colonial exploitation and plunder of India and most of the world. But, that was centuries ago. For 'progress', even in the 21st century, can human 'civilization' allow such a path of development?

Can the degradation of the earth and 'civilization' be halted without doing away with the present system of obscene inequality? And can that happen without the toiling and exploited people, the wretched of the earth, taking away from the so obviously degraded imperialist masters of today's world and into their own hands - the command of politics, economy, culture?

It is the call of the hour - support the resistance of the adivasis in the resource-rich areas, join hands to come out and organize the anti-displacement struggle at the national level.

Surely, we shall defeat the plundering imperialists.

A Sureshot against Cervical Cancer?

- Rema Nagarajan, TNN 2 August 2009

SEOUL: Despite a vaccine being available against cervical cancer, the most common cancer among women in India, it might be of little help at the prohibitively high current price of \$360 (for three doses) or about Rs 16,000 per adolescent girl.

At a symposium held here by the International Vaccine Institute, an international research organisation devoted to vaccines supported by various governments, companies and foundations, several health experts and policy makers called for the introduction of routine HPV (human papilloma virus) vaccines into national immunisation programmes, even as they expressed concern about its affordability.

"Cervical cancer caused by HPV comprises over 34% of cancers among women in India, making it the most common. Of this, 70% of the cancers are said to be caused by two strains of the virus - HPV 16 and HPV 18 - against which a vaccine has been developed," explained Dr Neerja Bhatla, additional professor of the Department of Obstetrics and Gynaecology at the AIIMS.

The vaccine is of no use once a person is already infected with the virus. Hence, being a sexually transmitted virus, for the vaccine to be effective it has to be administered before a girl becomes sexually active. In India, this would have to be between 12-18 years as early marriage among girls is prevalent.

This would mean vaccinating a population of over 100 million girls at the cost of Rs 16,000 per child. That would amount

to thousands of crores of rupees, several times the size of the entire national immunisation programme.

Yet another concern is that being a newer vaccine, it is not known how long the vaccine will remain effective. So far, it has been found to be effective for six to seven years. If a booster shot is required to maintain protection, the cost could be even higher.

Moreover, the vaccination is to be given as an intramuscular injection in three doses, each dose costing about \$120. If the costs of trained manpower required for such an immunization programme and that of safe disposable needles are taken into account, the cost would be even higher.

However, Linda Eckert of the World Health Organisation (WHO) explained that WHO had recommended the use of HPV vaccines in immunization programmes as it was programmatically feasible and since sustainable financing could be secured. She claimed it could be made cost effective as the Global Alliance on Vaccines and Immunisation (GAVI) could help subsidise the vaccine for the poorest countries and the Unicef could procure it for poor countries by negotiating for lower prices with the vaccine companies. However, she didn't elaborate by what percentage such efforts could bring down the price of a vaccine costing over Rs 16,000 per child.

Source: <<http://timesofindia.indiatimes.com/NEWS/India/A-sureshot-against-cervical-cancer/articleshow/4847068.cms>>

Note on Consultation on Falciparum Malaria Control Held at Jan Swasthya Sahyog, Ganiyari, February 2009¹

The control of falciparum malaria at the National level is now under the national vector Borne diseases control programme since 2005. The strategy to control this important disease has undergone many changes in the last three decades, and yet falciparum malaria does not seem to have undergone a major decline in its impact. In 2008, under the advice and support of the WHO and the World Bank, the programme for control of malaria has been completely revised. The changes are substantial.

Some of the new recommendations include the preferential use of Rapid Diagnostic kits (RDTs) instead of strengthening the microscopy services to diagnose *Plasmodium falciparum* (Pf) malaria; the use of Artesunate Combination Treatment (ACT) for all cases of Pf malaria; the withdrawal of chloroquine chemoprophylaxis in pregnancy in women in endemic areas; use of only Long-lasting Bed nets as the mainstay of control strategies in the programme; the district hospital being the minimum level of health care delivery for treatment of severe malaria. Finally to deliver all the aspects of malaria control at the community level, the ASHA would now become the main provider of services, in fact the expectation is that these new initiatives will infuse new energy into the ailing public health system.

A consultation to discuss issues related to falciparum malaria control in India was convened by Jan Swasthya Sahyog at Ganiyari on 19th and 20th February, 2009. It was felt necessary to discuss the new recommendations for the control of falciparum malaria that have been made by the NVBDCP in order to develop a common understanding of the issues involved, and to build support for reducing the burden of malaria in central India.

The issues raised in the consultation focused on the following areas:

- a. *What is the status of resistance to chloroquine in falciparum malaria, especially in the five central states that contribute to over 90% of falciparum malaria? Is the switch to ACT justified for non-severe malaria?*
- b. *What is the best diagnostic strategy for the diagnosis of falciparum malaria- microscopy or*

rapid kits or just a clinical diagnosis?

- c. *Issues in management of severe malaria:*
 - a. What is the antimalarial of choice? What is the oral switch recommended?
 - b. How do we provide the other components of severe malaria care such as safe blood, checking blood sugars, and dialysis care in the public health systems?
 - c. What is the prescription for pre-hospital care in these patients?
 - d. *How do we protect a pregnant woman and her unborn child from the five times higher risk of death or of severe disease as a consequence of falciparum malaria?*
 - e. *What should the preventive strategy focus on? Should it be the long lasting insecticide treated bed net(LLITN)?*
 - f. *What should be the strategy for building capacity among service providers in malaria prevention and care?*
 - g. *Malaria and primary health care*

The consultation was held to exchange views and information, share experiences and documented literature. There were several technical, operational and governance issues to discuss. Thus, the format used for discussion included a basic presentation of the issues in each sub topic and then responses by the involved or affected institution or group in the form of points and counterpoints. The group had representation from a variety of people working with Malaria in the states of Chhattisgarh, Orissa, Jharkhand, Madhya Pradesh, Maharashtra, Gujarat, West Bengal and Assam. They included Directors from NVBDCP, New Delhi and social activists from NGOs working in malarious areas; representatives from international agencies like the WHO, World Bank, UNICEF, Medicine Sans Frontiers (MSF) and Drugs for Neglected Diseases Initiative (DNDi); and experienced clinicians treating malaria patients in the poorest parts of the country; State Health Secretaries/ Commissioners, State Malaria Officers and Experts in Public Health and Health Sector Reforms like the State Health Resource Centre, Raipur; Scientists from NIMR & NVBDCP and teachers of Medicine from Academic Institutions. The Consultation therefore brought together a unique mix of scientific, clinical, grass-root and governance experience.

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Though it seemed that there was serious engagement on these issues by a wide spectrum of people, ensuring that the national programme makes mid-course corrections needed continued engagement. While there was a development of a positive (malaria) community network at the field level, engagement at the policy level was considered very important.

The two days of consultations involved serious discussion on a wide range of issues related to falciparum malaria control. Several recommendations were made by the group and these were forwarded to the NVBDCP for consideration (see accompanying piece).

Subsequently, the Planning Commission requested JSS for a presentation of the issues raised and discussed at the abovementioned consultation, and a meeting was held on 13th May 2009, where the Health Secretary, Jt Secretary (Health), as well as the Director and Jt Director NVBDCP, Director NIMR, representatives from the World Bank, WHO and UNICEF were present. Three people (Drs)

Yogesh Jain, John Oommen and AV Ramani from among the participants of the consultation presented the recommendations to this group.

A representation was also made to the Jt Secretary in the PMO regarding the issue of malaria chemoprophylaxis in pregnancy.

The new programme has now been launched in Chhattisgarh and it remains to be seen how well it functions on the ground and how effective it is in reducing falciparum malaria morbidity and mortality.

The presentations and literature are being put together as an e-book, co-ordinated by Dhruv Mankad.

There is a need to pursue the process of raising questions about the problems in the malaria control programme and well as continuously engage with the programme implementation at the state level. The issues include technical and operational aspects of the problem as well as governance concerns. MFC should engage with this process of addressing concerns in malaria control.

Key Recommendations of the Ganiyari Consultation

This is a list of Key Recommendations. The text of the statement provides the rationale and a number of other recommendations and suggestions that are linked to the Key Recommendations.

Recommendation 1: To create effective mechanisms for authentic estimates of the burden of Malaria, at least in terms of mortality and morbidity, to capture and utilize information that is available locally but not feeding in to the official reporting system, as the present malaria reporting system suffers from gross under-estimation many fold.

Recommendation 2: To continue to monitor resistance to Chloroquine and Sulfa-Pyrimethamine (S-P) in a strategic manner. Where Chloroquine Sensitivity exists, effort should be made to record and preserve it. S-P Resistance could warrant a re-thinking on choice of ACT (Artesunate Combination Treatment).

2 A: The programme needs to be cognizant of the expected therapeutic life of ACT if it is used appropriately as the drug of first choice, before launching into its widespread use.

2 B: Given the local and focal nature of chloroquine resistance, the programme should reconsider whether the prescription change to ACT needs to be at a regional, state, district or block level.

2 C: Given the last option nature of ACT in the treatment of falciparum malaria, the possibility of

using the non-ACT drug options should also be considered.

Recommendation 3: Given that a large proportion of the treatment of Malaria occurs outside the public health system, initiatives are taken to build capacity to provide rational, appropriate and affordable management of Malaria in the private sector as well, including informal practitioners.

Recommendation 4: Artemesinin as a single drug in oral preparations needs to be withdrawn from the market immediately.

Recommendation 5 : To endorse the value of Microscopy as the gold standard of Malaria Diagnosis, and its role in diagnosis, prognosis and resistance monitoring, and to continue to sustain and strengthen the network of Malaria Microscopists, even as RDTs (Rapid Diagnostic Kits) are being used in a strategic manner.

Recommendation 6: To endorse the need to use RDTs especially in areas where microscopy is not possible or operationally difficult, with the following steps for quality control.

- Quality monitoring of RDTs at both procurement and post-distribution points.
- Regulation of RDTs in the market, with banning of brands of poor quality.
- Procurement, transport and storage of the RDTs,

given the temperature sensitivity and relatively short shelf-life, through professional and innovative approaches.

Recommendation 7: To review the new policy on malaria in pregnancy, with inputs from clinicians in highly endemic areas, so as to consider the following:

- resume chloroquine prophylaxis in pregnancy until concrete evidence is available about its lack of effectiveness even after proper implementation. Prophylaxis should be offered in all high burden states, both in stable and unstable transmission areas.

- Offering ACT in 2nd and 3rd trimesters of pregnancy for women with non severe Pf malaria based on the new WHO recommendations regarding their safety. We should strengthen the plans for the distribution of bed nets for all pregnant women.

Recommendation 8: To create clear-cut guidelines for case management of severe falciparum malaria and its complications at community, PHC, secondary and tertiary levels, including appropriate pre-referral steps such as rectal artesunate by physicians and health workers, with inputs from clinicians experienced in managing this illness in malarious areas.

Recommendation 9 : To create Referral Networks including Emergency transport system in high burden areas, with mapping of required facilities and services, in association with the NRHM and the private sector, to make primary, secondary and tertiary level

management of severe malaria available and accessible to patients. The community health centres (CHC) should be made severe malaria management competent as a test of their capability.

Recommendation 10: To persist with multi-pronged, integrated approaches to malaria control, based on scientific inputs on the local and focal epidemiology, vector behaviour, drug sensitivity, and social realities. Indoor residual spraying, provision of treated bed nets, use of repellent creams and oils and anti-larval measures all have their roles that differ in their importance in different ecological situations.

Recommendation 11: To take cognizance of areas in training that need more time as detailed above.

Recommendation 12: To invest in empowering affected communities with the knowledge and skills necessary to control malaria, and access to the tools they need for this, both in the Health System and outside. This can include the promotion of networking of Affected Communities and people with keen interest for malaria control.

Recommendation 13: To work with the NRHM to enhance opportunities for furthering the reach and scope for malaria control through areas of convergence such as First Referral Units, Blood Transfusion services, Village Health and Sanitation Committees and Rogi Kalyan Samitis.

- Jan Swasthya Sahyog, Ganiyari, February, 2009

Give Children Iron Supplements: They Don't Increase Malaria Risk

Iron supplements do not increase the likelihood of contracting malaria and should not be withheld from children at risk of the disease, despite World Health Organisation (WHO) guidelines to the contrary, a new review by Cochrane Researchers suggests (*The Cochrane Library* – Issue 3 Highlights 2009).

“Based on our review, children should not be denied iron supplements, even if they are living in areas where malaria is prevalent,” says lead researcher, Juliana Ojukwu of the Department of Paediatrics at the Ebonyi State University in Ebonyi State, Nigeria. “Iron is important for growth and development, and maintaining a healthy immune system.” Until 2007, WHO guidelines recommended that all children should be given iron supplements to help prevent iron deficiency and anaemia, which are significant public health problems in developing countries. It is estimated that iron deficiency is the cause of 726,000 childhood deaths each year. However, a recent large trial in Zanzibar prompted the WHO to change its guidelines, which now recommend that iron supplements are withheld from children under two years in areas where they are at high risk of contracting malaria. The argument against giving iron is that it could

help promote the growth of malarial parasites circulating in the blood. In response to this, Cochrane researchers reviewed data from 68 different trials involving 42,981 children. They concluded that iron did not increase the risk of malaria, as long as regular malaria surveillance and treatment services were available, and that there should not be any need to screen for anaemia before giving supplements. They say WHO guidelines rely too heavily a single recent trial, whereas this current research drew its conclusions after giving appropriate weight to a wide range of studies. Although the benefits of giving iron are greater for children with anaemia, any decision to withhold iron supplements should be carefully considered. “Any potential negative effects of giving iron have to be weighed against the quite serious implications of not giving it, namely anaemia and its contribution to childhood infection and death, especially in Sub-Saharan Africa,” says Ojukwu.

Source: Ojukwu JU, Okebe JU, Yahav D, Paul M. Oral iron supplementation for preventing or treating anaemia among children in malaria-endemic areas. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art. No.: CD006589. DOI: 10.1002/14651858.CD006589.pub2.

How Bill Gates Blew \$258 million in India's HIV Corridor

The purpose was noble, the money generous. But the software mogul's charity for HIV prevention in India has failed to make a lasting impact.

Elizabeth Flock in *Forbes India*

On a humid afternoon, former sex worker Fathima (name changed) welcomes a group of illiterate women - still in the trade and needing protection from HIV - into the Mukta clinic in Pune. As a "peer educator," it's her job to convey to them the message of safety. But the visitors shuffle tentatively as expensive-looking posters in English paper the walls around them.

Why would a clinic serving illiterate visitors use more English than Indian languages?

The answer lies in where that money comes from. The Pune clinic is part of a network one hundred-plus non-governmental organisations (NGOs) working under the umbrella of AVAHAN, India's largest HIV prevention initiative. AVAHAN, or "call to action," is a brain child of the world's largest philanthropist: Bill Gates.

Gates had announced the 10-year, \$100-million initiative to stop the spread of HIV/AIDS in India during his much heralded visit to the country in November 2002. This was to be the largest of its kind for the Bill & Melinda Gates Foundation.

The timing couldn't have been more appropriate. After nearly two decades of piecemeal efforts to counter HIV, India was hurtling towards an AIDS epidemic. Millions of poor people exposed themselves to the dreaded virus due to a lack of awareness. Government agencies and NGOs didn't have the money to preach safety or treat the infected. Gates showed his seriousness by later raising the budget to \$258 million.

Seven years later, back at the Pune clinic, Fathima has counselled the women, given them the sheaths of safety and sent them back. It is time to worry about the future. The bad news is AVAHAN is ready to pack and go; and Fathima is set to lose her income. She doesn't want to slip back into prostitution. At the age of 45, she doesn't have much of a career there anyway.

When it started on the ground in 2003, AVAHAN set for itself three goals: Arrest the spread of HIV/AIDS in India, expand the programme from the initial six states to across the nation, and develop a model that the government can adopt and sustain so that the

project could be passed on to it. More than five years later, AVAHAN hasn't achieved any of these goals. Doubtless, the initiative has made a dent into the HIV/AIDS problem, but the impact is marginal for a bill of \$258 million. And now AVAHAN is leaving, handing over the reins to the government-run National AIDS Control Organisation (NACO), which doesn't want to inherit it. It is too expensive for the budget-starved establishment that is as nimble as a sloth. If NACO takes over, it will try to prune the costs of the programme. Salaries for peer educators will go.

A Five-Star Initiative

When Gates Foundation got down to work in India, the priority was clear. It decided to hire the best minds in business to run its initiatives using sound principles of management. AVAHAN was ready to spend what it takes to get the best bosses and started its search at McKinsey, the consulting powerhouse. The recruiters zeroed in on Ashok Alexander, who had spent 17 years turning Indian businesses into global challengers. "They made me an offer I couldn't refuse," Alexander recalls, sitting at his plush office in New Delhi. "I liked the ambitious arch of the HIV/AIDS programme and it was a chance for me to do something new."

Soon, the 15-member team was in place. Ten of them had come from a private-sector background. The team members tackled HIV/AIDS much as they would a problem at McKinsey. Alexander's office is papered with data and maps containing hundreds of coloured dots plotting the disease across the country. The argot is sheer B-school: AVAHAN is a "venture," its HIV/AIDS prevention programme a "franchise," the sex worker the "consumer."

The classical business principles helped AVAHAN start on a big scale in six states simultaneously. But the lack of public health experience also led to a compromise on quality. Tejaswi Sevekari, director at Saheli, a sex workers' collective for HIV/AIDS in Pune, remembers observing the kinks during her stint at Pathfinder International, an NGO that works with AVAHAN. Data collection and reporting were entirely in English and had no pictures. Five years later, the

scene is the same; the project hasn't fully given up on English though no "consumer" understands the language.

AVAHAN operated in a pyramid, with Alexander and his team overseeing the work of more than 100 NGOs. The lack of practical experience at the top manifested itself in different ways. When AVAHAN introduced sleek mobile vans to bring clinics directly to the brothels, the expensive-looking vehicles were sometimes met with intense suspicion. At the Mukta clinic, Dr. Laxmi Mali says sex workers initially thought the van was from the police or the government. They refused help.

False Moves

The early missteps are largely anecdotal. But in 2005, an internal evaluation showed a big portion of AVAHAN's efforts had gone to waste. As many as 31,000 community members had been contacted by AVAHAN's outreach programme, but only 11,000 actually visited the clinics. The AVAHAN executives had assumed the peer educators would already know what the prevention services were without explanation; the reality was they didn't.

AVAHAN's craving for scale also meant it overshot quite a bit. It started with a bang in six states, with 50 sites for truckers in the south. But by mid-2005, only 12 percent of truck drivers were even aware of their services, and only 7 percent took advantage of them. This forced AVAHAN to reduce the sites to 20. For similar reasons, AVAHAN's 6,000 sexually transmitted infection (STI) centers were brought down to just 800.

Alexander's team tried to fix the glitches. For example, AVAHAN tried to allay the fears of sex workers (such as those who had met the mobile van with suspicion) by hiring them to act as intermediaries between the programme and communities. An insider could be more persuasive. Good idea, but AVAHAN's decision to pay them a salary has come in for criticism, because other NGOs can't recruit sex workers as volunteers.

A series of evaluations published in the AIDS Journal in 2008 show that the jury is still out on the programme's impact. The evaluations, funded by the Gates Foundation, were mostly on the methods of data collection. One study, which sought to determine whether AVAHAN was responsible for the decline in HIV prevalence in Karnataka, failed to prove that it

played a key role.

Where Has All the Money Gone?

At the core of AVAHAN's failure to make a serious difference to India's fight against AIDS is the way it spent money. It was an expensive operation, never tired of throwing money at the problem. In a country where a branded condom sells for just 10 cents, what did AVAHAN spend on? It's difficult to say because AVAHAN's finances are largely opaque. AVAHAN's outlets sell five million condoms a month and distribute another 10 million. Asked how so much could be spent on condoms, Alexander laughs, saying, "It's a bit more complicated than that." Probed further, Alexander says he doesn't know the financials off-hand, nor can he give them later.

Travel would have been one drain. Jonty Rajagopalan, AVAHAN programme officer from 2006 to 2008, says she would take flights every month from her base in Hyderabad to her focus areas in Andhra Pradesh and Tamil Nadu, instead of being based in a focus area. Another large chunk: salaries. Alexander's annual package is \$424,894, the second-highest in the foundation globally, not including the presidents and operating officers. AVAHAN's targeting intervention (TI) officers are also paid three or four times what a typical NACO TI officer is paid.

AVAHAN's marketing was done in style too. Eldred Tellis, head of Sankalp, an HIV/AIDS-focussed Mumbai NGO that has worked with AVAHAN, says he has seen a lot of money go into fancy publications on high-quality paper, reporting the programme's work. Very little went to the people on the ground. Vijay Mahajan, chairman, Basix, a microfinance institution, comments on AVAHAN: "There is too much money and too many really smart people with too little coming out."

An Uncertain Torchbearer

Knowing that it would have to inherit the project, NACO sent out evaluation teams to sites in four states to get some clarity on costs. NACO's head, Dr. Sujatha Rao, says the evaluation threw up one clear message: Large parts of the programme are not sustainable by NACO. "We told them you can't create a huge number of assets and then just leave and expect the government to take over everything," says Rao.

But Alexander disagrees. "We are not perpetual funders. We try to be catalytic," he says, ebulliently

confident that the HIV/AIDS epidemic will soon be contained, with or without the foundation. Either way, it will have to be - AVAHAN is now repositioning, focussing on maternal and newborn health.

Ashok Row Kavi, consultant for UNAIDS and chairman of Humsafar Trust for gay and transgender health, says AVAHAN's expectations were unrealistic. "They wanted HIV to disappear in five years. For that to happen, a lot of people would have to die."

NACO's annual budget is Rs. 1,100 crore (\$225 million), none of it spent on AVAHAN currently. Rao just can't find enough money to continue the project. "We can never offer a replicable model. And if we are unable to sustain the programme, all of their effort will be for naught," she says, shaking her head.

When probed about the difficulties of handing over the massive programme to the government, Alexander says the transfer is going just fine. Kavi differs; he says that the transfer discussions between NACO and Gates Foundation are "running into a brick wall right now. Costs need to be brought down, but they can't figure out how." He also fears AVAHAN's now-experienced MBA-graduate TIs, facing shrinking salaries, will depart. The question of running air-conditioned clinics like AVAHAN doesn't even arise.

The biggest hole in quality will arise where it can hurt most. Hussain Makandar, HIV counsellor at the Mukta clinic, is worried about condoms; the ones from AVAHAN lubricate; the ones from NACO break and the sex workers stop using them.

Alexander insists that only a 10th of the project will transfer to the government this year and the rest will happen slowly over the next five. "We're doing a transition programme. We're not saying, 'here's the programme, and we're off.'" But NACO and Mukta officials, among others, are confused over the timeframe.

So, the final report card on AVAHAN:

Goal 3: Develop a model for HIV prevention that can be implemented by the government sustainably. NACO's resounding vote: Not achieved.

Goal 2: Expand the programme nationwide. AVAHAN could not go beyond the six states it started with. Not achieved.

Goal 1: Arrest the spread of the disease. The number of Indians living with HIV/AIDS has been officially corrected from 5.1 million to 2.4 million. This was a statistical change, not an improvement in health. Impact not known.

Back in the great Indian sex bazaar, prostitution is a growth industry and condom an exception. "New faces keep coming in every month (to the brothels)," says Dr. Mali. "Twenty percent of the people we now see are infected, the same as when we started."

Source: <[http://business.in.com/article/cross-border/how-bill-gates-blew-\\$258-million-in-indias-hiv-corridor/852/0](http://business.in.com/article/cross-border/how-bill-gates-blew-$258-million-in-indias-hiv-corridor/852/0)> and Forbes India, June 19, 2009. Reproduced with thanks in public interest.

\$258 Million for Condoms?

The India Head of Gates Foundation Defends a High-Cost Project for the Fight against HIV in India

Interview by Elizabeth Flock, June 6, 2009

Ashok Alexander, Director of the Bill & Melinda Gates Foundation's Indian HIV-prevention project is interviewed by Elizabeth Flock

Q. *Please tell me about how you started. Why did you decide to leave McKinsey and join AVAHAN?*

A. They made me an offer I couldn't refuse. I was 17 years at McKinsey but I liked the ambitious arch of this HIV/AIDS program. McKinsey and the Gates Foundation know each other quite well. I joined at the end of 2002, and I officially started April 1, 2003.

Q. *How did you build your team?*

A. Most of the people came and found me and AVAHAN. People were all in good jobs, but they got excited about

this 'venture', and it was exciting enough for them to go. Alkesh Wadwani was a senior manager at McKinsey, and set his career aside to start with this venture. It was a chance at doing something new. There were two other McKinsey people. I have a team of 15. Ten are from the private sector, five are from technical backgrounds. For example, one has an MD in infectious diseases. From the private sector they are from consumer products, IT, and banking.

Q. *When you started AVAHAN in 2003, where did you start first?*

A. We wanted to do HIV/AIDS prevention, and be highly focused on the high-risk groups. This includes sex workers, truckers, and injecting drug users. These are

the highest risk groups. In a large country, people often prevention with school children, etc, but we are more focused on those who are most vulnerable. This was our focus from the beginning. We looked at the situation and the context. The first program was in 2003. Our first programs were launched simultaneously in many places. Mysore was one of the first, it was featured in the *Wall Street Journal*. There were no condoms there, and a lot of sex work was going on. We started with such scale and speed, there was no first.

Q. AVAHAN works in partnership with many NGOs across India. How do you find them?

A. We give different grants, identify organizations and ask for proposals. Sometimes, we pick the organization. In, Karnataka there was one large NGO so we didn't create another—the University of Manitoba is there. We started everywhere at once in six states to test the prevalence of HIV. The coverage was inadequate. The notion of coverage...the number of sex workers without reliable quality services. We said the fire is burning here so we went here.

Q. Can you explain your structure?

A. All our work is done through NGOs. It's like a big pyramid. We fund 20 large NGOs and 140 grassroot organizations through them. They set up the clinics. The programs are run by the NGOs. They deal with the local doctors, and refer sex workers to them. 280 some clinics. 650 sites. A site means we are working in a district for intervention. There are four-six towns within a district. A site may not have a clinic, but there is a referral arrangement there. It's really all about making sure people wear condoms.

Q. What is the total amount granted the Gates Foundation towards AVAHAN?

A. \$258 million have been given total in the first five years.

Q. How can you spend \$258 million on just condoms?

A. When I took the job I thought I would just be encouraging people to wear condoms. But it's a little more complicated than that (laughs). It's not a lack of awareness. If you meet a sex worker, she will educate you about how to use a condom. Yet it is often not used. Often the client doesn't want to, or he is drunk, or whatever, so the crux is not just telling how to use a condom. Also, we are working on the issue of violence, beating up a sex worker. \$258 million...well, a lot is on condoms and telling people about it. I can't recall exactly how much. 10-20%, maybe, on monitoring, evaluation, but we use sex workers to do this as well so doesn't cost as much.

Q. Can you be more specific about what is spent where? Treatment, vaccines, publications, etc?

A. Treatment? Nothing is spent on that. Vaccines? The Gates

Foundation is largest funders of vaccination in the world, but not through AVAHAN. Publications? We will disseminate these nationally or globally. But we are not in a hurry to publish until it's appropriate. We will be talking to different groups. We gave NACO \$23 million grant to strengthen capacity. This is part of the \$258 million.

Q. Is funding a government program directly problematic? Does this give the foundation too much power?

A. No. The grant is part of the transition program. Our people work in NACO's offices, working and spending time with NACO to pass on best practices.

Q. Can you put some numbers on how many people you've helped?

A. We work with 300,000 female sex workers: 220,000, plus 20,000 injectors. We work with six million men, and this includes 220,000 men who have sex with men, four million are in the truckers program on the All-India highway, and two million in the program are in identified hot spots.

Q. AVAHAN is now moving on from HIV/AIDS. Can you please explain how this is happening?

A. Well, on March 1st, the second phase of the programme began. The first phase was delivering through NGOs, through a private channel. We were not funding the government, but working closely with the government and in concert with them and the national program. We were following their framework, passing on what we were learning to them, and invited to a seat at the table. In the second phase, we will transfer to the government, 10 percent of the program is transferring to the government this year, and NACO (National AIDS Control Organization) will run things. We're not saying 'here's the program and we're off'. We are doing a transition program in the communities. Ultimately over the next five years they will take over. In five years we would hope the HIV/AIDS epidemic is contained enough that we will no longer have to be involved. We are not perpetual funders. We try to be catalytic.

Q. What will AVAHAN do now?

A. We will move into something else - the burden of disease and bad health conditions in India. We will take the lessons learned from scaling up this. We may move into maternal and newborn health. There are challenges there like immunization. Right now, it's just a gleam in our eyes. For the problems in maternal and newborn health, solutions exist. No noble prize is needed. One needs to know how to scale up. We are working with colleagues in Seattle to see if we can devise a strategy for India. Avahan is the program for HIV/AIDS, the next one may have a new name. We are just making plans. We

will build a project and see if it can go large scale. See if we can transfer. Not going to wait five years to start the next one. Funding for HIV/AIDS has peaked now. Now we are transferring to the government. In health, though, lots of people are spending money. Ours is a drop in the ocean.

Q. Has AVAHAN's efforts been evaluated? Are those evaluations external?

A. We have our own evaluation advisory group. It is convened by WHO, and national and international health experts. Two independent reviews have been done, but not complete, not out yet. Six universities have done research projects on us. At the top is the advisory group, like a secretariat, conducting an orchestra, appointed by the foundation. It is made up of the world's experts.

Q. But if the evaluations aren't external, where is the accountability?

A. They are not there to rubberstamp what we are trying to do. Most are respected experts, and they aren't getting paid. They are volunteering their time for Gates Foundation. A tech advisory board advises on different parts of the HIV prevention. There is a big gap for every NGO globally on the aspect of evaluation. Asking, what came out of what we did? Must look if the biological prevalence has been brought down.

Q. Have you drawn lessons from your time at McKinsey?

A. We draw lessons from business. The business model is highly relevant in HIV and public health. Large part of our success depends on that. I think the big missing element in public health is that. The core of management is applied, principles of data, measuring, analysis. Training people in management—that needs to be done in public health. What I learned from business I use everyday. Not from McKinsey. We use classical business principles, like how do you segment the market. For example: the sex worker as the consumer. People say there are five or six million sex workers. We are working with 300,000, this is market segmentation. You have a disproportionate effect if we look at the frequency of the sex act, etc.

Q. How do you work with the sex worker?

A. The way we work is this. NGOs recruit sex workers, and part time they work for our program, and part time they do their work. 8000 women do this. Many of those women don't know how to read or write, but they are a sales force. Sex workers devise the tools to maintain this data

Q. Have you ever scrapped what you were doing and started over?

A. We have changed course plenty of times but not fundamentally. For example, we changed the truckers

programs. There are actually relatively few sites with truckers. We had started with 50 sites for intervention, but we whittled that down to 20. We've changed the STI program. Initially it was a franchise, with 6000 STI centers all over India, but the distribution of STIs is not even. We had 6000 sites, brought that down to 800. We changed the money to spend on demand creation

Q. How has the response been to AVAHAN's work in India?

A. I think the response has been good. When we started it was more challenging. The national response was there was a fair amount of denial, but things have changed. The government of India recognizes our contribution. We pass on what we learn, but also take from other good programs. We are not the first in the field.

Q. Can you talk a little about the controversy over numbers in 2002? Bill Gates quoted numbers for the level of HIV/AIDS that were later found to be exaggerated?

A. The problem in 2002 was with the global fund. I don't know too much about that, but groups felt that the India numbers were exaggerated. We had no part in this. We haven't put out estimates.

Q. The HIV/AIDS figures have historically been disputed in India. Is there a recognized figure now?

A. Yes, in the summer of 2007 there was a correction in figures. There was a change in methodology from household to sample survey. The only time we had contributed to the estimation was in 2007, we agree with those figures.

Q. Has there been any angst expressed from NGOs or those in the public health field toward AVAHAN?

A. We are transparent about selection processes. There has been some anxiety and angst from NGOs but not many. We have an independent panel.

Q. This is the Gates Foundation's biggest grant in India. What's the next largest? Does some go to vaccination?

A. Aside from AVAHAN, the second biggest grant is Sure Start with PATH, \$25 million. After that our grants are smaller. We are not doing anything in vaccination. Vaccination is a small amount in India, a small part of research is done here.

Q. So do you spend time on PATH and other Gates Foundation initiatives in India?

A. Well, I head the Gates Foundation in India. But 90 percent of my time is spent on AVAHAN.

Source: <[http://business.in.com/interview/magazine-extra/\\$258-million-for-condoms/1182/0](http://business.in.com/interview/magazine-extra/$258-million-for-condoms/1182/0)> Reproduced with thanks in public interest.

WHO's Wrong Advice on Pneumococcal Vaccine

Letter from AIDAN to Margaret Chan

4th July 2009

Dr Margaret Chan,
Director-General, WHO
Geneva

Dear Dr Chan,

This is in continuation of Drug Action Forum-Karnataka's (DAF-K - a member of All-India Drug Action Network, AIDAN) letter dated 2nd September 2008, regarding the "revelation" regarding the pneumococcal vaccine that is being promoted by WHO globally and in India that "for every four children in whom pneumonia is prevented, two children develop asthma because of the vaccine." Subsequently AIDAN in its letter dated 10th February 2009 had further reiterated the same concerns and in addition AIDAN members appreciated your comments in the *The Lancet* dated 15th January 2009, titled "Primary health care as a route to health security."*

*[The entire correspondence can be accessed at: <<http://alturl.com/dkty>>]

Your personal assistant Alison Porri, has acknowledged having received DAF-K's letter on 4th September 2008, promising that "your letter will be carefully reviewed and a response will be forthcoming." Further AIDAN has received a reply on 3rd April 2009, where in you mention that:

We think that the introduction of pneumococcal vaccines, where merited by evidence of the disease burden, would be of tremendous benefit, saving many lives, particularly of children. WHO stands ready to assist its Member States to assess the need for the use of specific new vaccines, to aid in decision-making, prioritization and introduction, and to work on solutions for financing them. We look forward to creating a world where no person should die of a vaccine-preventable disease and to cooperating with countries and partners to realize this goal.

AIDAN has reservations about the first sentence of this statement because a letter published in *The Lancet* (2nd to 8th July) points out how this policy in effect siphons off money to vaccine manufacturers - the funds that are actually donated for the MDG without commensurate benefit for the children. For the pneumococcal vaccine, the letter suggests that \$250,000 will be spent to prevent 4 children getting

pneumonia. Instead the 4 cases could have been treated by WHO protocol for \$1 each.

The journal *Vaccine* of 9 July 2009 (Mathew JL. Pneumococcal vaccination in developing countries: Where does science end and commerce begin? *Vaccine* 27 (2009) 4247-4251) has also published a scathing indictment of the WHO recommendation on the pneumococcal vaccine.

This is what the WHO recommendation states:

WHO considers that it should be a priority to include this vaccine in national immunization programmes, particularly in countries where mortality among children aged <5 years is >50/1000 live births or where >50,000 children die annually". (No authors cited. Pneumococcal conjugate vaccine for childhood immunization – WHO position paper. *Wkly Epidemiol Rec* 2007; 82:pp. 93-104.)

The authors point out that the first criteria of under five mortality >50/1000 live births was met by 32 countries but the total population to be vaccinated was 18 million. By including the criteria dependent on population size of 'where >50,000 children die annually' only 7 additional countries were added but it added 161 million to the numbers eligible for vaccination (in populous countries of India, China and Brazil). The WHO recommendations seem dictated by needs of increasing demand for vaccines and profits for manufacturers rather than the needs of public health.

We earnestly appeal to you to reexamine how recommendations are arrived at by the WHO or else repeated exposures of this nature will erode the very credibility of the WHO. AIDAN and its members restate its demand that it should review its stand on the wrong advice given towards the vaccine in question.

Please let us know what action you propose to correct this or whether you think the policy needs no correction, as you did when we wrote last time.

Yours truly,

Dr Gopal Dabade, drdabade@gmail.com;
Dr Jacob M. Puliyeel, puliyel@gmail.com;
Dr Mira Shiva, mirashiva@gmail.com;
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*Obituary***Dr. C.M. Francis**

Dr. C.M. Francis who passed away in Trichur in Kerala on the 21st of January 2009 was a man of many accomplishments, whose professional life spanned over a period of more than five decades. He made his mark in the areas of medical education, community health, health policy and planning, community-based rehabilitation, rational drug use and medical ethics.

Dr. Francis underwent his basic medical education at the Stanley Medical College at Madras. He later did his Ph.D in Physiology at the Cambridge University in the U.K., with a special interest in the field of Endocrinology. After finishing his studies, he returned to his home state of Kerala and was a part of the faculty of the Government medical colleges in that state. He became Principal of the medical colleges at Calicut and Kottayam, before he was appointed the Founder-Director of the Sree Chitra Tirunal Institute for Medical Sciences & Technology (SCTIMST), Thiruvananthapuram.

In 1974, he was invited to head St. John's Medical College, Bangalore as its Dean, a position he held till 1982. During this time, he developed the academic and administrative framework of the newly established institution, including the expansion of its community health work. He is remembered for capably steering the construction of the Hospital and College buildings, and for greening the campus - most of the trees around the buildings were planted at his initiative. His concern for academic standards sometimes brought him into conflict with some of the senior faculty of the institution - he was against the faculty doing private practice, and closely monitored the quality of teaching. He showed an equal concern for the students, though he was regarded by some as a strict disciplinarian. He was against ragging and tried to enforce a ban on it. Sports and other extra-curricular activities were encouraged.

He was associated with several other universities, hospitals and medical colleges. His vast experience in hospital and health management was brought together in a book on Hospital Administration, co-authored with a graduate of St. John's Medical College.

Dr. Francis was a member of the Karnataka State Task Force on Health and Family Welfare and played a vital role in the drafting of its report. He contributed to the planning on Primary and Secondary Health Care, and Health Systems Development. The chapter on Vision 2020 was his special contribution to the document.

He had a deep interest in the ethical dimension of

health care, and was instrumental in introducing the subject in the undergraduate medical curriculum. He wrote a book on Medical Ethics, which is a prescribed reference textbook for undergraduate medical students. He served on the ethics committees of several hospitals. His long term commitment to this area of health care was recognized at the Second National Bio-Ethics Conference in 2007, when he was felicitated.

Continuing Medical Education (CME) was another area where Dr. Francis was a pioneer. He set up the Department of Continuing Medical Education at the Christian Medical College in Vellore. This department conducts regular training for medical professionals all over the country through distance learning methods as well as contact sessions. To this day it remains the only such department in any medical college in India.

Dr. Francis was the Founding Editor of the magazine *Health Action* which is perhaps the most widely read health magazine in India. He brought to the publication an emphasis on community health, but also covered many other related areas of health work like essential drugs, rational use of drugs, low-cost health care, medical ethics, and health and hospital administration. His meticulous editorship of the magazine ensured that articles on these subjects were easily understood even by lay persons.

The values of integrity, transparency and accountability in professional life were very dear to Dr. Francis. In his administrative responsibilities he was never afraid of taking unpopular decisions if he felt they were right.

The handicap of having a paralysed limb (following an attack of polio) did not come in the way of his everyday activities. Dr. Francis drove his own car and played table tennis quite well.

Dr. Francis was an unfailing source of reliable advice, help and guidance to many in the field of community medicine and public health. Behind his simple and unassuming demeanour was a razor sharp mind. He was a good listener and his opinion or advice (which was very frequently sought) drew on his extensive experience in different areas of health care. He was particularly encouraging and supportive to students and young professionals (including the author of this article), especially when they were discouraged and disillusioned. He will be very sorely missed.

May his dear soul rest in peace.

-Dr. Ravi D'Souza, May 15, 2009

Armchair (re)Views

- Dhruv Mankad¹

The most exciting phrase to hear in science, the one that heralds new discoveries, is not 'Eureka!' but, 'That's funny...' - Isaac Asimov

Once you eliminate the impossible, whatever remains, no matter how improbable, must be the truth. – 'Sherlock Holmes'

The armchair reasoner, a person who watches and solves the world's great and small problems while never budging from an armchair, is rare. One of the most famous armchair reasoners, Mycroft Holmes, brother of the detective Sherlock Holmes, was a fictional one and of the past era. He is a well known character as a person who never verified his reasoning – but his brother Sherlock did it.

Somewhat, all of us have a mycroftian flair at some point in time. We have suggested ridiculous or thought to be so during heated discussions but we never applied them. Why? Let's take what we have done at project or field level? We have found solutions of health problems of the community in 10, 20 or 100 villages as part of our projects but never actually applied it at a macro-national level. That has been done by The Government. We have suggested solutions to the rulers' problems but we have never been the rulers. But certainly, we have in the past, in present and hopefully in future have come out with some odd, rib tickler answers!

Discovering and re-discovering ASHA as a solution of community health problems has a stint of such funny truths. The charaks, Gandhi, Mao, Werner, Antia, Arole and so on discovered, rediscovered and continue to discover solutions for health care problems persisting in villages and communities elsewhere. Who would provide me first contact care where there are no doctors around? The barefoot doctors would – that was the answer. The reasoning was simple but certainly a non-mycroftian one. They applied their own reasoning under daunting circumstances and served its purpose to some extent.

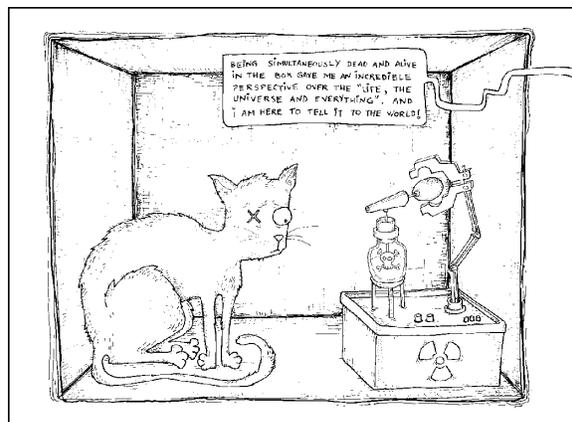
But making such reasoning funny is an achievement. While doing the reasoning for the barefoot doctors what was stumbled upon during the Long March in China may have looked funny by the politburo of the Chinese Communist Party, it is not historically

recorded. Several such discoveries were maverick and funny when they were discovered but had a deep, long-term impact on praxis (both theory and practice!) later. Just two examples could be enough to start the funny but scientific ball, rolling.

1. Schrödinger's Cat

Schrödinger's cat is a famous illustration of the principle in quantum theory of superposition, proposed by Erwin Schrödinger in 1935. Schrödinger's cat demonstrates the apparent conflict between what quantum theory tells us is true about the nature and behaviour of matter at the subatomic, experimental level and what we observe to be true about the nature and behavior of matter at the macroscopic level.

What is the experiment? We place a living cat into a steel chamber, along with a device containing a vial of hydrocyanic acid. There is, in the chamber, a very small amount of a radioactive substance. If even a single atom of the substance decays during the test period, a relay mechanism will trip a hammer, which will, in turn, break the vial and kill the cat.



Now here is the funny part: The observer *cannot* know whether or not an atom of the substance has decayed, and consequently, cannot know whether the vial has been broken, the hydrocyanic acid released, and the cat killed. Since we cannot know, the cat is both dead and alive according to quantum law, in a superposition of states. It is only when we break open the box and learn the condition of the cat that the superposition is lost, and the cat *indeterminacy* or *the observer's paradox*: the observation or measurement itself affects an outcome, so that the outcome as such does not exist unless the measurement is made. (That is, there

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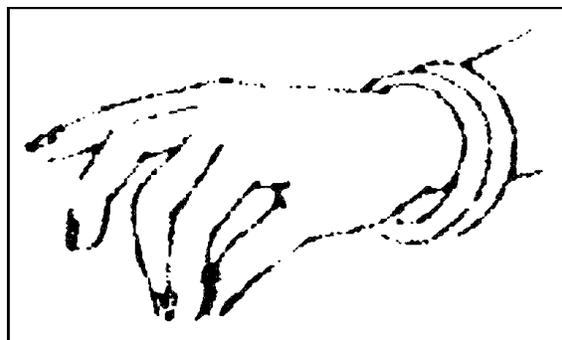
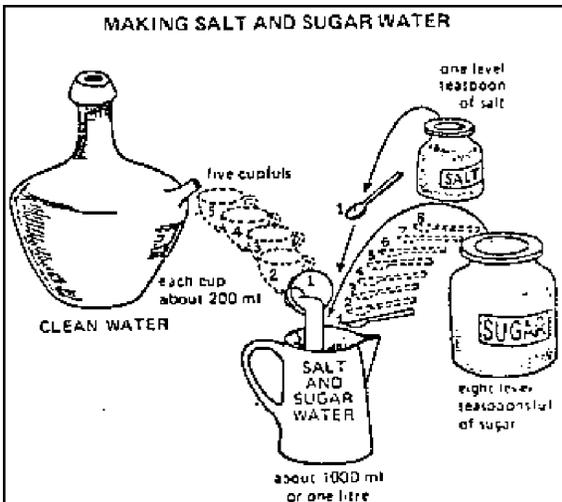
is no single outcome unless it is observed.)

We know that superposition actually occurs at the subatomic level, because there are observable effects of interference, in which a single particle is demonstrated to be in multiple locations simultaneously. What that fact implies about the nature of reality on the observable level (cats, for example, as opposed to electrons) is one of the stickiest areas of quantum physics. Schrödinger himself is rumoured to have said, later in life, that he wished he had never met that cat.

Some of us may have been or become later a Schrödinger's cat at the Dr Sunderaman's lecture at Pune on Objectivity, Complexity and Reflexivity of Evaluation. Can you share such paradoxes?

2 A Pinch of Salt

How much salt it is really in a pinch or a teaspoonful of salt - a very mundane question. But making Oral Rehydration Salt at home by an ASHA has been a bone of contention since long. 1 flatly full teaspoonful of salt and 8 flatly full spoonful of sugar in a litre of clean water is the standard recipe of home-based ORS. And so is a 3 finger pinch salt, a half handful of sugar in ½ litre of water, too.



Now, what is the correct teaspoon if we want exact quantity of Sodium and Chloride – and so the osmolarity of the ORS? According to an experiment I had done a few years back, it is the teaspoon available as a part of cutlery set and well known branded iodated fine salt comes closest to the exact content of sodium and chloride per litre. All of the other salts and teaspoons had wide variance to be reliable.

I did a study using 3 types of teaspoons available in the market – there were many! One, as a part of cutlery set, second a flat and broad spoon available in the roadside market and third free teaspoons from a standard utensil shop. Digital chemical balance at a pharmacology college was used to measure the weights. Three types of common salts were used. A total of 900 readings were analysed.

Similar experiment was conducted for measuring pinches of salt and handfuls of sugar! The variance was very wide and depended on size of fingers and size of salt and sugar grains! Ultimately, use of ORS sachets as a first option is emphasized for oral rehydration therapy. In absence of teaspoons etc., recipe 2 using your hand to make the sugar salt solution is accepted as the second option.

These experiments or rather *doing* these experiments and their results are funny. But, unless such variances were determined through such funny results, emphasis on ORS sachets as the best option may not have sustained.

Several such improbable may have been derived after removing the impossibles. Thermocol box or warm bags for the temperature control in Low Birth Weight or premature newborns must have been thought as “funny” when Dr Daga designed and experimented with. Barefoot doctors as health care providers must have been ridiculed when applied for the first time because they were funny!

Do you have such funny but scientific truths which are relevant to the existing health situations? Do write about it in this feature. I propose that armchair (re)view can also include your views about films, articles, debates, events, awards and so on. So, pick up your pen and start scribbling!

Medico Friend Circle Statement

35th Annual Meet at Rowmari Village (the ant), Chirang Dt., Assam, Jan 16-17, 2009

For two days, thirty members of the medico friend circle met at Rowmari Village (**the ant**) in Chirang District (Bodoland Territorial Council) of Assam for the 35th Annual Meet of mfc (16th-17th January 2009). The theme was “Forced Displacement and its Effects on People’s Health”. At the end of the two days of discussion, those present prepared the following statement:

Displacement affects a huge section of the Indian population today. Most causes of displacement are man made, or have a significant human hand especially in the pattern of suffering and which sections of society bears a disproportional burden. The causes range from natural disasters (floods, drought, earthquake, tsunami, etc.), to political and ethnic conflicts (as in Kashmir, the North-East, Gujarat, Chhattisgarh, Orissa, etc.), to the crisis in rural economies (agrarian crisis, labour migration), to projects of development (dams, mining and industries, SEZs and ports, highways) supported by the state. It is estimated that development projects have displaced 50 million Indians, of whom 70% are tribals. Over nearly two decades of economic liberalisation, the process of development has expanded in scope and momentum. Numerous state governments have signed MOUs worth hundreds of billions with both Indian and foreign corporates, unleashing massive land acquisitions on rural and indigenous populations. These are in outright violation of the principle of local self-determination enshrined in *panchayati raj* law and with total disregard to needs, priorities and dignity of local communities.

While in most dominant discourse displacement is reduced to the loss of land for which one can show a ‘patta’, in reality the process of displacement alienates and dispossesses people from their cultural, social, political, economic and environmental resources and support systems. It intensifies poverty, social disorganisation and political unrest, violating people’s dignity and robbing their basic rights to health, livelihood and civil liberty. It must be seen that these displacements are *forced*, and the greater burden falls on the very populations that are consistently left out in the development process – the same communities that face the highest infant and maternal mortality and the greatest morbidity and mortality from infectious diseases including HIV. We now find them also carrying an increasing burden of diseases like hypertension, diabetes, cancer, and mental disorders. Displaced from their homes, highly ‘at risk’ in terms of both the bio-medical as well as the social determinants of health as well as suffering

from grave ill health, these ‘development refugees’ are off the map of both public health facilities as well as any national health programme.

In enacting its role in governance, not only is the state plagued by inadequacy, inequity and corruption, we also find it colluding with profit-driven corporate interests to displace people in the name of “the greater national interest”. Its response to displacement of people has ranged from non-recognition or trivialising of the facts, to inadequate and inappropriate rehabilitation, to brutal suppression of dissent and protest. Its reply to various people’s movements and civil society organisations in their legitimate and non-violent quests for rights and civil liberties has never been adequate to match the situations and has often been marred by brutal repression.

The North-East gives us a particular perspective on displacements due to ethnic conflict and ecological crises, and reiterates the centrality of culture to people’s lives. The sectarian and elitist functioning of the government means that the genuine needs, priorities and aspirations of the people are totally neglected. Moreover the rough shod treatment of fiercely autonomous tribes and the subsumption of local sensitivities to a distant and a many times oppressive notion of nationhood has resulted in long-term and permanent displacements marked by grossly inadequate and insensitive rehabilitation measures. In the conflicts of indigenous vs. non-indigenous populations here, the non-indigenous are sometimes more marginalised and humanitarian response is particularly difficult. Also in this Meet we heard more about Chhattisgarh, with large scale displacement of indigenous communities and culture through the so called ‘spontaneous’ ‘Salwa Judum’. There the state has vacated hundreds of tribal villages and forced the indigenous youth to arms and to perpetrate atrocities on their own people in the displacement camps.

Behind the large picture of displacement in India is the state’s pursuit of the development model of ‘economic growth’ with a voracious urban-centredness that has pushed rural life, livelihoods and agriculture into crisis. In the ‘seventies the green revolution created a myth of food and nutritional self-sufficiency while subverting the potential of diverse rural farming and food systems – a myth still virtually unquestioned by social and medical scientists despite the stark reality reflected in health statistics. The impact of this development model on people’s health can be gauged

from the unprecedented decline in availability of food per capita since the 1990s and the worsening of nutritional status in children as per the periodic National Family Health Surveys. The crisis deepens now with the steep rise in food prices, high input costs for farming, decline in soil fertility, shrinking area under cultivation, stagnating food outputs and the uncertainty introduced by climate change. This is at a time when there is increasing evidence that 'being undernourished' as the major risk factor for ill-health.

Looking behind even the economic growth model that directs our state's policies, one needs to spot the prevailing social paradigm (world-view, set of values) of competition, domination and of seeing diversity as a threat. The fact that this paradigm is in crisis and untenable and unsustainable has been widely recognised by thinkers in the sphere of environmental concern and agriculture and even industry, but it is yet to seriously challenge the medical world. In this Meet we, as a group concerned with health including doctors, acknowledge the dire need for us to face the 'paradigm shift' question head-on. *What does it mean for us?*

The crisis in the medical world begins with the fact that provision of health care has undergone a nearly complete transformation from a basic 'essential good' for realisation of healthy life into a market commodity ('healthcare') to be bought with money by 'consumers'. Aiming at maximising its profits the healthcare industry only drives up the costs and leads people deeper into the poverty trap. Secondly, the view of healthcare is modeled on the notion of health and disease specific to modern western medicine that sprang from the post-industrial revolution world-view of 'man conquering nature'. It sees the body in mechanistic and reductionist terms without need of reference to social or environmental factors, hence obscuring the obvious social determinants of disease and ignoring the clear social gradient in health, and focusing only on individuals as units, on their behaviour or on their germs. It produces misleading notions such as that TB is caused solely by specific bacteria (*M. tuberculosis*) in spite of evidence that 90% of infected people escape the disease. Thirdly, despite the myth of democracy, the medical world in India shares faith in the paradigmatic notion of hierarchical power. Someone or something is dominant over another who/which is subservient or less important (variants are: doctor-patient, doctor-nurse, brain-body, male-female, allopathy-alternatives like ayurveda or local medicines, technology-nature, educated-illiterate, etc.) and everything is cast in this kind of lop-sided frame.

Abiding by that kind of frame or mind-set, it can be

difficult to see a 'web', rather than a hierarchy, of disease causation. However, let us recognise that our epidemiologic view of disease, with interplay of host, disease factor and environment, does resonate somewhat with the more holistic views of health that are found among traditional and indigenous cultures and in the formal codified Indian systems of Medicine. We must go beyond the narrow notion of biological causality in health and disease and include the social, cultural, historical, geographical, economic and political determinants. We need to reject the inherent notion of conquest and violence in the current dominant medical paradigm, including gross and subtle forms of gender and other discrimination. We need to reverse the discounting of local traditional knowledge and affirm the need for active involvement of all groups of people in planning, implementation and monitoring of health-linked actions. As mfc, recognising the importance of culture and knowledge systems, we must actively engage ourselves in the 'politics of knowledge'.

In this light, as members of the medico friend circle, we have decided:

- To challenge the assumption that the "price of development is inevitable" and it is to be borne by the poorest and most marginalised, and that this price includes increasing inequity and destitution.
- To seek the broadening of the established definition of "displacement" and further to clarify the concepts of rehabilitation, health and justice for displaced persons.
- To deepen Indian democracy by revitalising institutions of deliberative and participative democracy, and to encourage the strengthening of indigenous democratic systems.
- To oppose the dehumanisation of victims of forced displacement and support restoration of dignified, healthy and fulfilling livelihood including sensitive and inclusive rehabilitation policies with provision of appropriate, accessible health care facilities.
- To work towards a paradigm shift in the medical world, including bringing back ethics into medicine within a sustainable new world-view of healing, and towards rejection of the unsustainable economic growth model currently driving the development of modern medicine.
- To learn from the worldviews of local and indigenous communities for the sake of practical ecological balance and human sustainability and for the deepening of our democratic system.

Medico Friend Circle Annual Meeting 2009: Minutes

January 16-17, 2009 at IDEA Campus, Rowmari Village, Bongaigaon, Assam

The 35th Annual Meet of the mfc was held in the IDEA Campus, Rowmari Village, Bongaigaon, Assam. Dr. Sunil Kaul and Ms. Jenny Liang (the hosts for the meet) welcomed all those who came, highlighting that this was culturally important festival of “Magh Bighu” and a great occasion to celebrate. It was also historic in the sense that this was the first meeting of the mfc in the North-East region.

Since this was the 35th Annual meeting it was decided that the senior members present could recap the major events and milestones of the group. Numerous members who had been associated with mfc over the years contributed to the discussion and the following major points were shared.

□ The mfc was an off-shoot of the JP movement. It consists of people working broadly on health and the uniting feature is of a pro-poor and pro-people perspective, and a questioning of the dominant paradigm of health.

□ The Group over the years has been built up on the twin pillars of the meetings and the bulletin. There are usually two meetings in a year. With the Mid-Annual Meeting (MAM) being held for organization discussions and planning of the Annual Meet, and the Annual Meet being arranged on a much larger scale focusing on a theme. The *mfc bulletin* was a space and forum for expressing the circles views and every few years the various articles and debates in the *bulletin* are compiled into anthologies. More recently with the formation of the e-forum a third space for discussion and sharing has been opened up.

□ It was opined by those who have been involved from the early days that in general due to the fact that this was run purely on a voluntary basis, that it was difficult to sustain motivation and that in general the debates have mellowed down over the years.

□ The initial incident of the cyclostyled letter sharing concerns of hopelessness and impotence of the educated elite at the terrible situation during the 1972-73 famine and scarcity and the discussion and coming together that it triggered was recounted.

□ mfc was also clearly secular – with the response during the Gujarat riots and PIL against Praveen Togadia in the Indian Medical Council being examples.

□ Other issues like the fact that mfc considered itself a “thought current”, the very heated and sometimes intellectual debates that occurred were shared and it was pointed out that as each member was involved quite deeply in their own work, mfc was

a forum for clarifying dilemmas, perspectives etc. and recharging ones intellectual batteries and perspectives.

□ Everyone stressed the fact that finally the meet was supposed to be an informal forum and therefore the newer members should not feel intimidated and should not hesitate in raising questions or clarifications.

Since this was the first meeting in the North-East and the mfc members traveling to the North-East was more than a mere overcoming of geographical barriers. Everyone from the rest of India (that is not from the North-East) felt that before we go into the main aspects of the theme we should have a presentation of various Socio-Political-Cultural aspects of the North-East, and especially those relevant to health.

Three persons including Raju Narzary, Sunil Kaul and Digambar Narzary made the presentation that spanned a whole range of issues including geographic, demographic, history of political/separatist movements, pathways of development, social issues including the relevance of caste and about the Armed Forces Special Power Act, ethnic conflict and displacement, etc.

Some of the major issues shared include the following:

□ Among the major public health problems was malaria – most cases are chloroquine and quinine resistant. The most frequent area affected are the forest fringes. There is also the presence of Japanese Encephalitis. Among the more recent emerging public health issues is the high fluoride content of the water in 25 of 27 districts in Assam, and the suspicion of high arsenic content given its close proximity to Bangladesh.

□ Among the major development projects that is causing a lot of concern among the civil society groups is the plan to build nearly 236 dams across the Brahmaputra. This follows the projection of the North-East as the future powerhouse of India. It is estimated that if the first 50 planned dams are constructed the river bed of Brahmaputra will rise by nearly 2 meters – leading to the potential displacement of nearly 10 lakh people.

□ One of the key aspects of the problems here is that of “erosion”. This is different from flooding – usually flooding, though it causes problems in the initial phase actually is beneficial as it brings in fertile alluvial soil. On the other hand erosion is when land is actually lost due to the flooding and rapid flow of water. Erosion can cause rapid and overnight

pauperization.

□ With regards to social issues – unlike in the mainland “caste” does not play as major a role as does ethnicity. While caste is present peripherally like the priest cooking his own food, and barbers, sweepers and sanitary workers coming as migrants from UP and Bihar, untouchability is rarely seen. The Sankardev movement played an important role in rooting out untouchability. Contrary to common perceptions only 13% of the population is Christian and nearly 30% of the population is Muslim. But a common finding is large numbers of internally displaced communities over the centuries.

□ The private sector was reportedly very poorly developed and government jobs continue to remain the main source of employment. While Mizoram is considered the least corrupt states in India, Assam, Meghalaya and Nagaland are considered very corrupt.

□ There was a brief presentation about the Armed Forces Special Powers Act as well as the fast unto death taken on by Irom Sharmila Chanu.

□ A brief account of the various stages in the developments of the different resistance movements were traced, highlighting the continuing sense of alienation felt by the people of the North-East towards the people of ‘mainland India’. This included the landmark 1828 Treaty of Yandavoo which was signed between the Burmese and the British. This taking over of the land by the British led to the rise of a movement for freedom from the British by the people of the North-East in cooperation with the Indian National Movement – however there was an implicit perception that post the British rule the North-East would revert back to the original independent states. However after Independence they found that all the lands were shown as being within the larger India. Subsequent systematic neglect of the region and continued extraction of the natural resources without leading to any great benefit to the region further alienated the region from the rest of India. There were movements of resistance and independence and included movements in Mizoram, Assam, Tripura. A more detailed sharing about the Bodo struggle was also presented and also the fact that there were still people living in relief camps many years after the violence.

□ It was pointed out that due to the ethnic conflict there was also a huge amount of internal displacement, and migration to other locations. This not only leads to tension between the displaced people and the original inhabitants but also huge demographic and sociological changes.

□ It was also noted that a large number of youth migrated to mainland India for education and job opportunities. There was concern on the possible effect

of the experience of this tension and conflict on the youth have experienced this continuously from a young age.

Theme Discussion

It was decided to discuss the theme of Displacement and health under four broad headings. The first being displacement due to natural disasters, floods and famine etc; the second broad group was the displacement due to development projects / overall path of development; the third group was displacement due to ethnic conflict; and finally was the discussion on economic induced migration.

Broader Discussion on Displacement

At the outset Binayak’s letter to the mfc on the theme meet was read out. He noted that displacement had been a continuous feature of human history – whether in the case of Indian Americans, African slaves, the partition of India or even in the situation in Palestine, or by the Salwa Judum in Chhattisgarh. It was thus important to see the broader historic and structural issues involved in displacement. He noted that, “It is important to choose your politics before politics choose you.”

It was noted that displacement is sometimes by choice and sometimes forced. However it is crucial to understand that within displacement is embedded the issue of power. We need to note that alongside displacement there is also dispossession, disparity and discrimination. Given the already vulnerable situation of much of the population displacement leads to sometimes intense struggles between the incoming migrants and the already marginalized original inhabitants of the area. This led to a tremendous strain on the public services of the areas including health, education and infrastructure. This also at times leads to furthering of ethnic conflict.

It was also noted that there were three core issues that need to be identified – one was the fact that much of displacement was seen as ‘inevitable’ and this was not being challenged despite the fact that only one particular section is consistently affected and the availability and demonstration of viable and more equitable alternatives. The second issue identified was the narrow definitions of various aspects of displacement – for example the compensation being merely restricted to the market price of agricultural land and leaving out completely the complex realities of the lives of the people who are displaced. The third issue being the need to deepen democracy to enable the voicing of concerns and priorities of all sections of society.

It is also a well established fact that the people who are invariably displaced regardless of what the

'development' project is or where are the dalits and the adivasis. This is compounded by the fact that there is an agricultural crisis, with reducing employment and livelihood opportunities. Similarly the primary victims of climate change are also predicted to be the rural masses especially the poor.

It is also a fact that Migration mitigates the effect of the work of community health projects / works all over the country, as the population is always in an unstable state.

It was pointed out that many rehabilitation packages were incomplete as well as insensitive to the people's needs. For example in the North – East the government currently offers the refugees a paltry sum of Rs. 10,000, which in reality does not amount to anything to start a new life.

Natural Disasters, Floods and Famines

Rakhal spoke about the work of Community Health cell in the Tsunami-affected areas in Tamil Nadu. They had just concluded a 3-year program of work with the affected communities. Some of the main issues highlighted were:

□ It is important to note that when we enter a community who has been affected by a disaster we need to be aware that this community has a history and its own set of problems many of them ongoing and still not reached a conclusion, it is over this complex history / reality that the disaster strikes and that we must plan our rehabilitation strategies.

□ It is also important to take into account the complex socio-cultural reality of the community – blanket approaches to rehabilitation without realizing this reality can some times backfire badly.

□ There was also a note that there seemed a pattern in disaster situations where the sudden disaster situation is used as way for Right wing groups to enter and gain a foothold in the communities.

Satyashree pointed out that nearly 7% of the fertile land of Assam has been lost due to erosion. This along with a massive increase in the bed of the Brahmaputra leads to the displacement of a large number of people. In most tribal areas there is no system of land records and this leads to a lot of problems in claiming compensation. It is also a fact that the large number of bunds and embankment constructed by the government have in fact worsened the situation by causing siltation and increased river height – but also leading to increased vector borne diseases like malaria, JE, etc.

Another major issue in post-disaster situations is the specific effects on women, and their rights / needs in a disaster or conflict situation. While more women were killed in the tsunami than men, those who

survived had the additional burden of tending to those left behind as well as finding firewood, fuel, cooking etc. thus becoming more marginalized in a difficult situation.

Public Health Responses in Conflict Situation

Anurag described the situation in Chhatisgarh, especially Bastar where the problem of the Naxalites as well as the Salwa Judum dominated the scene. Displacement in the State as well as in Bastar particularly was happening due to two major reasons, (a) socio-political causes; and (b) due to development projects mainly mining. It is this situation of displacement and impoverishment parallel with large scale natural resource extraction that has in fact aggravated the Naxal problem in the state.

In Dantewada for example, the population officially recorded for the nearly 640 villages covered by the Salwa Judum is about 3, 00,000. Of this population about 50,000 are in the relief camps while about 50,000 are thought to have crossed over to Andhra Pradesh, the remaining 2, 00,000 are totally unaccounted for. People are living in the camps due to their being forced there by the Judum, and the Judum is known to have burnt up villages twice and even thrice to keep the people from resettling.

The relief camps themselves are very bare and basic. While the conditions within the camps are deplorable, the conditions outside the camps are also pathetic. Thanks to the conflict anyone living outside the camp is automatically labelled a Naxalite or a Naxal sympathiser. In this situation none of the basic social services are existent outside the camps. The situation of the people on the Andhra side of the border is also apparently deplorable.

The mental health situation is also grim, with more than 80% interviewed having been either subjected to high levels of torture or having witnessed cross fire. Men have been sexually abused. It is estimated that one third of the people in camps etc. have depression. There is also a huge uncertainty about the future and people are thus totally withdrawn and numb. Except for sketchy data on child nutrition there is no data and despite this horrific situation Dantewada state level data are among the better indicators in the state.

Rakhal who was part of the team that had visited Dantewada and seen some of the relief camps etc. recollected some of the main highlights of the visit. He described the number of cases of significant morbidity they witnessed in the camps, the general hopelessness people there felt, the lack of basic amenities and especially facilities for referral in an emergency as well as a number of skin diseases and

infections. He also noted the fear that was prevalent and the fact that the 'truth' the people described depended on the presence of an SPO (special police officer), it took the team sometime to realize this as many of the off duty SPOs were not in uniform. He also described the situation where there was no possibility to do any authentic research because the Salwa Judum would beat up the researchers etc. It was also a fact that on paper the government seemed to have a very good comprehensive plan for the health of the people in the camps, but what ever the team saw showed that these wonderful plans were not translated to action.

It was also highlighted that this situation was in fact presented to the National Human Rights Commission in 2006-07, but the NHRC accepted most of the lame answers of the state and has done little since.

Others in the discussion pointed out the deliberate role of the state in the creation of this horrific situation, and stressed that one needs to understand displacement in terms of power, dispossession, alienation and loss of liberty. The state seems to be always initiating and then settling conflicts and seems to be running proxy wars all over the country. It was also mentioned that while proper research and documentation is impossible in these situations any humanitarian worker is faced with a hostile response from both the state as well as the non-state actors who benefit from the continued existence of the camps. Such displacement and relief camps have led to the de-humanization of communities and overall degradation of their existence. It was also pointed out that not only does displacement lead to a loss of socio-political and economic resources but also leads to a wiping out of the rich culture and traditions of the communities. Another example from the communal violence in Udalgiri in October 2008 was also cited as showing clearly the role of the state in inciting these tensions. It was also pointed out that sending different battalions of the the reserve police forces like the Assam rifles, and the Naga Battalion to different states, the government is purposely trying to divide people, it was suggested that people doing research refrain from referring to the ethnicity of the army battalion as it furthers the efforts of the government.

Jenny described the heightened sense of insecurity and helplessness of the people displaced due to the Bodo-Santhal ethnic conflict in 1993, who were still in the refugee camps sixteen years later. She described the situation where the refugees were not accepted by the local groups, they couldn't be relocated and had no scope of a better future. It was also difficult to reach aid to those most deserving as it was usually interfered with by local power groups. She also mentioned that such places were breeding grounds

for right wing elements. It was also a fact that the state was keen on closing down these camps and since these were forest areas, the refugees suddenly overnight became illegal settlers, they could not go back to their villages either as by this time that land was also converted to forest lands. It was a fact that health facilities were non-existent, doctors were unavailable and it was very difficult for doctors to work in conflict-ridden area.

Raju described the case of Udalgiri riots of 2008. These riots displaced about 2 lakh people with about 30,000 still in different relief camps (in 2009). He described the fact that no state relief reached the camps for the first 5 days and only student union groups were mobilizing relief. He described how that throughout the riots there were numerous events that suggested the overt or covert role of the state. It is suspected the politicians played vote-bank politics and it is finally seen as a proxy war of the state, where the communities were made scapegoat for political expediency. More recently it is reported that the government is forcefully moved from the camp and forcefully relocated in their ransacked homes without any support or aid or compensation.

He recounted how in another instance the CRPF jawans had raped two local women, despite it happening in broad daylight, no one was permitted to even file an FIR and it was only nearly 2 days later that the FIR was filed and the medical examination was performed. In the identification parade also due to the tremendous fear there was some confusion. Letters have been sent to the CM, governor and other authorities requesting for intervention and justice. Nothing has happened so far and the justice for the victims still remains elusive.

Renu also recounted how the sexual abuse of women in many of the riots and the targeting of men (for example in Kashmir and Iraq) were a way of showing power. She mentioned how the definition of rape in the laws was still stuck on 'penile' penetration. What then we term the use of swords and guns for violations? In the newly drafted communal conflict bill the definition of rape has still not been broadened despite our repeated demands.

In conclusion, it was shared by various members present that there was an increasing role of the state in perpetrating and also perpetuating the conflict situations in the country. It was increasingly difficult to work with and intervene in such situations. How does one work with and negotiate with the one who is both the perpetrator as well as the one who is supposed to provide justice? People noted that Indian democracy was witnessing shrinkages in the spaces available for the people. All protests and movements

are increasingly being met with repression and oppression.

Economic Migration

Discussing the issue of economic migration many of the discussants noted that some of the studies had actually shown an improvement in the nutritional status of migrants (reflecting the tremendously marginalized existence in their original areas). For example studies showed that child labour in Rajasthan showed increase in nutritional status, similarly the regular stream of young boys to work as menial helpers in hostels and hotels (despite the threat of sexual abuse) pointed to certain benefits people got by migrating. Studies among street children showed low levels of anemia (because of the high calorie food rummaged from the dustbins). And daily wages being given in the metros like Delhi and Chennai for example is much higher than one can expect in rural Chhatisgarh for example.

Talking about the various aspects of migrants' health Anurag in his paper had highlighted a few cases of migrants being badly hit by illness in their new locality and coming back to Chhatisgarh as they could not bear the extra burden of illness. This basically reflected the extremely vulnerable existence of the people and the complete lack of decent, ethical medical services that are accessible to these people. Many a times the migrants are even blamed for the various outbreaks that occur in the area.

One suggestion that came up was the evolution of a network of doctors who would provide information support for groups working with these people over the phone.

An example from Tamil Nadu was shared where an NGO group working with migrant workers have lobbied with the government to get permission for people to use their ration cards in the areas they migrated to, where people were allowed to transfer their children to schools in the area into which they migrated even if it was during the academic year.

Others pointed out that while the government rules were written down the individual interpretations given by the government officials who were in charge of implementing the project was varied and explained a lot of the variation.

Other people pointed out that during the migration people were not in a position to prove their entitlements like the BPL card – thus they are unable to avail of the schemes meant for them.

There was a discussion on the emerging NUHM/JNNURM – the finance minister expressed a vision of India that was 75% urban. This is only going to mean so much more migration and so much more ill-

health. Moreover with the whole vision being the dependence on the private sector we are likely to witness more inequality than anything else.

Obalesh reflected how in the early days dalit movements supported the migration of dalits into urban areas as it is liberating. But the migration of dalits to urban areas itself is leading to various problems including the loss of various certificates like caste etc. and the very oppressive nature of the situation in the cities. It seems in retrospect like a liberation that turned into slavery.

Summing Up

Some of the major points/issues that have come up in the meeting over the last two days were discussed.

These were:

- We need to break the myth of the inevitability of displacement.
- There is a constriction of the meaning of compensation and rehabilitation. Most norms are very narrow and do not take into account the reality and totality of people's lives.
- While for some people displacement is actually having positive results, much of this displacement when it affects the social determinants is problematic. Unfortunately people are forced to migrate, and while there is a need to figure out ways of reducing migration we also need to figure out a good way of handling it once it does occur.
- It is in the mindset of the upper class/caste that somebody else has to sacrifice – but as it turns out the same group of people have to sacrifice again and again.
- There is the need of the people's priorities/voices to be taken into consideration when deciding on definitions of migration and deciding on the contents of a displacement package.
- The whole concept of national interest needs to be questioned. Who defines the interest? Who benefits? Who is left out? It is also crucial to accept that thanks to diversity of contexts in the country no ONE national interest is possible.
- We need to question the very development model itself which allows for the myth of the 'inevitability of migration'.
- There is the need to build up an alternative epistemology of health. There needs to be a paradigm shift in favor of more support to agriculture and self-sustaining communities.
- There is a need to find a way out in this era where there is no philosophy and the only religion is money. There is a need to bring back ethics and human dignity as the center of work.
- It was urged that this was a very significant meeting discussing very many crucial points and that a statement could be brought out.

Message from Binayak and Illina Sen

June 14, 2009

Dear friends,

This letter is long overdue. It took us a while to navigate through the first few days of reunion with family and friends, and cope with the media which stalked us at every step.

Our heartfelt thanks to all those who associated themselves with the nationwide and international campaign for the release of Dr Binayak Sen. The outcome of the campaign has vindicated our stand and is a glowing affirmation to the voice of the people.

We thank especially all who took part in the demonstrations and satyagraha in Raipur and other cities, and the distinguished legal voices that upheld our cause at different times. We also thank the many friends who offered us their warmth and friendship in bleak times.

We remember also at this time the many others who continue to be incarcerated under similar charges, the many prisoners who are victims of a legal system that makes nonsense of their lives, and the thousands upon thousands of our compatriots who remain displaced, terrorized, and hungry.

Binayak and Illina

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Contents

Health System Challenges and Elements	<i>Abhay Shukla</i>	1
The Myth of Regulation: A Critique of Draft ART Bill	<i>Sama</i>	8
Locally Relevant, Affordable Diagnostics	<i>Anand Sivaraman</i>	14
The Gravest Displacement of Our Time – Part 2	<i>Sudha Bharadwaj</i>	17
Note on Consultation on Falciparum Malaria Control		29
Key Recommendations of the Ganiyari Consultation		30
How Bill Gates Blew \$258 million in India's HIV Corridor	<i>Elizabeth Flock</i>	32
\$258 Million for Condoms?	<i>Elizabeth Flock</i>	34
WHO's Wrong Advice on Pneumococcal Vaccine		37
Dr. C.M. Francis	<i>Ravi D'Souza</i>	38
Armchair (re)Views	<i>Dhruv Mankad</i>	39
Medico Friend Circle Statement		41
Medico Friend Circle Annual Meeting 2009: Minutes		43

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