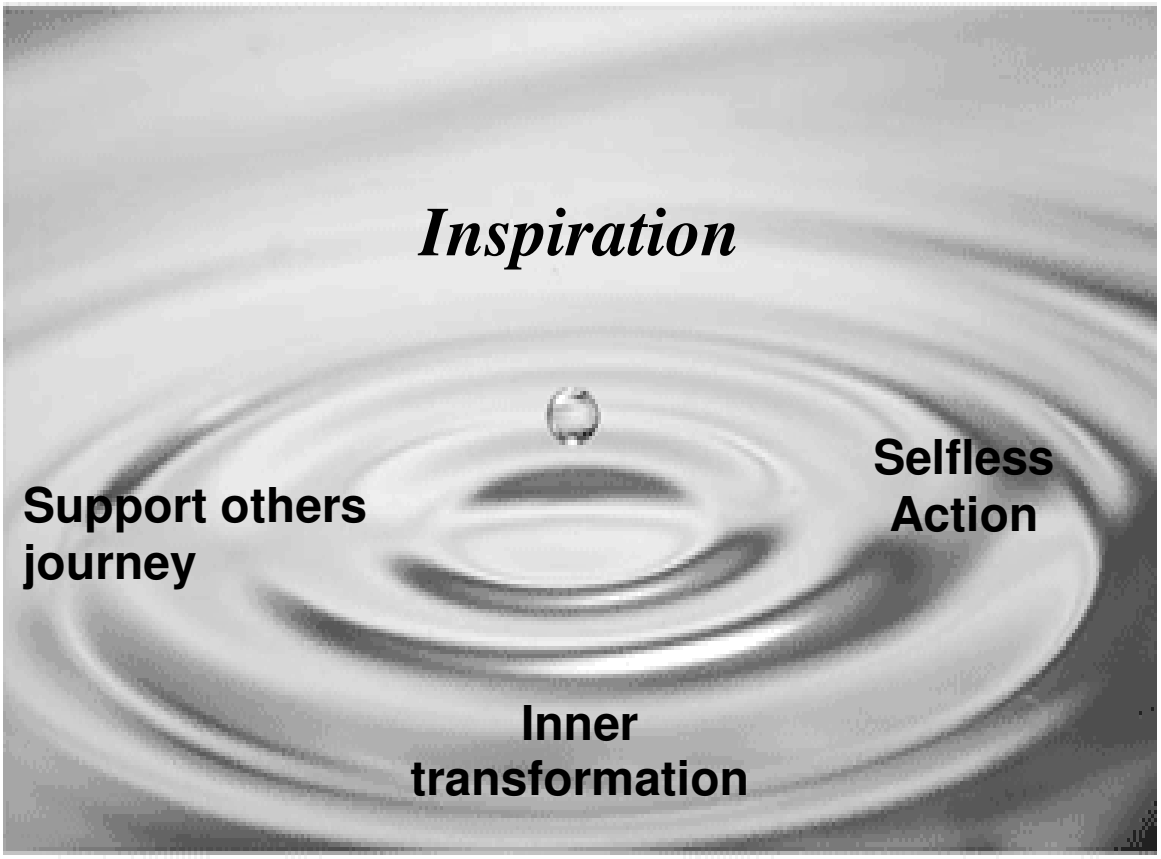
the change ripple



Report of the community health fellowship
September 2005 to March 2006

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Service is an attitude- a mindset. It means putting the best of yourself forward no matter where you are or what you're doing. It's the generosity of spirit that transcends our disabilities. Some people wonder what they have to give the world; without exception we all have something to give -- arguably one of the best gifts of all – ourselves!!

What the report contains...

1. Driving Point
2. Six months at a glance
3. Pictorial Framework
4. Annexure

A. Community Health Concerns: Assam
B. Pilgrims Progress
C. Drugging northeast India to dependency and isolation
D. Learning Objectives
E. National Consultation on Food Security Corridor, Hyderabad
F. Food Sovernity Alliance DDS Pastapur
G. Visit to Plachimada
H. WTO and People's Caravan
I. JSA-NRHM Watch and CSDH
J. AIDAN meeting vellore
K. Mfc meeting vellore
L. Review of the NHRC on the National Action Plan

Driving point

When my eyes opened the clouds came in through the window of the bus and as I looked down there was a crystal green river flowing much below, on the other side were the

huge Himalayan Mountains and we were in the Subansiri valley on the north eastern most border of India. As the bus moved a little further I could see the Chinese territory, which was equally beautiful, and at that point in time it did not matter if we were different countries because nature didn't differentiate anyways. In another three hours of this beautiful journey we crossed Dumporijo a small town (rather a large village) where smoke emerged from bamboo and thatch houses on stilts, very small shops sold grocery and schools with sprawling campus were prominent, another half an hour and we were in Daporijo town- my destination to begin my tryst with community work way back in 1994 September. After twenty-two years of life on earth I was filled with idealistic and revolutionary ideas of working for people who according to my ideal and learning needed help and I had gone there (where eagle's dare) to "help" the poor and needy! I had actually waited for this day for nearly five years and on that day I had eloped from the material world with the belief that I will live in this remote, geographically inaccessible and difficult mountain terrain all my life and work with women men and children for their welfare!

As I boarded the train in Kacheguda to reach Bangalore on 18th September 2005 I realised I had eloped again to a very unknown place and people. I had lived in villages not just of Arunachal Pradesh but also Rajasthan, Assam and Andhra Pradesh for the last eleven years of my life. Now I came with a whole baggage of a different kind of experience; there was a lot of disillusionment and confusion that came with me too as I landed in my dear friend Eddie's place. Probably the idealistic me had a come a long way and the revolutionary was dead but there was a deep conviction inside me that I had not reached the end of my work and goodwill for working towards equity and social justice. The past eleven years had unfolded to me great mysteries of "working for the poor".

Tryst with Community Work

In Arunachal Pradesh I realised that something more than doing transfer of technologies science camps, health worker training running non formal schools was required; at times the disinterest of people bugged me and led me to think why couldn't they simply accept what is best for them for me. I always felt that since I was educated in posh institutions and had topped my university they ought to know that I was right. Today when I look back I am glad I didn't force difficult pills down people's throat but read and thought a lot. I started analysing with my colleagues and going down to the root cause of the problems and realised there were these things about which the people or I knew very little

1. Constitution of India and the entitlements it gave us etc
2. Policies- what they were, how they were born, what they did to our lives etc
3. Economics and finance- Forex, ex-chequer, hawala money etc

However I also felt that it was really difficult for me as a person or voluntary organisations to do much to change policies. I lived with this very disturbing thought for a long time as I left Arunachal and came down to work in the Bramhaputra valley of Assam in Dhemaji district.

Realities and Real Determinants

The organization I worked with began from scratch; it was called Rural Volunteers Centre (RVC) based in a village called Akajan. The experience here was phenomenal, unlike Daporijo where there was tremendous response from the people for the services we were delivering, making low cost latrines, sanitary dug wells, imparting skills training etc. I was actually amazed as to why the same things were not in demand in Arunachal where remoteness and infrastructure development was very low! Suddenly the entire issue of constitutional entitlements, policies and economics seems to make sense. The policies, constitutional entitlements and economics are entirely different in the two states touching each other!

By the year 1996 I was deeply involved with relief and rehabilitation activities for the thousands of people who had either lost everything or parts of it. There was still my question of the larger issue of what are the core changes required, what are the constitutional entitlements, the appropriate policies and the economy involved. I was also convinced that if we do not provide relief to people that won't solve the problem either, yet there was certain obligation of the State that were not being fulfilled. I juggled between community work and understanding this larger picture and It was not until the year 2000 when 14 villages were washed out because there was a dam breach in China that I was convinced that there are certain things which cannot be solved by voluntary organizations doing work in isolated pockets however valuable and meaningful for the area.

While doing all these I was also involved in training community health workers, the first batch of 25 young women that I trained and monitored showed amazing results in their allotted villages. They travelled by boats, took up walking to many place and their dedication to the cause was amazing and I drew strength form the fact that prevention actually is the cure to a lot of our health problems. Somehow this enthusiasm and eagerness started dwindling as the first phase of RCH was launched. Almost every woman screened in the two districts had some or the other form of Reproductive Tract Infection and the doctors came with a whole lot of drugs as we watched with awe with what ease they though the infection could be cured!! This led to the larger debate of whether such government interventions were doing well or they were making our women more dependent on clinical medicine?

Facilitating Corruption- The real turning point

While this exploration went on I realised I needed to get in touch with my self and question as to why I was so disillusioned after so many years of relentless service to communities. Under my supervision there were more than 250 women trained in preventive health, they were doing well, the schools I worked for were doing well, there was a ten years commitment of resources but I was constantly questioning myself.

I was a part of the UNDP's Human Development Report in 1997 when I was as young as 25 years, various State Governments' would invite me to formulate projects for them. While I did these I suddenly realised that I was actually helping increase corruption in the country because the projects I formulated were implemented only 25% or never implemented at all!! This was the real turning point and my exploration into the entire

concept of development began. There was enough arrogance by then me to think that academics, research and efforts carried out for development from urban centres were meaningless and this came from my constant association with SWRC Tilonia and its allies. I started exploring working out of the North East India and found reassurance that I was not wrong in my thinking and that I should continue my search for the real meaning of work.

Exploration of Rights and Dignity

As I moved ahead I realised that Human Development is basically a process of liberating oneself and others – liberating from paralysing tradition, from exploitative situations, from expectations, denial and deprivation. By this very definition, development cannot be brought, but must come **from within** through the unleashing and channelling of one's enthusiasm, creativity and energy. This also requires the creation and involvement of committed groups and individuals who, first and foremost, care for and work with it in setting in motion a process of critical self-awareness for self – directed action for change.

Rights depend on one's dignity and self-worth, which cannot be given but need to come from within. It is "about enhancing human well-being" and their "sense of self-worth and dignity" and not just their net-worth. There are all kinds of good struggling to be born from way within the person. There are also anxieties and hatreds that are struggling to be expressed. Deep within, there is a great touchiness for one's own integrity - a great tenacity in the face of adversity. They have the unlimited ability to take whatever comes, to go on surviving in the midst of unbelievable difficulties and persecutions. With these ideas then not so well formed I went to the Health and Human Rights (HHR) course offered by TISS and Cehat in Mumbai. It was extremely information packed; though the theoretical understanding of health and human rights increased there were no answers to the questions that I harboured. Somehow I thought the session that Abhay Shukla had conducted on People's Health Movement could be an answer

Why Community Health?

I now call it one of the best train journey that I took with my dear friend Premdas from Mumbai to Bangalore. We had just finished the HHR course and going back to the selected destinations. I was very disillusioned and had a strong feeling that I did not want to go back without my answers. Since the AC compartment in which I was travelling was empty Premdas came there and we started discussions that led me to understanding that there were efforts being taken up on holistically looking at community health. He went on to explain the principles on which CHC functions and I was amazed that here was a group (approach) I was looking for to explore my confusions and doubts. Community Health I realised was a integral part of what I had been doing in the last decade and that I was real causes and remedies (that seems like a strong word now). I then thought knew answers to other problems like education, bad governance etc. but the medicalisation of health and not the human being as the central object of medicine was disturbing.

Soon the fellowship was announced and I applied. In the meantime there was a lot I read about health status of the country and was involved in preparing a note on the health

status of Assam because I was convinced and determined I wanted to carry out exploring community health. The note is attached here as **Annexure A,** the facts that were revealed through this study stunned me, 80% women in Assam suffered from anaemia! And I was again convinced it was not just Iron folic acid but a larger social problem.

Pilgrims Progress

Well as I entered the CHC fellowship I could feel here is an invitation to explore as an individual or a group on the role each of us has taken in our work situation and the self with its joy, aspirations, hope and also the feeling of hurt, neglect, anger which are lying unexplored in our subconscious and acting out today in our lives. How can we integrate both our role and self and find a 'meaning' that can result in the well being of both the group and the individual.

The orientation started and the sessions started tickling my thoughts and intellect and there were times when I wanted to say this far please and no further. Internally I felt I was told there will be no 'right or wrong' judgment amongst us, but understand each other's feeling and the situation and help each other to find a meaningful resolution both in our differences and similarities. Our attempt is to articulate those unarticulated feelings without being judged but understood as legitimate feelings, which need to be taken into consideration as a group in resolving any present contradictions. We share those events, which is blocking our relatedness to the present changing situation due to various experiences in the past and holding back our progress towards the mission set. **Annexure B** talks about this experience during the fellowship

However I felt at many times during the orientation that I was being isolated because people knew so little about the situation prevailing in the north eastern part of the country; sometimes I also sensed there was a indifference in people to understand the situation. There was actually a lot of bitterness in me and I poured out all of it in a article given here in **Annexure C**. As time went by however I learnt it was not really indifference but the policies that were formulated specifically for this part of the country surrounded by international borders that made it so isolated most times!

During the orientation we had enough space to set up our learning objectives and re-look at them over and over again and work on a plan to work towards community health during our fellowship, attached as Annexure D. I was guided by the larger objectives but I could not work with the plan I fixed because the learning that I gathered during the course of the fieldwork and my reading helped me reflect and go slow. One of the biggest learning was there was no hurry, I could take the liberty (during this fellowship) of understanding, reflecting and designing the work gathering pace with the experiences. A brief understanding of the events are given in the table below-

Six months at a glance

MONTH	DATE	PLACE	EVENT	LEARNINGS
Sept'05	19th onwards	CHC Bangalore	Orientation on Community Health	Community health from a broader perspective, linking of government policy with grassroots realities and the need to work for convergence
Oct'05	1st to15th	CHC Bangalore	Orientation on Community Health	
	16th to 19th	DDS Hyderabad and KVK Zaheerabad AP	National meeting on Village Grain Bank and AP Food Alliance	Understanding Govt. policy on food Security and studying its effects on rural communities in AP
	20th to 22nd	Plachimada and Pallakad Kerelam	Field Trip	Collective strength of people can affect the wrong doings of faulty policies there leading to the closure of the Coca Cola factory in Plachimada
		Akajan village Dhemaji district of Assam	Field work	Understanding people' priority so far as community health is concerned. People's perspective of a healthy society was explored
Nov'05		Guwahati	Workshop	Understanding flesh trafficking and its larger affects on community health especially women and their lives later
		Akajan village Dhemaji district of Assam	Field work	Translation of relevant materials regarding various policies and the entire concept of globalisation and related information was very welcome by the community.
Dec'05	4th & 5th	North Assam and Guwahati	People's Caravan	There were a lot of links to globalisation, WTO and how adversely people's lives and livelihood was being affected; yet the entire concept of globalisation there is vicious cycle within the benefits from it
		Akajan village Dhemaji district of Assam	Field work	Need to keep people informed regarding policies that affect their lives. People are also very keen to know how certain programs are designed for them without they being aware of it.
Jan'06	9th &10th	Vishwa Yuvak Kendra New Delhi	JSA's National launch of People's Health Watch (NRHM) Watch	There is a need for civil society to play a very active role in engaging with the government on the one hand while also doing a systematic study of the implementation problems on the other
	11th	Vishwa Yuvak Kendra New Delhi	JSA's National meeting on Commission on Social Determinants of Health	WHO has recognised the Social determinants of health this would be really helpful for the third world to address their problems fro a holistic perspective.
		Akajan village Dhemaji district of Assam	Field work	Working with various CBOs and the leaders of three panchayats on understanding the implication of NRHM and the State Health Insurance Policy at the grassroots

	23rd to 25th	Bangalore	Mid fellows meet	Sharing and learning from field experiences
	26th	Vellore	AIDAN annual meet	The politics of the pharmaceutical industry and the global forces acting to make more profit; government of India's policy problems etc.
	27th to 29th	Vellore	medico friends circle (mfc) Annual meet & visit to CHAD and CMC vellore	Quality care in the present state of poverty in our country is not a possibility. Whose understanding of quality do we look at? The low cost efforts put in by CMC were a learning that if there is a will to cut costs one can still do it.
Feb'06	2nd	Guwahati	State meet on flood early warning	In chronic disaster situation public health of the community is at stake, therefore all the stakeholders have to be involved to work on preparedness and early warning of the community
	3rd to 5th	Guwahati	All India People's Science Congress	The BGVS is a large network of teachers across the country but their understanding of community health is very limited and restricted. However this was a good forum to launch mass based action, as their presence across the country is large.
	6th to 14th	Imphal Manipur	Training on HR & Documentation and Report writing	The exposure and orientation of young people of Manipur is very different from the youth of India. They have to relate many issues related to human rights in the everyday political and economic context of their state. At the same time the redressal mechanism was very different from the rest of the country. The civil society movement is very intertwined with the political situation; therefore the strategies used there are different from the other parts of the country.
	16th & 17th	Guwahati	Right to Food Campaign	Hunger is not reducing inspite of the State introducing more and more policies to tackle food insecurity the number of hungry people in India are increasing. Therefore a concrete efforts are needed from all across the country to watch the implementation and let the poor and hungry people know their entitlement
		Akajan village Dhemaji district of Assam	Field work	Understanding people's knowledge of the financing and economic policies of the country. It was very interesting to note that people were very interested in knowing about finances related to development but not really about health.
March '06	3rd	New Delhi	JSA preparatory meet for NRHC review	There was joint preparation done by all the state JSA groups and it was very encouraging to see that all the states were working towards the common goal –health for all now!

	4th	New Delhi	NRHC review meeting on National Health Action Plan	This was a great learning experience to understand the power equations between the policy makers and the people's movement groups like the JSA. It was very interesting to learn that though there is a general willingness amongst the bureaucrats to work for people's benefit but many decisions are very person centric in the bureaucracy. Very less thought is given to the fact that whether the last house in the village will be able to access government facilities.
	5th	New Delhi	JSA meeting	Even though a network wants to work in a very inclusive way there are problems that they encounter to keep such a diverse network together. Since a movement does not access funds from external agencies, that could also be a block for the movement to function effectively
	6th to 8th	Bangalore	Annual Fellows meet	Experiential learning and sharing was very helpful. The context of globalisation as experienced by the fellows in the field were very interesting as to how very small so called development by the government can be harmful to people. There were many informal sessions were the fellows could think of a way forward.
	9th to 16th	Bangalore	Closing of fellowship	The rich experiences of the co fellows and my own reflection of the process took me through a very emotional journey. This was one of the best parts of my life and the learning from the entire experience of six months has made me stronger as a person and strengthened my resolve to work for community health and community development.

"Much of what we do is like planting trees under which we may never sit, but plant we must."

Pictorial Framework of the work done during the Fellowship


People's lives and struggles
Campaigns, Collective efforts
Public Health policies national and international policies
Community efforts
Geographical Challenges

Annexure A

COMMUNITY HEALTH CONCERNS: Assam
focus on Dhemaji district

According to the government's formula, India is supposed to have one sub-centre for every 5,000 people (3,000 in hilly areas), one primary health centre for every 30,000 people (20,000 in hilly areas) and one community health centre for every 120,000 people (80,000 in hilly areas). Whereas the National Health Policy 2002 aims to increase usage of public health facilities from the current level of less than 20% to more than 75% by 2010, a study shows that the country still need 7,415 community health centres per 100,000 population which is presently less than half the number. The basic staff not being in place in these facilities, only 38% of our primary health centres have all the required medical personnel.

Background: India's North East

The North East of India is usually referred to seven states: Arunachal Pradesh, Assam, Manipur, Megalaya, Mizoram, Nagaland and Tripura, though Sikkim too has been included in the region. The region forms 8% of India's land mass and has 4% (33-35 million) of India's population. Modern democratic politics based on numbers does not give space to the northeast region to voice its concerns. The feeling of being 'unheard' further accentuates the feeling of neglect and alienation in the people. The strategic location that encourages physical isolation of the entire North Eastern parts of India makes it a low development priority for the Centre; it is seen that entire NE is considered as deserving of singular treatment.

Status in Assam:

Characterised by the presence of river Brahmaputra, the State of Assam shares its borders with 5 states and three countries assuming geographic, cultural, economic and political significance. The river runs a regal 800 kilometres in Assam forsaking its channels each flood season. The State of Assam for the first time has brought out the Human Development Report 2003 and has done a detail district wise indexing of the Human Development Index (HDI) considering the three issues of wellbeing- first Income, Employment and Poverty, secondly Education and Literacy and thirdly Health. The indicators used for health were Infant Mortality Rate (IMR), Crude Birth Rate (CBR), Crude Death rate (CDR), Life expectancy at birth (LEB) and nutritional status.

The report reflects uniformly across all the indicators of health a distinct rural urban divide and a gender gap. It is also seen that though there is an improvement in the indicators, Assam's performance as a whole in the health sector in the last decade is lower than the country's average (refer Table No.1). LEB of Assam is one of the lowest in major Indian states, the IMR, CBR and CDR in Assam is higher than the national

average with a clear urban rural divide. The infrastructure of community health also reflects lower status than India showing clear urban and rural divide.
The HDR further records that the most common ailment is asthma followed by malaria, jaundice and TB with very high prevalence of water borne diseases which are on the rise during floods and monsoons. **Being the record high in India, 70% of women in Assam suffer from anaemia** according to the report and Diarrhoea is a common cause of mortality among children followed by ARI (pneumonia). The expenditure on the health sector in proportion to the total public expenditure has declined from 5.23% in 1980-81 to 4.65% in 1998-99.

Table 1 Comparative data of the community health

INDICATORS	YEAR	INDIA	ASSAM
Crude Birth Rate	1998	26.5	27.9
Infant Mortality Rate	1998	72.0	76.0
Still Birth Rate	1998	8.0	17.0
Institutional Birth	1999	26.6	21.0
Birth attended by trained birth attendants	1999	28.9	16.2
Neo natal mortality	1999	53.0	45.0
Doctors per 100,000 population	2000	54.27	53.72
Nurses per 100,000 population	2000	75.89	33.29
Hospitals	2001	1.52	1.01
Dispensaries	2001	2.08	0.51
PHC	2000	3.10	2.64
SC	2000	18.63	22.13
Beds per 100,000 population	2001	69.34	47.66

Source: Review of Healthcare in India- *Cehat*

The private health care services is sub standard and interestingly the Government of Assam has enacted the Health establishment Act but the rules under the Act are yet to be made. The recently announced (July-Aug 2005) Assam State Health Insurance Scheme tying up with ICICI Lombard has enabled the private drug dealers to flourish further.

Scenario in Dhemaji District

The Dhemaji district of Assam is located in the north bank of river Brahmaputra across the tea town of Dibrugarh on the south bank. Bordering Arunachal Pradesh Dhemaji is one of the lowest ranking in HDI district being 20th amongst 23 districts. The data given in Table 2 explains the population and health status of the district. Chronic flood is the salient feature of Dhemaji district which leads to the district being isolated every year for over 30 days.

The roads, railways and telecommunication are most often disrupted during the 4 monsoon months. Therefore it is important to note that even if there is any meagre health service available, lack of communication isolates it; this is the phenomenon with most of health sub centres made under the World Bank assisted IPP programme. The district

having attained a difficult and remote status, the health staffs refuse to be posted in the district and specialist doctors are rare to find.

Table 2 Indicators of well being status of people of Dhemaji district of Assam

District-**DHEMAJI**	
Area	3237 Sq Km
Population (2001 census)	569468
Urban population	6.91%
Population of 65 years above	4.15%
Population under 15 years of age	45.1%
Decadal growth rate (1991-2001)	18.93
Sex ratio	Rural 932 Urban 717
Households with Sanitation (1991)	16.37%
Households with Safe Drinking water (1991)	48.58%
No. of Hospitals (2000-2001)	3
No. of PHCs- (2000-2001)	9
Rural Family Planning Centre (2000-2001)	1
Dispensaries	5
Hospital Beds per 10,000 population (2000-2001)	4
Infant Mortality Rate (1991)	Males 113 Females 117
Child MR (under the age of 5 years) (1991)	Males 140 Females 138
Crude birth rate (per 1000)	25.90

Source: Government of Assam.

Community Health and civil society efforts: WHAT NEEDS TO BE DONE….

The historical Assam accord that emerged as a resulted of the Assam movement does not focus on improving the community health scenario though there is emphasis on increasing access to medical education. The last budget of the Assam Government also emphasizes on repair and renovation of the medical education infrastructure which has not been done. However there are only sporadic instances of resistance to the deplorable condition of the medical colleges from the student bodies and rarely from teachers associations.

Over a decade it has been observed that the voluntary sector in Assam has not actively involved in ensuring people's right to health care. Though there are state chapters of national networks of organizations working on health, the lobbying and advocacy efforts are very meagre. There are organizations working on preventive health issues and collaborating with the Government in implementing vaccination programmes, though there are no organised pressure groups to ensure the right to health care. Most of the time it is seen that voluntary organizations treat community health program as an appendix to rural development programmes. The Christian missionaries have mostly concentrated on service delivery which at times is no better than private hospitals where discrimination on the basis of religion is also seen at times.

Given the above situation a strong need has emerged to carry out focussed work on ensuring access to health care for the people of Assam. To begin with it may be proposed that initial work can be started in one district –Dhemaji district of Assam. As mentioned earlier this is one of the most underdeveloped districts and due to multifarious reasons community's access to health care is seldom a reality. However over a period of time concentrating on a few issues of community health, a state level pressure group can be formed with various organizations. It is strongly felt that there is a need for development professionals from Assam (and also North East India) to interact with persons working in community health in other parts of the country to understand the issues better. The people of Assam have always considered themselves distinct which has led them to hesitation in accepting the mainland discussions. Therefore efforts have to be made to replicate some of the initiatives carried out in other parts of India after tailoring them to suit Assam's needs.

The people's health movement (PHM) in Assam and most states of North East India has not yet been actively launched. In collaboration with organizations from mainland India work on the people's health movement can be taken up also involving other interested civil society organizations and voluntary organizations. One of the major drawbacks for the people in this region is that neither do they have access to information on development planning nor is there any effort to access such information. There is tremendous need to fill in this information gap to people and further translate material into vernacular. Systematic networking with the media, voluntary organizations, civil society groups and concerned individual not just from Assam but even outside the region will greatly enhance work on accessing health care by all in the long run. Assamese agrarian community need support to improve their lives by accessing what rightfully belongs to them and live healthy life.

Annexure B

Pilgrims progress

Amazing Welcome

This unique fellowship is a journey within oneself. Often exploration of ones reasons of being here and working towards an equitable and just society can cloud one's thinking. I was going through such a phase of partial disillusion and confusion; though wary whether I will be accepted me with my confusions, I decided to be open about it. I nearly fell of my chair three times when I was more than welcome at Community Health Cell Bangalore with my bundle of confusion and I could hear three people tell me in unison (through in three different places and times) we welcome all confusions and you!! This was the first time I was told that questioning one's work while doing community work is indeed healthy and that I should carry on this pilgrimage and my exploration simultaneously.

Pilgrimage of self-exploration

Over three weeks now in the company of fellow pilgrims it has been a pilgrimage of self-reflection. This fellowship is about community health and in one of my very first discussions with Fr. Claude, he says that unless the community is devoid of jealousy and selfishness, community cannot be healthy whatever amount of medicines may be pumped in. I was amazed at such a profound meaning of community health! This fellowship takes one through the corridors of prevailing inequity, injustice and deprivation that most people face today. The inequitable distribution of assets and the conspiracy to let skills be concentrated in the hands of a few has left the majority of the people impoverished world over. The journey of the past few days have bought to light the fact that the people who have been called to be living in the periphery (the poor) actually are very centrally located. The resource rich are frightened to acknowledge this fact and therefore imaginatively keep pushing them to the periphery.

Silent invocation

As we go through the orientation process there is a very silent invocation of ones inner resources to question the injustice one experiences and witnesses in day-to-day life. The basic erosion of values in the family and society and across communities raises questions in one's mind regarding the future of human race. However there is a constant reminder that there is a very strong need for more and more people to start reflecting, thinking and drawing up action to work against this prevailing persistent

injustice. The emphasis is on working through the collective strength of common people who are struggling and facing the challenges in their lives every day.

Together towards hope

The pilgrims tend to tire out most times as they get exposed to the injustice and inequality that is so rampant and prevalent in every corner in life today. At such time the story-tellers remind the pilgrims that there is always hope around the corner. They talk of journeys that people have undertaken in the past and through an inclusive approach and that there are many milestones that have been crossed and much success celebrated. It is important to critique but not to criticise it is pointed out by the story-tellers time and again. The most beautiful part of being a fellow here is having mentors who hold hands and softly tell you to come back to the path without disturbing the reflection process. It is not a journey of solitude, the mentors always remind the fellows that there is hope and that every one shall walk hand in hand in this pilgrimage of reaching health- mental, physical, social, spiritual for all!!

9th October 05
Bangalore

Annexure C

Drugging north east India to dependency and isolation

throughout history, it has been the inaction of those who could have acted;
the indifference of those who should have known better
the silence of the voice of justice when it mattered most
that has made it possible for the evil to triumph
- Haile Selassie

Men with sophisticated arms and uniforms (read Indian army) intrude your kitchen or bedroom for no reason ever known to you is what it means to live life in a land where the draconian Armed Forces Special Powers Act (AFSPA1958) was imposed and applied by every leader who was elected by the people since 1958. This happens in the world's largest democracy in the north eastern corner connected by a 22 kilometre wide chicken neck to the mainland India. Under the AFSPA fundamental human rights of an individual is not only lost but the seven north eastern states of India has at least two generations with increasing feelings of alienation and hostility towards democracy. Internationally India has been questioned by UNHRC on the validity and the constitutionality of AFSPA to which the attorney general of India replied that the AFSPA prevents "secession of North Eastern States". India has signed the international covenant on civil and political rights since 1978, and imposition of AFSPA is a violation of the Covenant; Time and again India has been questioned on the biggest imposition of AFPSA that is the violation of "right to life". Whose life are we talking about? Children, women, men, elderly and the youth for whom armed personnel in whatever denomination they appear can never be their friend or provide security, they are people whose shadow makes entire village deserted in matter of few minutes and at whom if a woman looks she is not assured of her dignity the very next moment.

Significantly political leaders and Government policy writers pretend to be blind and deaf to the army conducted mass rapes, deformed sexual organs, mutilated limbs, punctured eyes, bullet ridden bodies, burning villages and burning granaries, they allocate more and more funds in the name of defence budget of our country! As I write this piece, the All India Radio informs in the morning news that Government of India has decided yesterday to send these armed men to Karbi Anglong district of Assam to control violence!! Interestingly such policies are largely linked to the flourishing arms market that is provided for by the larger lobby of the world's largest industry- the armament industry; while this happens some Delhi homes get palatial with more conditioned air and a son's marriage gets people landing down with choppers chartered by the bribe they offer. The other side of the story is arming of the resistance movements in the northeast India, which is a double benefit to the same industry and therefore this industry, would do everything possible to let the unrest remain and more resistance grow.

The conspiracy does not end there, the British used poppy cultivation to silence voices by drugging people and numbing their thinking; even five and half decades after they left the country's northeast corner is subject to increased flow of drugs to which the pharmaceutical companies contribute by sending high dose through cough expectorants (read phenydrly). There are no concerted efforts to curtail the infiltration of drugs into northeast by the Indian Government thereby numbing the people's ability to think and react to the denial of people's entitlement to life. Many people from mainland India also blind themselves and support such draconian acts as they have very little access and willingness to know that northeast of India is not just jungles, hills, waterfalls, rhinos and semi naked people doing slow dances but it has laughing children, lively creative women, young men and story telling elderly people. Many people outside the seven sister states live in a state of denial of human existence in this area to the extent that when a person from that region dresses and speaks at par the national tongue or English with the appropriate phonetics they refuse to believe the person belongs to where s/he claims to belong to. They unknowingly fall prey to the conspiracy of "prevention of secession" of the Indian Government and the larger global forces of arms and drugs supporting the Government. Until the Manipuri women forced themselves to nakedness on 15th July 2005, the oppression was not a part of the Indian subcontinent and its media, like always the northeast remained tucked away in people's memory as a disturbed troubled corner.

The State Governments of the seven states succumb to the entire conspiracy and instead of concentrating efforts for mental de-addiction of their constituencies they go on a begging spree in the name of eyewash development projects but basically to support party funds. It is not that people of this region have not resisted oppression. As a young child of eleven I have witnessed over 10000 people marching more than twenty kilometres on foot to break the first curfew imposed under the president's rule during the Assam Movement led by the students of Assam. Only children and the very old were left back at home, the women, men, youth, shop owners, cart vendors and elderly walked to the oil pipeline in the Oil India Limited (OIL) campus to stake their claim over the revenues Government earns from natural resources of the region and use it for the development of the northeast region. Rich in resources like oil, natural gas, minerals and tea, the state of Assam barely receives any revenue from these for its development. When a section of the students took to a movement to question this there was mass support from the people of Assam but the dream slowly and steadily collapsed as the new student leaders' led Government succumb to the same gimmicks of the conspiracy.

Then came the youth (with arms) who talked of a fair independent state of Assam in protest against the revenues from the natural resources and the businessmen (mainly from Rajasthan) being taken away from the region for development elsewhere thereby forcing the region to take to the begging bowl. Presently though they sometimes explain their existence through series of bomb blasts and kidnapping they are also more than often seen satisfying the armament industry with extorted resources from the exploiters. The victims of extortion are more than happy to extract the extra profit from the common person and hand it back to the flourishing arms industry through the independence provider youths. One of the governors of Assam managed to make his way through the "independence providers" and start another conspiracy of these youth surrendering and

returning to the mainstream. They were instead used as agents to identify their colleagues of yesterday and some police officer receives accolades for shooting the pointed one down. The mainstream returned is not spared either, because there is arms and revenge on the other side too, who promptly shoot the pointer down amidst Z class security provision of the Government. This vicious cycle continues as the large global forces is interested in selling arms and drugs and drugging the entire region to dependency and isolation.

Suddenly the World Bank and its allies have started realising that while the world's resources for extracting power and water is depleting the hitherto untapped rivers, streams and minerals still exist for them to exploit in this very same northeast corner of India. There is a mad rush to set up energy and water shop now by various corporate giants, psuedo-development banks and of course the political leaders to pass the political "will"! The conspiracy continues….

The fundamental question is -Who is going to ask for their entitlement? When people are (kept) busy confronting the arms conspiracy from the "defence providers" and/or the "independence providers" or they are in deep mental slumber under the influence of cocaine or phenadryl how, when and why should people ask? … the voice of justice is silenced and the conspiracy succeeds!

Annexure D

Learning objectives for the community health fellowship

- ✓ Self-reflection on working with community health in a holistic way.
- ✓ Understanding the shift in working from welfare mode to people's struggle towards their entitlements
- ✓ Self development – clarity of global concepts

The work will concentrate on the monitoring the implementation of National Rural health Mission (NRHM) 2005-2012. The NRHM has a special focus on the North Eastern States and 10% has been the committed outlay is for the north-eastern states. My work will concentrate on working in Jonai, Sissiborgaon Machkhowa and Dhemaji blocks of **Dhemaji district** and Dhakuakhana block of **Lakhimpur district of Assam**. The work will be done in collaboration with four NGOs in these blocks SRIJON in Jonai, RVC in Sissiborgaon, SARBU in Machkhowa, SEDO in Dhemaji; ***shakti*** will work directly in Dhakuakhana block of Lakhimpur district.

The work will be mainly done in November and December 2005 and half of January and entire February another half of March 2006; a total of 4 months. Some of the activities that I intend doing (tentatively) are-

November – Meeting health officials at the state level to understand the planning process for the implementation of NRHM. Have a meeting of the four NGOs in the area to discuss in details about NRHM guidelines for implementation and mission; if possible this meeting will be held together in RVC's Campus for 3 days otherwise it will be held in each organization separately. Introduce PHM and health as a right in this workshop. The expected outcome of this meeting would be to take up some common criterion for monitoring the implementation of NRHM.

December – community meeting in selected panchayats on the implementation guidelines and details of the NRHM with the help of the four NGOs. Try to access government information if any on the NRHM specifically for Assam and send it to other organizations in the state.

January - meeting of the four NGOs to understand the progress in implementation of the NRHM. Decide on the strategy to approach the problems in a collective manner.

At personal level there are a few things I shall be doing:-

- Regular reading for an hour or more on the subject of health and human rights
- Helping other NGOs conduct training for the community members on right to health and health care issues.
- Regular visit to the blocks to understand the implementation of the NRHM
- Be in touch with other NGOs in the State like, The ANT Bongaigaon, VHAA Guwahati, Manav Shakti Jagaran Nalbari, Tezpur District Mahila Samity Tezpur, GHAROA Silchar, ERLISID Kokrajhar, Morigaon Mahila Mehfil Morigaon,

CASA Guwahati etc. these are the organisations I am in touch with personally since a long time. If possible try to work out a common strategy for following up the implementation of NRHM

- Be in touch with CHC mentors telephonically or over email and discuss the progress and get clarifications for my doubts if any.
- Try to work with Dr. Sunil Kaul on the implementation of the State health insurance scheme in Assam.

Though I have listed out a lot, my priority will be to work in the 5 blocks of two districts of Assam and stress on personal growth towards understanding the implication of health policies not reaching the vulnerable and marginalized section of the society.

Annexure E

National Consultation on Food Security Corridor

17th and 18th October 05,
Venue MANAGE Agriculture University, Rajendranagar Hyderabad
Organised by Deccan Development society Hyderabad and
Development research communication and service centre Kolkata

The major deliberations were about the two models developed by the two organizations DDS in AP and DRCSC West Bengal. There was emphasis on the fact that after independence the first decade concentrated on converting forest and wasteland into farmland to increase productivity and to reduce hunger. After fifty years of independence India still has over 60 million hungry people and godown full of food!! The green revolution brought about wide disparity both social and environmental and has practically made Orissa food deficient. 80% of ground water is consumed by irrigation leading to social conflict. Apart from that agro chemicals are found in all stages in our food chain. Further there was discussion on the alternative public distribution system of the Deccan development society, which ensured food sovereignty for 77 villages.

The presentation on the second day was by various organizations across India who are directly or indirectly working on food sovereignty issues with various communities. The days deliberation also focussed on Government of India's revamping on the village grain bank. So the emphasis was on storing food produced by the community and not FCI food. There were four presentations -

Mr. Rajeev Khedkar ADS Maharashtra
His organization works in Thane and Raigarh district which are predominantly tribal areas however with urban and industrial influence. In these areas Grain bank was started to combat moneylenders. Grain Banks are there from time immemorial and ADS revived them and made them poor people friendly. The emphasis is not just on storing food produced by the community, but it is also communities' way to say no to FCI food. It is also not just a solution to starvation period, but it increases people's bargaining power, as moneylenders no more remain powerful. The members of these banks are mainly landless and small and marginal farmers. Livelihoods of Adivasi people are lost as the forest is shrinking or they are being asked to leave the forests also land alienation by urban people is another problem because although they are cultivating in these lands for over 120 years they sill don't have ownership of the lands inspite of repeated appeal to the authorities.
He added that Government of India village grain bank scheme called- navasanjeevani yojana and 25% of this was non functional as they are neither managed nor controlled by people, food is from outside sources and is not traditionally stored.

Ms. Sheelu from Women's Collective Tamil Nadu
The women's collective works in 1500 villages and they have 90% small and marginal women farmers as their members. The main focus of their work is political empowerment

of women, the rights of women capturing it locally is an alternative for the marginalized and the women specifically. The women are trained to contest elections at the panchayats and stop the MNC entering the GP. Last six to seven year they are focussing on food security/sovereignty. Organic farming is being facilitated for vegetable cultivation and organic farming seeds are provided to the women with basic training, these seeds are then rotated. Women's groups also take government tamrind trees on lease and process the tamrind. A new trend is set by the collective where local production is for local people while the excess production is exchanged with grains from other community village groups. Chillies, tamrind and dry fishes are now included from Tsunami area. Tsunami relief work was carried out by food brought from Kodaikanal. Earlier during rice producing season, the moneylender fixes the price of the rice whereas now credit from the women's groups are given and grains were taken back as refund and gave it back as grains to farmers as credit during difficult time. This has empowered the women. She concluded by saying that food sovereignty can be ensured only by local people and through the community consent on how to store, where to store and what to store for redistribution amongst there community.

Mr. Oswald Quintal, Kutumbam Tamil Nadu

Kutumbam was inititated in 1982 for facilitating sustainable agriculture and have been doing so along with training of NGO field staff in that together with AME low external input sustainable agriculture in 13 district with 82 NGOS 10000 farmers in Tamil Nadu. Documenting traditional agricultural knowledge, and finding alternative solution to green revolution and related problems and traditional alternative to the problems is the focus are of work of Kutumbam. Some farmers have developed alternative to chemical pesticides, soil fertility and water management; documentation of farmers experiments and shared with the village through wall newspaper. Family food security is of utmost importance but capacity to purchase food is non existent amongst farmers. Food from outside is meaningless because of the faulty ration card system.

Ms. Sagari Ramadas, ANTHRA Hyderabad

ANTHRA works with issues of livestock development people's food sovereignty mainly with Adivasi and Pastorilist communities working for their rights to resources and ownership of knowledge, ownership of lands, water, alienation of lands and struggle for forest. Pastoralist has been blamed as destroying forest and grazing. By so-called development of resources and arena of production in the last 20 years primarily through Government of India the pastoralists have been alienated from seeds and breeds. Food can't be imported where people's own seeds and multiple cropping systems exist. There are no efforts from the governments end towards conserving the breeds and build an integral relationship of livestock and agriculture. Not losing the female is very important and local cattle were conserved through community efforts. However the local breeds are lost by government's efforts and the local market, destined to be a failure because it has not touched the local productions. Local national and international policies are a challenge to the community efforts. The VELUGU (DPEP) has grain banks from FCI and local production is not there. Micro level hard work has little meaning because the policies work for promoting international markets, control and ownership of their own knowledge and production and markets.

Dr. Prasad Agriculture Man and Ecology
AME started in Netherelands and has eventually the main focus is providing ecological agriculture and alternate agriculture to farmers. Holistic farming is neglected and the community degraded lands and ignored by extension agencies. AME hat works in AP, TN and Karnataka promotes Eco friendly technologies through appropriate participatory methodologies. Helping people help themselves, participatory technology development, reabsorbing thing they have forgotten are the focus of the activity called the farmers field day along with building linkages with key biomass actors.

Mr. Bhanwar Lal Secretary to Government of AP, Ministry of Consumer Affairs, Food and Civil supplies, Hyderabad

He spoke mainly on the Government of India's decision to revise the village grain bank scheme and establishment of new village grain banks. He said production rather than distribution that has to be the ultimate aim of food security at village level. What we are aiming at may take some time. In the mean time the person has to survive. GOIs grain bank may be a time being solution and not ultimate solution it is to provide some relief to save the person from hunger. In the context of several such schemes, TPDS, Antodaya Annapurna PDS, EAS in the gamut of all these scheme the role the grain bank can play along with these schemes. Since capacity to buy food is not there with people so this helps. Management will be given to NGOs and GOI will see how best the NGOs can be facilitated. Since it is a revolving scheme, so local production can compensate it. It may not give the intended results.

Parts of the Joint statement from the participants of the National Consultation on Food Security Corridor to the Govt. of India

After this Sathyasree was given the responsibility to compile a statement on participants response on GOI's village grain bank proposal and the following was compiled and read out by her-

In the view of the Government of India's decision to revise the village grain bank scheme and establishment of new village grain banks the participants from Andhra Pradesh, Assam, Chattisgarh, Delhi, Karnataka, Maharashtra, Orissa, Tamil Nadu and West Bengal, that people across the have expressed the following concerns-

The principles of **Local production Local storage and Local distribution** have proven to be success in many community projects, Therefore these principles may as well be used for the revise the village grain bank scheme

Procurement of food that is produced locally:-*It was uniformly agreed by all present that food produced locally is available, acceptable and accessible to people which is nutritious in the combination people eat. It is appreciated that government of AP will be*

procuring millets for public distribution; however there should be efforts to leave the choice to people of the village what food they want to procure for their consumption. It may be suggested that each mandal may be allowed to procure what has been locally grown. This would also ensure people's ownership and control over the programme which is theirs. In the scheme the 76% is going to FCI, it looks like more a way to get rid of the rotting grains in FCI godowns. there would also be minimal wastage if the local food grains are produced as compared to the FCI grains. Food security can be provided only with uncontaminated food and the permanent damage has been seen to be done by the rice provided under the TPDS

Local Decentralised storage- *There are traditional designs of grain banks that people have used in their own areas that are made with locally available materials. People have used such storage designs for a long time now, which ensures that the scheme is community friendly. Apart from that in the models that have been followed centrality of women in management has been proved. It should also be kept in mind that the food scarcity period is only two to three months, therefore to have NGO staff for the entire year would be a waster. By allowing the women to take charge of the programme the overhead costs can be reduced.*

Local distribution- *The other strong concern was tat the management of the grain banks should be in the hands of the community right from planning, storage and distribution. The failure of the TPDS is obvious and it has been proven in the case of Alternante PDS system carried out in 77 villages of Medak district facilitated by DDS that people controlled distribution is possible.*

Some other concerns expressed are that the government officials at the mandal and the panchayat level needs to be sensitised. This scheme should not be looked at the permanent solution but just a stopgap arrangement; the efforts should be towards permanently removing hunger from the society

Annexure F

Food sovereignty AP Alliance, At Deccan Development Society Pastapur 19th and 20th October 2005

The alliance was started in view of Global week of action with ten networks of NGOs who are working on sustainable agriculture and natural resource management and working directly with community. The members of the networks who are present today are from Andhra Telangana and Rayalseema areas of AP and Mr. Nammalwar who is a very experienced in organic farming from an organization in Tamil Nadu called *Kutumbam.* The objective of the alliance is moving beyond food security to food sovernity on the one hand and looking towards building conclaves on both sides of the food security corridor.

Mr. P.V. Satish gave an overview of the entire context -
From **food security** to livelihood security; looking at increasing people's purchasing power. In the World food summit in Rome, large north countries made very less commitment (800 million hungry people in the world), Castro walked out of the summit. Food security was seen as production problem; therefore international measures were designed to take care of the above problem. However comparative advantage was seen with northern countries. The conspiracy was that trade was linked to foods security by the north countries as they said that they have better productivity. By the end of the world food summit, ground was ready for TNCs and now world food trade runs into hundred of millions of dollars. Food and seed are seen as new tools for imperialism (petrol and oil was earlier tools for imperialism). There has always been one dimensional argument (only on low production). Even though south Asia is self sufficient in grain production, in the last decade 8% rise was there in food grain production and 8% rise in hungry people also! Food security also meant adequate calories and nutrition out of reach of people as people had too little money to buy food and access food where and when needed.

Then a shift in paradigm happened and the term **FOOD SOVEREIGNTY** was coined by ***Via Campasina*** which meant ones right to produce one's own food in one's own location. Food sovereignty within the COMMUNITY **(even if the godowns are full of grains in the country food security is not ensured).**

Critical perspective on the process of globalisation and understanding that inequities are inherent to free market. Critically understanding the position of the government and inter government positions in the international trade matters questioning credibility of government. No rhetoric but grounded in the fact that State cannot address the food needs of the people since it is seriously curtailed by multi lateral trade regimes and numerous bi lateral agreement linking trade, and security arrangements. Denying food is culturally inappropriate and political act (destroy the food culture…. Colas and pizzas). Eg. Star Bucks Cafe of US kills the culture of people by introducing their cafes in culturally important locations. Food sovereignty means food appropriate to ecology and culture. Further food sovereignty implies….Ecological techniques and stewardship of agriculture,

agriculture biodiversity, moving away from intensive agriculture, creating of rural employment and diverse food culture.

At national and local level it should advocate farmers' control of regime that involves access to land, control over seeds and ending women's exclusion. There cant be patent on life. At global level reforms are required in global food trade, which ensures end to duping and subsidies for intensive agriculture and ensuring fair price for farmers and protecting local markets. Preference for domestic food crops over export crops has to be stressed and realised. Some of the current experiences he mentioned are that There is a conspiracy of denying food producers the right to remain food producers (grape farmer will get subsidy, jowar farmer wont get) which can be explained very well in case of the Phillippino farmer's case where the change in govt policy with trade regime changed the farmers from food producers to commodity crop growers from that to contract from contractors to so called importers and finally telling the farmers they cannot do any of these so the option left to them was to be construction labours

Ardhendu Chaterjee

spoke on the ecological sustainable agriculture and food sovereignty. Farms are agro eco systems designed to increase harvestable food and fodder he said. He began by saying Humans were hunters gatherers, nomads, the first watershed was when man learned how to domesticate animals, this meant settling down, man needed water. The 2nd watershed was irrigation system carrying water from the farm. The 3rd watershed was feeding human food to animals (earlier humans cannot eat food was given). Inequitable relation in other countries started countries consuming high beef; therefore there were colonies of fodder growing in Asia and Africa. Eventually the faring system has becoming mechanised and substitution with synthetic and unnatural things- pollination, irrigation, seed propagation, mannurization everything replaced by synthetic and unnatural things! He said Man is becoming Super god by genetic modification by crossing cow with pumpkin!!!!

Crisis in India

Social crisis

1. Productivity per hectare increased but hunger has remained (social, ecological and social equitable reasons) and malnutrition has remained with people with or without land and increased low purchasing power
2. People consuming wrong food (out of season vegetable, same vegetable through out the year, potato is a starch tuber becoming vegetable)
3. Farmers are not getting remunerative price; farmer will remain poor because he cant produce enough, farmers will remain poor because he produces more…. So where do farmers go???

Environmental crisis

1. Soil pollution and degradation, accelerated land soil erosion leads to silting of river resulting in flood with shallow river and also drought because rivers dry up

2. Filling water into a pot with holes is like letting the top soil to flow away (top soil….. blood of earth flowing in the red waters in the rivers); 1 inch of top soil from 1 hectare is equal to 20 lorries of soil going away
3. Forest and rivers of India are sick or dying…. They are our insurance which is gone because many varieties of fishes and birds are disappearing everyday and not much is discussed about this.
4. Many valuable plants are there like the hibiscus (gongura), The yams (diascorea) that are disease tolerant flood drought tolerant are never taught in the agriculture university. Potato create heart disease, yam cures heart disease… we have left yam to poor because they don't look good. They are not water intensive, high yielding yet the government does not encourage us to cultivate it.

A good farm is where a lot of animals birds and fishes get protection along with the entire eco system unlike a high yielding farm that gives us a lot of yield. There is difference between a Productive rice field and a deadly rice field because more rice and profit less food and decreased fodder. Ecological farming is a combination of all the diversified integrated ecological farming (nutrient for the farm is produced in the farm)…… more welfare, employment. Ecological farmer does not throw away and create harm but are more responsible …. Conserving ecology these ecological farmers don't get paid for doing this service to the country. **Diversity means** many varieties, elements and yields and **Integrated** means no export of water, nutrients, poison

Shalini Bhutani

A lawyer from an international organization called GRAIN talked against genetic engineering, understanding the trade regime related. Sovereignty means self-governance, a concept less than a decade old. It is neither an absolute right nor meant as ownership over genetic resources by the state govt. though it seems so because government is signing treaty after treaty at the international level. Legally without consulting the communities sovereignty cannot exist. Food sovereignty is an attempt to realise the Right of the people of each country to determine the sowing, growing, reaping and eating. Some other points she spoke are-

VIA CAMPESINA (international peasant movement) principles

- Right to food
- Agrarian reforms
- Resource conservation (free of IPRs)
- Reorganising food trade (food first trade later)
- Addressing globalisation
- Social peace (change in the Iraq govt. policy totally written by US)
- Democratic control

Food sovereignty is a counter proposal to the neo liberal macro economic policy framework . **How….** Politically……. at the national level while Practically……. at the

local level. **Why….** Sovereignty is obvious in a sovereign country… but why do we need to state it??

The challenge is with the trade regime is…

- Trade oriented production
- Handling of hunger and malnutrition
- Technical solutions (pharma crops)
- Alienation of resources (physical and the intangibles…. Patent regimes)
- WB-IMF-WTO are Funding welfare activities by WB and the IMF have paved the way for WTO and More trade and commerce to come in

Why did agriculture come under WTO regime? Because Food is the ultimate weapon

AGREEMENT ON AGRICULTURE

- Domestic support
- Market access (cant protect local industry because same treatment has to be given to foreign countries)
- Subsidies (remove in India but can increase in their countries)

WTO's TRIPS

- Patents
- Plant variety protection
- Geographical indicators

GATs (privatisation of the three sector under the GATs agreement)

- Environment
- Health
- Water

Hong Kong will want to derail WTO as people want that WTO must get out of agriculture to ensure people's food sovereignty throughout the world, as WTO is the antithesis of the idea of people making their own decision about food. The Indian laws are being made in keeping with the WTO. In the last decade the following laws are passed-

- Biodiversity
- Seed
- Protection of plants
- Agriculture
- Geographical indication of goods act
- Patents
- Seeds Act

WTO+

- WTO-WIPO-UPOV
- World intellectual property organization
- Bilateral trade agreements
- Bilateral aid agreements

- Free trades Agreements
- Signing away resources and countries property

Sagari

From Antara a organisation working for pastoralist spoke on Livestock diversity. She began by a saying from chittor- No fodder------ no livestock------ no crops----- no fodder

Development of dual purpose animal was the focus after independence animals that contribute to agriculture (work) and milk. In 60s World food Programm was the first dumping. That was the time dairying was also brought in operation floods. 5th to 7th plan had emphasis on dairying as a separate enterprise, approach was to bring animals from outside and convert our animals to high dairy outside animals. The green revolution and the white revolution went hands in glove with each other. Those animals need more water, more fodder when on the other hand the intensive crops did not give fodder. Poultry industry had nothing to do with the farmers, **International Food research Institute** (IFPI) brought out **"livestock revolution 2020"** in early 90s, they have done analysis of international economics says the developing countries will need 30% demand huge opportunity for produces, this means opening new markets (TNCs trade in dumping of poultry, milk product etc Africa)

If the small farmers have to rise to the challenge, they have to do 4 steps prescribed by IFRI

- Verticalization (corporate farming that is Feed to TNCs)
- Improve hygiene and standards upto international trade
- Livestock health a major issue and privatise veterinary care
- Open dairy to private sector

The current issues are-

- Dividing livestock and agriculture. AP bullocks have come down y 25% therefore mechanisation of farming
- Manure is fading out in A P more than 50% farmers are without any livestock
- Micro credit and what is happening… micro credit groups are being pushed with crossbred cows by Financial Institutions. No loan is given for local variety breed.
- All the livestock are export oriented. NDDB can't sell milk at present how will the farmers who are pushed for export sell the dairy product?
- Anti goat syndrome, get rid of goats for JFM
- Withdrawal of govt from vet services
- FAO- pro poor policy initiative program
    - Working with policy makers of privatisation
    - Poor pay for the services of veterinary
    - gopal mitra (para vet)
- High capital-intensive livestock production
- The picture without livestock food sovereignty is only half

Nammalwar

Very appreciative of DDS's APDS and feels that all NGOs are in a battle field. The crisis of agriculture is fast approaching and the natural resources are being privatised. The organic farming movement was launched from the south as the green revolution which is launched in south had done much damaged mainly from AP and TN. Swaminathan is promoting computer in every village for that corporate farming can be done. People have realised in TN that organic faring is the way out. People are listening to Nammalwar now because he was doing organic farming in own land, once working in green revolution in university, now again doing organic so none can challenge him. Have faith in the knowledge of people. He spoke that Salt application preserves lemon, fish, meat etc…. but does not become a part of nature. Salt in lorries is being put on our lands like Urea

Soil, animal and human beings are three things being fed by permaculture, but our women have been practicing this since a very long time. . We give to soil and cow what we don't need. Green revolution said bring fertiliser, fodder everything from outside…. This was the paradox. Biodiversity is same everywhere, suebabool used in phillipines for fattening cows, glyrecidia used as fodder, and pesticide, crutalilia sun hemp is nitrogen fixing (12000 legumes in India), suppressing TB one of the ornamental plants, stylanthus (nitrogen fixing) and wild rabbits get attracted and then leave manure n the soil. Marigold controls nematodes if cultivated in between crops. Acacia has very good leave drop for mulch. under the shade of the acacia we can plant other trees than cut the main tree., the seeds are protein rich. Wild mint is a pesticide, soak in cattle urine for 10 days and 10 times water and pesticide s ready. Nothing in the environment is waste. He prescribed a few organic compositions.

Amrita pani

10ltreWater c1KGdung 1Lurine and jaggery 25 gm keep 24 hrs, add ten times water and spray on plants

Herbal pesticides

Plants not eaten by cattle is soaked in cattle urine for 10 days and added with 10 times water, spray,

Panchagabya

COW- 5 Kg cowdung, 3L cow urine, 1Kg cow ghee, 2L cow milk, 2L cow curd stir it for 21 days, after fermentation becomes rich in all the minerals, tested in the lab and certified (30 ml in morning 30ml in the evening for human consumption) kept in mud pot and 3litres is enough for 1 acre. Buffaloes also this succeeds in Erode, goat was also tried and it was twice as efficient as the cow.

What the scientist are telling is not science. Green leaf is the kitchen of the plant. Scientist tell that the plant has to be fed, but right from blue green algae to banyan tree they are all producers. Human is a consumer; consumer can never give to producers. We are providing food to animal's and the soil not to the plant. Scientist are foolish as they think they are feed the plant, they are only agents of fertilizer company. SOIL has three properties Physical Biology and Chemical; it is a living thing. The American told us to start with chemical element put UREA and kill all the micro-organisms. Traders, scientist, ministers are all against us n the battlefield and it s difficult to fight them. So build people to people relation in our state and strengthen

Annexure G

Visit to Plachimada in Pallakad district of Kerelam

T. Pratap

At Pallakad Mr. hosted me, an ex activist from the Silent Valley Agitation that succeeded in stopping the government form building the dam in the silent valley over a decade back. I had a detailed discussion with him on the state of Kerela. He gave the overview of the water availability status of the district. It was surprising to know that in one panchayats of Pallakad district there are four dams that have come up in the last ten years but that is driest panchayats and as a result of which the rivers are drying up and the government is working on plans to decommission the dams!! He further accompanied me to meet the people and also acted as a interpreter and could explain the matter in the local context.

Krishnankutty

It was in a place called Vandithavanam of the Perumatty Gram Panhayat we met Mr. Krishnankutty sitting MLA of the left front who was eagar to talk about the Plachimada issue in its present status. Plachimara is located in the perumatty panchayat under pallakad district of Kerela. Mr. Krishnankutty informed that people were suffering from a lot of stomach ailments, as food could not be cooked with the water available locally and also because of presence of cadmium in the slurry in the agricultural fields. He informed us that the entire state of Kerela has 12 TMC of ground water and pallakad has 10 TMC out of that, however due to the Coca cola factory exploiting water the ground water table has fallen from 120 feet to over 900 feet. He also pointed out that since the ground water table has fallen below the sea level of 625 ft, there is ground water contamination by the sea water further rendering the water un potable. Over 66 water sources of the area have dried up he said. Further he mentioned that the panchayat os also using a study conducted by the UN in Bangladesh that when ground water table falls, further drawing water through bore wells could result in oxidation thus rendering the water source very harmful.

Valayodi Venugopal

was in the NAPM historic Samarpanthal in front of the Coca Cola factory in Plachimada along with a few others like Muruganam. They explained how the agitation was on the 1279th day that day on 22nd October 05 ever since the agitation began. He further explained that the palnt has stopped its operation for the last 20 months. Hpwever Murrugan went to explain how the company had diveted the water from parambikula, Chulliyar, Kambalathara, meenakara and Vengalakayam canals and replenished their open wells to continue production while people went thirsty. Further the company has not yet received clearance from the Kerela land use board.

Thus the trip to Pallakad was a learning how an empowered panchayat could work for people's right over their resources successfully!

Annexure H

Health and (derailing) the WTO

The other incident that happened was the **" peoples' caravan"** that was started in the entire country to build public opinion on the WTO ministerial meeting that WTO should be derailed. For the caravan it was seen that not much information was available on how WTO affects health and health care, therefore a translated version of the book **"Health for All NOW!"** chapters 1, 2 and 5 of section 1 was done and 1000 copies published in Assamese with financial support from Rural Volunteers Centre (RVC); over 300 copies were distributed free to village people, NGOs, people's representatives, media personnel etc. further another book was also published by RVC which was sources and layout done by me- "Derailers Guide to WTO". The concluding meeting was held on 4th and 5th of December 05 and on the 5th Dr. Sunil Kaul and I conducted the session on affect of WTO on the health sector jointly. Some of the major subjects of discussion of the session were

- the Assam government should have a proper drug price control policy and make drugs available to people in the public health care units
- the people were unaware of the Assam Governments recently launched State health insurance for all voters, this should be made more public and transparent
- since food security is related to preventive health, government should out the food security schemes in place
- the entire public health system should be more transparent and more focus should be on improving the public health sector rather than giving sanctions for the growth of public health sector.

Though a host of academics and educated people were present in the meeting of over a crowd of 150 people, not many people were aware about the NRHM, state health insurance or other matters that relate to public policy, WTO related to health sector.

Annexure I

Jan Swasthya Abhiyaan's People's Rural Health Watch

8th and 9th of January 2006 *Vishwa Yubak Kendra Chankyapuri*
New Delhi

A two-day meeting of some members of the Jan Swasthya Abhiyan was convened at New Delhi to discuss and initiate the activities of the Peoples' Rural Health Watch.

8th January

The introductory remarks were followed by a short presentation on the NRHM, on the reasons for the launch of National Ruaral Health Mission, current way it is advancing and JSA position on various components of NRHM.

The presentation and discussion on the NRHM and the Peoples' Rural Health Watch was followed by updates from the representatives of the states present.

Updates from state JSA units on status of NRHM and their respective activities

ASSAM

In Assam the NRHM was launched in November 2005. There was much publicity over baby shows in the districts. While there is not much talk of NRHM per se right now, it is also being confused with another programme, namely the CM's Health Insurance Scheme, launched with ICICI-Lombard. There is talk of raising funds – Reliance is promising measures for health. There has been an increase, by 10 per cent, in user fees in hospitals. The perception at the district level is that the AWW can be trained to ASHA, as there is no remuneration for ASHA. Questions arise about where the funds allotted for the SCs will go, as there are no SCs in many districts, including ours. A similar situation prevails in the neighbouring state of Arunachal Pradesh, where NGOs are to run PHCs. Tenders are being floated for this purpose, and nursing home owners are taking NGO-status for this purpose.

BIHAR

In Bihar the NRHM was inaugurated at a function held at the Maurya Hotel in Patna. Not all civil society organisations were informed. When a JSA team tried to meet the Health Secretary in connection with the NRHM he claimed that he was very busy with the Mission and did not have time for us. There is much misinformation in the state over the selection and honorarium for ASHA, who is being addressed as ASHA DEVI. It is being told by the PHC and Block-level officials that she will get Rs 2000 pm. While selection of ASHAs is yet to take place, several NGOs in Patna are offering training courses and awarding certificates for ASHA. There have been

demands of Rs 10,000 as bribe for ASHA to be selected. At the village level people say that they need not do anything about the ASHA selection – the *mukhiyaji* will do the needful. In brief there is no clear understanding about the programme. PHC officials appear to have some information. Also, in Bihar tenders are being floated for NGOs to run hospitals.

CHHATTISGARH

In Chhatttisgarh village-level monitoring committees, comprising largely of women, monitor performance of ANMs, availability of ANCs, at staff availability in remote PHCs, DOTS functioning, and so on. As far as the implementation of the NRHM is concerned, the *mitanins,* who function in almost 60,000 villages, have been recognised as ASHAs. The amount of Rs 10,000 has also been given to the SCs. The Collector and CMO between them took decisions on what items should be bought with the funds. They placed orders for items such as sterilisers for institutions where there is no electricity supply, and so on. However, the local peoples' organisations have put pressure to not to go ahead with such purchases, and so these items have not been bought. Some local organisations was called to participate in the formulation of the District Health Plan. While most of their suggestions were accepted, some were turned down (which ones were accepted and which were the ones turned down?).

With respect to involvement of panchayat institutions, there has been some training of panchayats on health indicators and health status. With the help of the panchayats. a survey (by whom?) on these aspects has been conducted in about 80 blocks. So there is some awareness among panchayat members of health issues.

A survey on drug procurement found that the drugs were from some local traders, and did not conform to WHO standards.

HARYANA

Haryana is not among the focus states for NRHM. It is being implemented as part of the RCH-II programme, under the RCH Director. There has been increase in the budget allocations in the state. There is much worry about how this amount is to be spent, as even the smaller sum of 40 crores was not being fully utilised (some clarification on this?). Some amount has been spent on building delivery-huts. The money has been spent `on paper'. In some instances, delivery huts have been constructed where SCs already exist. Medical Officers have been ordered to select ASHAs. They have completed this work and sent the list of selected ASHAs. Their training has not yet begun. As regards PPP, private gynaecologists and anaesthetists are being hired and being paid on case-by-case basis. 2 CHCs are being selected for upgradation. There has been improvement in infrastructure, such as in condition of building, availability of ambulance, and or medicines. JSA intervention is possible in ASHA training. There has been no activity so far towards the Rural Health Watch.

HIMACHAL PRADESH

The NRHM is being implemented in HP, although there has been no formal inauguration, nor is there any talk about it. According to newspaper reports since August 2005 the state has already received more than Rs 7 crore under the mission and the authorities

have disbursed much of the funds to the grassroot level institutions. However, the functionaries at this level do not seem to be aware about the Mission. According to the Director looking after the NRHM in HP 45 PHCs and 15 CHCs have been selected in the first phase of the Mission; those having required structure and staff for 24-hour service have been identified (for strengthening or for 24-hour service?). The sum of Rs 10,000 each for strengthening of the selected SCs had also been released and there was a sum of Rs 20 lakh each for CHCs which was to be utilised as per need. Not all the institutions chosen for strengthening seemed to be aware about their selection. Or about how to utilise the funds given to them. According to the doctor at one such PHC chosen for 24-hours service, his PHC did not have the infrastructure. Several of these institutions identified for upgradation for 24-hour service were either located on highways, or were very close to each other, thereby leaving remote areas uncovered. Recruitment of new personnel is not taking place. There is resentment among the specialists in the district hospitals over the move to shift them to CHCs.

District level health committees have not been constituted; no training of officials concerned; no involvement of civil society organisations so far. Selection of ASHAs has not taken place; it is anticipated that AWW will be converted to ASHA.

There are indications of promotion of PPPs. For instance – at a FP camp the concerned doctor did not turn up. The private doctor who came instead charged Rs 200 per case and had made a lot of money at the end of the day. At a government hospital the Red Cross approved laboratory has been vacated and a private laboratory instituted in its place by the District Commissioner, as head of RKS. The MS of the hospital was reprimanded by the DC for not getting the place vacated for the private laboratory.

Some of the health schemes, which were previously under the RCH programme and that were subsequently shifted to the NRHM in August 2005, were not doing well, for want of initiative and monitoring on the part of district health authorities.

JHARKHAND

In Jharkhand there has been special emphasis, and pressure, on FBOs (faith-based organisations) to participate in the District Health Planning meeting. There were only 3 NGOs and a large number of state officials. After the Planning FBOs have been sidelined; people from XLRI have been involved in the Planning process. The District Health Committee comprises largely of local Sangh parivar organisations, the FBOs that helped in forming policy do not figure in it. Health coupons are being distributed among the people, and they are being told to go private nursing homes/doctors. One private doctor has three different syringes, each corresponding to the denomination of the coupon! While there is a district order on sahiya [ASHA], the procedures regarding sahiya selection are not being followed. Sahiyas (ASHA) are being trained by the TATAs and few big NGOs. There is no interest about sahiya as she is not being paid (not very clear). PPP and health insurance are being pushed strongly. Private nursing homes and private practitioners are being assisted by the government to extend their services (how exactly is this happening?). There is

emphasis on institutional delivery, safe abortion and the 2-child norm, but no talk of safe delivery. The big investors in steel – Tatas and Mittal have promised investments in health in the state.

Civil society organisations were called for a meeting with concerned NRHM officials, to discuss about resource centres and training. The criteria for building and infrastructure were such that the specified facilities are available only with Tata. There is a move towards privatisation of diagnostic facilities (x-ray facilities in 16 district hospitals are non-functioning – all 16 are reported to have burnt down). However, this may turn out to be time-consuming process

MADHYA PRADESH

In MP a team has already been constituted for the Watch programme, and meetings have already been held on the NRHM.

There is a proposal to change the selection criteria for ASHA, and to convert anganwadi workers (AWW) into ASHA. The processes of selection and training have started. The target is that 40 per cent of the ASHAs should be selected (by when?). While the Centre guidelines allow some flexibility in the ASHA selection criteria, however it is not there at the state level. For instance: in one place there was insistence, even by the state health committee, on education upto class 5. District Health Committees have been formed in some places. A team of 5-6 Collectors has been constituted for the entire state. This team says that there is no information yet from the Centre, and there has been orientation or communication regarding the NRHM. Even the CMO-HO has no information. In some places awareness on NRHM is being sought to be created by combining it with AIDS slogan. (Circulation of posters by the state on worship of *Dhanwantari*). The overall situation in MP regarding the NRHM seems to be chaotic implementation needs to be watched. In MP, as in Rajasthan, actual implementation is proceeding as per instructions from Centre, funds are tied to the Centre's orders. This needs to be challenged.

RAJASTHAN

Acccording to the Centre Rajasthan is reported to be ahead in some NRHM activities; in some parts nearly 40 per cent of the ASHAs are reported to have been selected. As regards selection of ASHA, what is actually happening is that either the female member of the couples working in the Jan Mangal Programme, or the worker in the non-formal education programme is being selected as ASHA. The amount of Rs 10,000 has been given to the sub-centres, although no guidelines have been framed yet for their utilisation. While these activities have been initiated, the District Health Plans have not yet been drawn up; according to officials it will be done in due course (*plan baad me ban jayega*). A workshop on PPP was conducted in the state, for which local people were not invited. Parties like Apollo and Escorts were present and there was talk of connecting hospitals through telemedicine, while the situation is such that local health functionaries are not available in many places.

Civil society organisations feel that the implementation of the NRHM is taking place in an extremely mechanical manner. The spirit behind NRHM has not been grasped.

(*jis bhavna se bana hain, uska koi andaza nahin hain*). Civil society organisations have not yet been drawn into the process of implementation. The programme is being implemented as per instructions from the Centre (*Dilli se sab chal raha hain*); state-level initiative and activity is nil. According to state-level officials disbursement of funds is tied to implementation in the manner that the Centre wants, no matter what the documents say. There is also pressure to utilise funds quickly. So, in reality the programme is not being implemented by the state, but is taking place as per instructions from the Centre. The state health system officials view the NRHM as merely another way of getting funds. In short it is felt that the whole process of implementation is taking place in a very haphazard manner, the focus is on the end-product and no attention is being paid by the implementors to the processes by which such a programme should be implemented.

Civil society organisations have held a consultation on the NRHM, and it was felt that a radical transformation was needed to achieve the objectives laid out in the NRHM. They plan to initiate activities to evaluate and monitor the programme. One of these was to have a discussion on the NRHM at a meeting on Women's Health, to be held on 1st February at Jaipur. This meeting is being organised by Prayas, Rajasthan.

UTTARANCHAL

In Uttaranchal the ASHA component has been implemented and there is a lot of publicity. According to newspaper reports 28,000 ASHAs are to be trained. District Health Committees have not been formed. Actually there is no clarity regarding the programme. We have been working on health issues, but have not been included in any programme.

UTTAR PRADESH

In UP the process of implementation of the NRHM has yet to begin properly; there is not much enthusiasm for it. In october 2005 about 8 CMOs were called for NRHM training; not all of them participated. Talks with the 2 CMOs who went for the training indicate that there is no clarity and awareness among them. Some PHCs tried to initiate the process of selection of ASHAs – ANMs were asked by the PHC doctor to select ASHA, we were asked to give a list of candidates. In Azamgarh ASHA is being addressed as ASHA KIRAN, and the (mis)information circulating is that she will be paid Rs 2000. Application forms are being sold, and many people are filling up these forms and handing them over to the panchayat in the hope of being selected. There are no District level health committees, nor is there involvement of panchayats. We have been told by the Director, RCH programme, that there is no role envisaged for NGOs associated with education. No role has been assigned to NGOs in training of ASHAs. While nothing is very clear now, we suspect that a female member of the *pradhan's* family will be selected as ASHA.

The **afternoon session** began with a presentation of the objectives of the Rural Health Watch, the specific activities to be undertaken by it, and the way of going about these activities. It was pointed out that the Rural Health Watch could be viewed as the next step in the `Right to Health' campaign of the JSA, as a way of assessing whether or

not people are getting health services with the introduction and implementation of the NRHM. With respect to the study envisaged by the Watch to systematically collect information on, and assess the NRHM, it was pointed out that the study was not purely an academic study, but more a way of looking at the performance of rural public health system and analysing the issues arising out of implementation of the NRHM, in order to make NRHM more accountable, and to be able to intervene at the policy level.

Each of the tasks that had been identified to undertake the Watch activities, was then taken up for discussion.

1. **Formation of a National Core Group:** to co-ordinate the Watch activities, with support from the Watch Secretariat. Besides the Delhi based people, the following persons who have been involved in NRHM activities at the national level were identified to be part of the Core Group. The names suggested: Abhay Shukla, Abhijit, Ashok Khandelwal, Annie Raja, Dr. Dahiya, Narendra Gupta, Sebastian, Sundararaman, Thelma Narayan, Renu Khanna, Dr. O.P. Lathwal. The Core Group will formulate the methodology, design the guidelines and tools for the field survey. **Members of the National Core Group will also participate in the state-level workshops for the orientation of field investigators for the survey**. Those members of the core group who were present in the meeting have agreed to be available for training at the state level.
2. **States for Watch:** Rajasthan, UP, Himachal Pradesh, Bihar, MP, Jharkhand, Assam, and Chhattisgarh and Uttranchal were identified for intense watch activities. While these maybe the `intensive watch' states, it was suggested that watch can be initiated in non NRHM focus states depending on the interest of respective state JSA units. In such cases the tolls and formats can be used. However the financial requirement should be managed by the states. The possibility of initiating watch activities in Orissa should be checked with JSA state contact persons.
3. **State core groups:** Those state JSA units that were present have decided to convene a one-day meeting, mobilise other organisations and for a state level core group in their respective state, The state core group will have to identify state-level partners for the watch survey, collect policy documents at the state level, assist in organising the orientation and training workshop, conduct the survey, prepare state-level Report, disseminate the report and other developments relating to implementation of the NRHM.
4. **Sampling:**
   It was felt that the district be considered as the unit for monitoring and for sampling. The number of districts in each states will be decided according to ability of JSA partner organization to undertake the watch activity. The following numbers of districts and blocks have been put forward by the states where they can conduct the survey:
   Himachal Pradesh: 12 districts and 15blocks
   Rajasthan: 5 districts – 20 blocks
   Uttar Pradesh: 7+
   Madhya Pradesh: 14 districts – 14+ blocks
   Bihar: 15 districts
   Chhattisgarh: 7 districts

The 'watch' need to be clear about what is feasible, keeping in mind the requirements of the quality of information. Hence need to balance quantity (numbers) with quality). It was suggested that Watch should try to cover about 3 blocks in every district – which means 3 CHCs, 3 PHCs, 9 SCs, and 9 villages. There was concern that the watch should exercise caution in assessing SCs, as they are the most vulnerable structure in the rural health system, which is likely to be dumped as there already suggestions in this direction.

A presentation was made to update states about the financial resources available for the Rural Health Watch activity. The finances available to states are about Rs. 20000 for organizing state workshops and Rs. 3000 for state level report preparation.

9th January

The participants split up into three groups to discuss and draw up the specific format/guidelines for collecting information in the selected areas on: CHCs, PHCs, and ASHA-programme respectively.

The group that had looked at ASHA-programme presented a list of questions, looking at the selection, training and the actual work of ASHA, and addressed to the ASHA herself, to the village community, and to the ANM. In the ensuing discussion it emerged that how we viewed the ASHA was critical. It was felt that in the NRHM the ASHA is conceived of as an activist, whereas in practice she has to function as a service provider with some remuneration. JSA needed to be clear about how it viewed ASHA, and that it should emphasize the activist-component, where she can empower the community and can be supported by the panchayat. There was concern that **'Watch' should not emphasis monitoring ASHA service provision component and hauling her up for any deficiencies in her functioning**. It was pointed out that `should we be scrutinizing a poor village woman with little education for not providing services, and let the highly educated doctors at the CHC-PHC go free of their responsibilities?' Rather **the objective should be to look at the way in which the ASHA-programme was being implemented, and was progressing, and clearly the idea was not to target individual ASHAs**. **In this context it was important to look at whether or not she was getting support from other personnel and from the health institutions**.

The group that looked at the guidelines for survey of CHCs used the IPHS Proforma on CHCs to initiate the discussion. It was felt that it was too detailed and comprehensive a proforma, and it was neither feasible nor necessary for our purposes, to use it. They suggested modifications to the Proforma, and their check-list consisted of guidelines for observation of certain indicator CHC services and infrastructure, and for an interview/discussion with the staff, with patients, and with health committees.

The group that looked at guidelines for survey of PHCs and SCs also had the IPHS proforma for PHCs. They also felt that it was too lengthy and detailed, and it was not feasible for them to use it. They drew up a schedule that looks at PHC infrastructure, as well as provides for interview/discussion with the village people about the PHC, with PHC staff about their working conditions and infrastructure, with patients, and with PRI members.

In the **afternoon session** there was a brief discussion on how to monitor state **Finances & Budgets** related to state rural health mission– on how to read and understand state-level and zilla parishad budgets, and locate budgetary allocations for health and family welfare. In this context it was pointed out that it is possible to get very detailed expenditure items in state budgets.
An important issue that was brought to notice, which has implications for programmes like NRHM, was that the bulk of the money for Family Welfare –nearly 95 per cent – comes from the Centre. This is projected to remain at 75 per cent. In view of this control will remain with the Central Government. This may affect the desire of state governments to own and implement the programme.

As far as analysis of budgets was concerned, it was proposed that firstly, Ravi Duggal may circulate a note/manual on `How to Read and Understand Budgets', and secondly, state JSA units could send their respective state budgets (which usually are in the respective regional language) to the Secretariat, which would forward it to CEHAT for analysis.

CONCRETE TASKS AND TIME-FRAME

- *The preliminary state level meetings, to discuss the NRHM and the PRHW (Peoples' Rural Health Watch) and to form a state core group – preferably should be held by the 15th February 2006.*
- *The survey design and the checklist/tools are to be prepared by the National Core Group and circulated by the 15th February 2006.*
- *While the survey format and tools will be prepared in English the MP state unit will translate it into Hindi, to be subsequently adapted by the states for use in their area.*
- *The Action Alert document will also be translated into Hindi by the MP Group.*
- *The survey schedule will be centrally printed. Additional sheets, in case of modifications, can be attached by the state.*
- *The orientation and training workshops are to be held through the month of March.*
- *An amount of Rs 20,000 is available from the Watch for certain state-level activities, namely, for the state workshop, travel of state participants for state workshop and Rs. 3000 for preparation of Reports. The state units should send a budget for this amount along these heads.*
- *The sources for obtaining state-level policy documents are: the website of the state health ministry; the NGO-members of state health missions; directly contacting the state health ministry; the Watch Secretariat and National Core Group members can pass on documents that they collect or have access to; and use of Right to Information Act, if the need arises.*
- *A review meeting will be held in April after the workshops have been held in all the selected states.*

Annexure J

National meet of the All India Drugs Action Network Vellore

DATES: 26th January 2006
VENUE: Sneha Deepam Retreat Centre, Sathuvachari, Vellore-632009

The major discussion centred around the Draft National Pharma Policy 2006. the Government of India had put the draft policy on the website and open to public comments. Since the last date by which the comments had to be sent was already over by 24th of January therefore this was taken as a priority agenda to be completed. Anant Bhan compiled the draft comments circulated by net and it was put up for discussion and comments. There were two parts of the draft, one was the general comment and the other was the section wise comments sections as taken from the draft pharma policy 2006. some of the major concerns of the draft pharma policy on public health and accessing medicines by the poorer sections of the society was discussed and compiled. It took over eight hours of work to compile this as thorough work was done and everyone's opinion taken into consideration.

This was a good exposure for me as this showed that unless there is enough reflection of the people's perspective in the public policies the policies will only benefit a affluent section of the society and cause more harm than god to the real needy people. The draft pharma policy is a clear reflection of the government being blind to the real need of people. There are sections of the policy where there will be indirect effects on the lives of the poor who are continuously being deprived of their entitlements over their resources. The policy proposes to set up large pharma parks (obviously of the private sector) in large areas of land; the question raised by many of us was that where would such large areas of land come from? It seems obvious that to implement these parks there will some land required and people will be displaced from their homes and these will obviously be the people from the economical weakest sections of the society.

Later the organization reorganisation of AIDAN was done and there were new co convenors and joint convenors chosen. Further AIDAN opened its membership to new people.

Annexure K

31st Annual Meet of the medico friends circle (mfc)- Quality and Costs of Health Care: in the Context of the Goal of Universal Access
27th and 28th January 2006
VENUE: Sneha Deepam Retreat Centre, Sathuvachari, Vellore-632009

With the objective to critically examine the cost and quality aspects of the health care in India, in the context of the goal of 'health care for all' the two days workshop was a great learning experience for me both in terms of the contents and format. I have coordinated in compiling the report and by the end of the two days we were able to (with a team of nine reporters) make the draft report of 24 pages and hand it over to Sathyamala for finalisation.

There were very enriching presentations on both the days and there was a plenary at the end of each session. Issues related to quality assessment were presented and it was understood that the concept of quality was very market driven as the entire understanding of quality came from the industry. Further it was also examined as to what is the benchmark from quality assessment come? Does it come from a person's background or does it come from the expectations of the community and the economically weak. In a country like India ca we even talk of quality when the basic health facilities are not available to the poor 70% population?

When the cost and access of health care was talked about there were many experiences from across the country that was narrated. Instances from the rural surgeons of Sittilingi to the leprosy hospital in Bilaspur and the cross subsidization of CMC Vellore were discussed in length. The most significant expression of the meeting was that even though you cut down costs to the last extent there are people who cannot access health care!! This was also a great learning for me and the entire house was left with the thought of how to make accessing health care a reality for all.

There were various sessions on Oral Polio vaccine, Leprosy, National Rural Health Mission and each day would almost spill over to the next day. Though many sessions were technical the people around helped in understanding and demystifying te technical aspects. There was a great turn over of many young people from all over the country and all young people left the meeting with a loot of warmth, love and exposure to many new areas of knowledge in relation to the present context.

The fellows of CHC Bangalore also met briefly on oe of the evenings and caught up with each others lives.

Annual general body meet of medico friends circle

visit to Christian Medical College the Lowcost Unit and the CHAD unit at Bagayam