

**Second National People's Health Assembly
23-25 March 2007
Ravindra Bhawan
Bhopal (M.P.)**

Submitted to

**World Health Organisation
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Organized by

Jan Swasthya Abhiyan

National Secretariat

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&
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1.0 Background of JSA

1.1 Peoples Health Assembly (PHA) in Dhaka in 2000:

The Alma Ata Declaration of 1978, to which all governments of the world were signatories, promised "Health for All by 2000". However as the year 2000 approached it was clear that this promise had been, largely, forgotten by governments and international institutions around the world. To remind people of this forgotten commitment the First People's Health Assembly was organised in Savar, Bangladesh in December 2000. The People's Health Assembly was a coming together of people's movements and other non-government civil society organisations all over the world to reiterate the pledge for Health for all and to make governments take this promise seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organizations working to advance the people's health in the context of policies of globalization.

1.2 Pre-PHA Activities in India

Prior to the Assembly there was extensive mobilization all around the world. India witnessed the largest mobilisation, spread across almost 30,000 villages. More than 2000 organizations participated in this country-wide mobilization in about 300 districts in 20 states. The campaign was jointly led by 18 National Networks. This was the first time the country witnessed the coming together of so many diverse organizations and movements. Based on village and Primary Health Center level enquiries, many districts drew up local health priorities which were fed into district convention and state conventions.

1.3 National Health Assembly (NHA-I) In Calcutta in 2000

The final culmination of this nationwide process was the National Health Assembly (NHA-I) held in Kolkata on 1st December 2000. **More than 2300 delegates from all parts of the country traveled to Kolkata for the National Health Assembly in five People's Health Trains.** The National Health Assembly declared the major goals of the Indian People's Health Movement and demarcated the specific issues on which the People's Health Movement in India would concentrate. It **adopted a 20-point charter known as the Indian Peoples' Health Charter**, outlining a critical analysis of the Indian health scenario in the context of globalization. This charter provides a statement of the shared understanding and goals that unite all the organizations working as part of this network of networks. The assembly culminated in a 30,000 strong rally followed by a public meeting.

1.4. Formation of Jan Swasthya Abhiyan (JSA)

The national networks and organisations that had come together to organize the National Health Assembly, decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (People's Health Movement). **Jan Swasthya Abhiyan forms the Indian regional circle of the global People's Health Movement**, which was set up after the Peoples Health Assembly in Dhaka.

1.5 Jan Swasthya Abhiyan: Perspective and Objectives

The Jan Swasthya Abhiyan believes that despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

The JSA is of the opinion that these trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation – all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug policies as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.
- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.

The major objectives of the Jan Swasthya Abhiyan (set out in detail in the Peoples Health Charter – see **Annexure I**) are as below:

The Jan Swasthya Abhiyan aims to **draw public attention to the adverse impact of the policies of iniquitous globalisation** on the health of Indian people, especially on the health of the poor.

The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the ‘Health for All by 2000 A.D.’ pledge. The JSA seeks a **renewal of this commitment, with the slogan ‘Health for All - Now!’**. The JSA locates the campaign to achieve this in the campaign to establish the **Right to Health and Health Care as basic human rights**. The JSA also believes that Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with **Primary Health Care as a major strategy** for achieving these priorities.

The thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the **need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care**.

Top down, bureaucratic, fragmented techno-centric approaches to health care lead to considerable wastage of scarce resources and fail to impact significantly on the health situation. The Jan Swasthya Abhiyan feels that there is an urgent need to promote **decentralization of health care** and build up integrated, comprehensive and participatory approaches to health care that places **“Peoples Health in Peoples Hands”**.

The Jan Swasthya Abhiyan seeks **to network with all those interested in promoting peoples’ health**. It seeks to initiate and promote a wide variety of people’s initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems.

The Organisational Structure of Jan Swasthya Abhiyan is provided in Annexure II

1.6 Major Programmes and Campaigns of the Jan Swasthya Abhiyan

1.6.1. Areas of Interest and Themes

The over-arching concern of the Jan Swasthya Abhiyan is to ensure health and health care for every Indian. Jan Swasthya Abhiyan has within its wide range of members, a large number of resource persons, and activities in a number of thematic areas. The important areas are listed below:

1. Policy level interventions for Right to Health and Health Care
2. Primary Health Care and health systems that can provide access to health care services for the poor and the marginalised
3. Community Health Worker Programmes and Community Based Monitoring of Health services
4. Women’s Health issues and Reproductive health rights
5. Child Health and Malnutrition
6. Right to Food and investigation of hunger related deaths
7. Violence & Women’s Health
8. Sex determination and sex selective abortions
9. WTO, Intellectual property rights, patents and Drug policy
10. Medical Professional Reform and Regulation of medical practice
11. Privatisation of health services and the commercialisation of health care
12. Health care in conflict situations
13. Indigenous Medicine and Folk healing traditions
14. Rational Drugs and Diagnostics
15. Drinking Water, Sanitation, Environment & Health
16. Health among Displaced people, Adivasis and other marginalized sections
17. Population control programme and issues of Contraceptive choice
18. Trends in Medical and Vaccine Research
19. Control of Communicable Disease
20. Mental Health issues
21. Human Resource Development for Health Care
22. Tobacco Control for better health

1.6.2. Major Co-ordinated Campaigns of the JSA :

- 1 The participating organisations and networks in the JSA have their own independent activities. In addition, the JSA co-ordinates national or regional campaigns/activities that involve all or a major section of its constituents. Some of the major campaigns initiated and co-ordinated by the JSA are as follows:
- 2 People's Rural Health Watch (PRHW): The PRHW is an initiative to collect information on, assess and analyze the activities under the National Rural Health Mission (NRHM), both at the state and national levels; communicate and disseminate all such documentation and information through reports and other means; and provide feedback for improvement.
- 3 Right to Health Care Campaign: A nationwide campaign by Jan Swasthya Abhiyan to establish the Right to Health Care as a basic human right for every citizen in India. As part of this campaign Public Hearing on Denial of Health Care have been organised all over India in collaboration with the National Human Rights Commission.
- 4 Campaign against Sex Selective Abortions: In response to the Public Interest Litigation regarding Pre Natal Diagnostic Tests and Sex Selective Abortions filed in Supreme Court, JSA initiated a campaign related to constitution of appropriate authorities, registration of ultrasound centers, ban on advertisements, displaying posters in clinics and the issue of son preference. This campaign was taken up intensively in a number of states especially in Tamil Nadu, Haryana and Himachal Pradesh in the second half of 2001.
- 5 Hunger Watch: Jan Swasthya Abhiyan has set up a 'Hunger Watch' group consisting of public health and nutrition experts to provide assistance to the Right to Food Campaign. A JSA 'Hunger Watch' group has prepared a protocol to investigate cases of hunger-related or starvation deaths.
6. Involvement in the Right to Food Campaign: In several states, surveys have been conducted by JSA constituents on the status of mid-day meal and other schemes. In several states, a convention on 'Right to food - Right to health' have been organised. A resource material package in the form of a book "If even one person goes hungry...." was brought out by Tamil Nadu Science Forum and Bharat Gyan Vigyan Samiti for the Right to Food campaign and it has served to inform the public and keep the issue alive. There is a growing focus on 'Children's Right to Food' and Jan Swasthya Abhiyan has played a key role in the development of this campaign and issue within the overall campaign for the Right to Food.

Civil Society Facilitation in the Asian Region for the Commission on Social Determinants of Health: JSA has been identified as one of the two organisations in the Asian regions to facilitate civil society participation in the Commission on Social Determinants of Health, constituted by the WHO. Towards this end JSA has helped convened meetings in 10 countries of the region. JSA is in the process of facilitating Civil Society inputs into the Commission's final report.

1.6.3. Interventions by the JSA in major issues related to Public Health:

In addition to the major campaigns described above, JSA has intervened in several national policy issues and processes. Some of the key ones are listed below:

National Rural Health Mission: The recently launched National Rural Health Mission aims to fulfill the United Progressive Government's commitment to meet people's aspirations for better health and access to health care. The JSA is, however, of the opinion that the Mission must move beyond populist policy rhetoric and become part of a bold paradigm shift, from providing services through top down planning to building capacity and empowering communities to manage their own health care needs. The JSA is engaged in impacting on the development of the Mission's perspective and plan of action through dialogues with policy makers, participation in the Mission's Task Forces, and mobilisation of its constituents.

TRIPS and the Indian Patent Amendment Act: The TRIPS agreement required India to change to a Product Patent regime in the area of pharmaceuticals and food, from the earlier system provided in the Amendment of the Indian Patents Act of 1970 which did not provide for Product Patents in these areas. Such a move has many negative implications on people's ability to access essential medicines. The JSA has been an active partner in the campaign to pressure the government to make full use of the safeguards available in the TRIPS agreement to safeguard Public Health.

Initiatives related to Drug Policy: The JSA has been active in pursuing the development of a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance. The National Policy on Pharmaceuticals was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared. JSA participated in a public campaign concerning the Pharmaceutical Policy, that was initiated by one of its constituent organisations – the Federation of Medical Representatives Association of India (FMRAI). Many states have held discussions regarding an essential drug policy and to build public awareness on the impact of globalisation on the pharmaceutical sector

Tsunami Response: Many JSA constituents have been involved in the relief and rehabilitation work after the December 2004 Tsunami.

Initiatives related to Health Policy: The JSA has been involved in a number of critiques of government policies both at the state and at the national level. The JSA elaborated a detailed critique of the National Health Policy draft in 2001. The critique served to educate all the JSA member organisations on this development, and has been published in booklet form. A series of seminars and press releases explained this position to the general public. This detailed critique with alternative proposals was submitted to Health Ministry but unfortunately could not influence the policy in a significant manner.

Pre-Election Dialogue with Political Parties : Prior to the elections in April 2004, Jan Swasthya Abhiyan initiated a dialogue with political parties to encourage them to focus on the real concerns of the Indian people especially political initiatives in health care - most important of which was making health a fundamental right and increasing the budgetary allocation for public health. A discussion with the political parties along with the panelists was organised in Delhi followed by a rally demanding "Right to Health Care". Prior to the meeting a pamphlet and policy brief was circulated to the political parties addressing the various issues concerned.

1.7. Formation of organising committees

In the process of formation of organising committees, peoples from various organisations came to join hand. M.P. Jan Swasthya Abhiyan took initiative to conduct National Peoples Health Assembly. On first October 2006 a Meeting of MP Jan Swasthya Abhiyan was held, in which organising committee was formed. Those organisation who were pro-people , were committed toward health, and agree on the concept of "Health For All" became the part of NHA-2 organising committee.

Following is the list of NHA-2 organising committee:

Advisers

- | | | | |
|---|----------------------|---|---|
| 1 | Mr. Habeeb Tanveer | : | Renowned director and progressive stage artist. |
| 2 | Ms. Nusrat Bano Ruhi | : | National Executive Committee Member of NFIW. |
| 3 | Dr. B.K. Nilosey | : | President MPVHA. |
| 4 | Dr. D.D. Bhawalkar | : | Ex- Director, CAT Indore. |

Chair Person of the committee	Mr. S.C.Behar, President MPBGVS and Ex- Chief Secretary Govt. of M.P.
Convener	Dr. Ajay Kumar Khare, Convener MPJSA and Vice President, MPVS, Bhopal.

Following organisations where included in organising committee ;

- 1 All India Peoples Science Network
- 2 MPBGVS
- 3 MPVS
- 4 SATHI-CEHAT
- 5 MPVHA
- 6 AIDWA
- 7 Jan Sanghrsh Morch
- 8 IWID
- 9 Samta Mahila Samiti
- 10 Samavesh
- 11 Sangini
- 12 Ekta Parishad
- 13 NAWO
- 14 Eklavya
- 15 CHAI
- 16 CMAI
- 17 Bhopal Gas Peedit Sahyog Evm Sangharsh Samiti
- 18 MPMSRU
- 19 MFC

- 20 Bachpan
- 21 Shuruat
- 22 Vikas Samvad
- 23 Mahila Chetana Manch
- 24 Sambhavana Trust
- 25 Bhopal Gas Peedit Mahila Stationary Karmchari Sangh
- 26 Nirashrit Pention Bhogi Mahila Sangathan
- 27 CITU
- 28 AITUC
- 29 Gram Sudhar Samiti, Sidhi
- 30 Jan Adhikar Manch
- 31 Shilpi Kendra, Indore.
- 32 Sandarbh DastavejiKaran Kendra, Indore
- 33 Anupama Education Society, Satna
- 34 Jagran, Raisen
- 35 Janvadi Lekhak Sangh
- 36 Pragatisheel Lekhak Sangh
- 37 Toolika Samvad
- 38 Sanskritik Morcha
- 39 Aanganwadi Karyakarta evam Sahayika Union
- 40 Pushp Kalyan Kendra
- 41 Asha Nikatan, Bhopal
- 42 Asha Gram Trust, Badwani.

1.7.1 Formation of Core Group

To discuss and take decision on day-today activities of core group was formed comprising following members :

Mr. Sharad Chandra Behar, Dr. Ajay Kumar Khare, Ms. Asha Mishra, Mr. S.R. Azad, Ms. Sandhya Shailey, Mr. S.K. Ghosh, Mr. Abdul Jabbar, Mr. Rahul Sharma, Ms. Sadhana Kande, Mr. Anil Singh, Mr. Balkrishana Namdev, Ms. Sudeepa, Mr. Anil Sharma, Ms. Sudha Tiwari, Ms. Urwashi Kalra, Ms. Meeta Ujjain, Mr. Sati Nath Sarangi, Mr. Sant Kumar, Mr. Amulya Nidhi, Dr. Shailendra Patne, Mr. Haleem Khan.

1.7.2 Mobilization.

In the preparation of II National Peoples Assembly various preparatory meetings were held. In all the states district NHAI committee were formed. With involvement of state chapters of member organizations. Various programmes like district conferences, state assemblies were also organized. In following states state assemblies were held.

1. Bihar
2. Jharkhand
3. U.P.
4. Delhi
5. Rajasthan
6. Gujarat
7. Madhya Pradesh
8. Maharashtra
9. Chhattisgarh
10. Andhra Pradesh
11. Tamil Nadu
12. Karnataka

13. Orissa
14. Kerala
15. Himachal Pradesh

Various meetings of organising committee took place for mobilisation. On 5/12/06, 07/01/07, 11/02/07, and 11/03/07 organising committee meeting was held. In these meetings planning regarding delegates, volunteers mobilisation and participation in NHA-2 was discussed in detail.

National workshop was also held on 4-6 January 2007 at Bhopal for selection of material for Jan Samvad. Delegates from M.P., U.P., Bihar, Jharkhand, Uttaranchal, Delhi, Punjab, Rajasthan, Chattisgarh, Maharashtra, Tamilnadu, Orisa, and Andhra Pradesh, participated.

Following books were presented and discussed :

- 1 Globalization and Health.
- 2 Issues in women health
- 3 Campaign issue in Child health.
- 4 Health System in India, Challenges and Alternatives
- 5 Access to Essential Medicines.
- 6 New Terminologies in Public Health, Who Pays and Who Benefits.
- 7 Impact of the Global Trade Regime on Access to Medicine: a Case Study of HIV/AIDS Treatment Access.

Followed after national workshop state workshop was also organised on 27th and 28th February 07. In this workshop 119 delegates participated. In this workshop volunteers required identified and organisations promised to provide them. it was discussed that nearly 130 volunteers will be required.

1.7.3 State Convention for National Health Assembly

Date 27th –28th Feb 07

Venue :Gandhi Bhawan, Bhopal

Background

Madhya Pradesh Jan Swasthya Abhiyan planned to organize two days state convention. This convention was aimed to discuss various issues related to improvement of health conditions in Madhya Pradesh. Now a days in M.P. no. of patients with HIV/AIDS is also increasing. They are facing social exclusion, denial of treatment and difficulty in getting proper care. Important issues like maternal mortality rate, malnutrition among children, sex selective abortions, availability of drugs for HIV/AIDS patients, violence against women, report of national rural health watch and follow up of health denial cases presented in national human rights commission Jan Sunwai was also on the agenda. As Jan Swasthya Abhiyan have decided to organize 2nd National People Health Assembly on 23-25 March 2007 planning of the same was also done.

Report of State convention

The convention was organized on 27th and 28th April 2007. Dr.Prakash K.Deo, State representative, UNFPA M.P., Dr.Udai Jain, Ex. Vice Chancellor, Avdesh Prakash Singh University, Rewa, Ms. Nusrat Banoo Ruhi, National Executive Committee Member, National Federation of Indian Women have chaired the convention.

In her inaugural address Ms. Ruhi said due to globalization many necessary commitments of the government could not be done. Many activities like providing health, education could not reach to general public due to increased costs. Patent rules are forcing increased costs on our companies. Poor are afraid of going to private hospitals. Even for common diseases and long term diseases like diabetes or blood pressure is becoming difficult due to costly treatment. Health is a fundamental right and without health any person cannot enjoy life. It is necessary to give importance to health.

Dr. Prakash K Deo said I am from poor family of a small village so I understand difficulties and problems of village. It is common that government accuses private and vice versa for lack of health practices or difficulties. Due to globalization values are also changing. Attitude of society towards teachers or government servants have changed.

Improvement in maternal mortality rate (MMR) and immunization is due to health staff especially ANMs contribution. We need to have positive attitude. It is necessary to work collectively. In a village many more agencies are working, we need to have information regarding them and should work jointly. Role of NGO may be more in the sphere of healthy life. There is no dearth of money. National Rural Health Mission has so much money that it is not able to utilize it properly. We all shall join and work in the schemes where government is not able to perform better. Under NRHM state level plan is under preparation. Government agencies are for people's rights. If we all join then we can reduce IMR and MMR.

In his key address renowned theater personality Mr. Habib Tanveer that war and conflicts pose new difficult situations in the society. After II World war due to imbalance in sex ratio because of large number of deaths of young people Europe faced crisis of polygamy and prostitution.

There is wild spread corruption among doctors. They are acting as dacoits. Earlier they were respected but now corruption is main factor for admissions in Medical Colleges. Social inequality causes differences, injustice and corruption. This is not found in tribal communities. Now young people are earning lot of money. Advertisements are there lot of money is coming but we find that our youths are ruined. Large quantity of money coming to the youths pulling them towards alcoholism, self centered and crime. There is direct relationship between crime and poverty as well as economic disparity. Now a days Prime Minister, Finance Minister and Vice Chairman Planning Commission are looking at economic records, not looking at the dark side or poverty.

Tribal were illiterate but humanity was there which is still there. There is no sex selective abortions. They love son or daughter equal. Only rich hate girls, kill them even murder daughter in-laws. Media wants thrill so silent killing of unborn girls do not attract them. There is need of non government organizations and change public opinion. Corruption among elite class is high, which should be targeted.

Poor do this work. Development which kill humanity we do not need such developments. America is doing blood shed for petrol in Iraq.

Mr. Makrand Purohit from SATHI CEHAT Badwani presented his report on sex selected abortions. He said that in 14 districts of Madhya Pradesh Sex ratio is less than 900.

In the discussion Dr.Prakash Deo said we can informed competent authority for PNDA Act, for which Collector is appointed . Mrs. Arti Pandey said in the case of sex selective abortions it must be registered under rule 302 in place of 306. Ms.Ruhi said Act is O.k.but due to desire for son it is not effective.

Following recommendations have come out from discussion.

- a. List of Ultra sound clinic should be make public.
- b. Health facilities in the village should be improved.
- c. In the case of death of less than 1year girl verbal autopsy should be conducted.
- d. Doctor performing MTP should take family history of patient if it is after daughter it must be recorded.
- e. Other issues related to health need to be addressed.

Women health and its policy

Mrs. Sudeepa Das spoke on these issues and said that issues related to women should be included rather they are prisoners, commercial sex workers or employees. We find that on mental health only 0.1% is spend in relation to health budget while we see that women are mostly mentally, disturbed. In general violence against women is seeing only as domestic violence, eve teasing, molestation or rape. Violence should be an issue of health rights.

Vijay Raje Janani Suraksha Yojana is started only for 1 year and too by private institutions. Why need private hospitals rather government hospitals should be constructed. There is insurance for women if she dies after delivery. There is one case in Morena district in which she was murdered for want of money. Deen dayal chalit hospital yojana is for all . It need to be gender sensitive under Janani Suraksha Yojana for each delivery in govt. or recognized private hospitals mother will receive Rs.1400/- in rural area and Rs.1200 in urban area. Motivator will get Rs.600/- . Generally, this amount is not given at the time of delivery , it is given after very long time and some part of it not given.

Employment guarantee act cards should have facility like election, photocards. Under EGA there is contradiction also. Serious concern was raised for increased institutional delivery. We find that there is no increase in facility so how the deliveries are increased.

Mr.Raju Kumar BGVS has reported regarding maternal mortality rate . He said because mothers are not getting complete food and TDS shops are at quite distant so they are malnourished. Mr.Praveen from Jan Adikar Manch informed that MMR has some known responsible factors. Govt. has accepted 13000 deaths due to maternal mortality but in state assembly only 200 questions are out of 20000 questions. ANMs are not sitting in their centers.

Mrs. Nusrot Bano Ruhi said television advertisements are giving very bad image of women. They are not giving proper report of violence against women. Counseling center do not maintaining respect of womanhood. T.I s issue notification after bribe. Poor are worst sufferers. Without help of men women are not able to do many things. Divorce is also a kind of violence .

Recommendations

1. At EGA site there should be first aid box
2. Mobile health clinic by private should be stopped and PHC be upgraded.
3. Sexual harassment committee should be formed.
4. Monitoring of the act and schemes should be very strict.
5. We need to find the places of coercive family planning places.

Malnutrition among children

Mr.Sachin Jain from Swasth Samvad said when we linked malnutrition with continuous starvation or death. It is a political issue. It is surprising that at the one level there is increase in malnutrition while govt. is claiming of development. The population of under 6 years is 16% of the population but budget allocation is only 0.88% . For children below 5 years is only Anganwadi. This is only scheme which cater pregnant women and children. Up to last year there was allocation of Rs.1/- per day per children for 1.06 Cr. Children . There should be provision of Rs.312 Cr. But there is provision of only 85 lac Rs. 22 lac children are enrolled while only 11 lac children are getting food. Supreme Court has issued one order under which information regarding SC /SC is to be collected. There is increase in malnutrition in Badwani, Khargone , Sidhi and Sheopur.

Disability Rights

On Disability Rights Mr. Bijoy Kumar Swain from Asha gram trust informed regarding community mental health programme. He said there is 1% mental patients - 48 lacs.

5% common mental disorder 30 lacs. 3% mental disorder 18 lacs. In 2001 census there is no disability data . In Pati, 51% patients are in the age group 15-31 years. 25% of these cases are recovered from disease.

Recommendations

1. District mental health programme need to re revived.
2. Stop electric shock
3. Train Psychologist should be appointed at appropriate levels.
4. There is need to gave informations on mental health to judges and police.

Bhopal Gas Tragedy

28 Feb.2007

Mr.Purnedu Shukla member of monitoring committee setup by Supreme Court for treatment and rehabilitation plan of Bhopal gas tragedy expressed his concern regarding gas affected people. He said monitoring committee is visiting health institutions and held 36 meetings, recommendations are given to the government and Supreme Court . Majority of them are yet to realized.

During visit to Health institutions we found that in Dialysis unit there was no trained staff. Now training is provided so dialysis of patients is possible. Positive attitude of officers help a lot. Councilor is given duty in registration section. There is need of logistic support to the committee. DME list convener of the committee but he is not able to give proper time. Many times we need to do English typing from outside. Exclusive dedicated officials are required. Patients record is not kept properly. Due to which proper treatment is not possible. For the same disease he is getting treatment many times from different sources without providing information of earlier treatments. Due to

Rogi Kalyan Samiti there is increased involvement of Collector and Commissioner, they are affecting its functioning.

Pulmonary Medicine center was established in 1994. ICU and OT are not working yet. There are 45 machines which are not used till now. 25 machines are not opened from their packing. Committee is not satisfied with the quality and arrangement of medicine.

It is suggested to link with Medical College and Malakhedi hospital should be given to PSM Dept. of GMC Bhopal.

Mrs. Sadhana Karnik from Bhopal Gas Peedit Sangharsh Sahyog Samity said Bhopal Gas Peedit are worst sufferer of this disaster. Due to faulty categorization and without proper investigations very less compensation is fixed by the government for the victims. Many of the victims are still suffering while they are categorized in affected but no damage. There is emergency to focus on worst affected area. The toxic waste dumped in Union Carbide premises is reaching in to surrounding hand pumps and affecting lakhs of the persons. Responsibility should be fixed and it should be cleaned immediately with appropriate compensation to the affected.

Occupational disease

Mr.S.D.Verma said, It was reported that in Jhabua and Badwani district thousands of tribes are going for working in quartz factories in Dahod and adjoining districts of Gujarat. They are working in very hazardous environment. Survey conducted by us had shown that in 20 villages of Alirajpur block of Jhabua district 458 deaths are reported. 200 families surveyed and we found 266 persons of silicosis disease. In the family of Mrs.Idla Bai , 11 persons has died.

Recommendations.

1. Preventive equipments should be established in all the quartz factories and proper compensation of deaths and affected people should be given.
2. Life Insurance of quartz workers should be done
3. After certain period the should be full compensation to the workers.

HIV /AIDS drug related issue

Mr.Manish from Positive People Network Ujjain said people are afraid of HIV/AIDS . Please do not make horror of it. We are getting medicines only from Indore and Jabalpur. It should be available in other places. IN Indore they are usually recommending CD4 test which cost Rs.1500 . It is only done on Monday, Wednesday and Friday . Same test is done in Rs.250 in Choithram Hospital. There is need of Councilor . ORT is not available . It is necessary to strengthen govt. system in place of private hospitals .

Others express concern regarding exaggerated reporting of HIV/AIDS patient. They feel it is under politics to divert health budget towards non important disease. Why we are not talking of common diseases which are more dangerous and killing large number of patients. There is need to understand the social aspects of disease also. Social determinants should be improved even TB is causing more deaths than HIV/AIDS. There is need to watch dog the availability of medicine and blood bank .

There was discussion on NHRC review held earlier at Bhopal . 9 cases were reported in 2005 but till now only 3 cases joint inquiry could be done. Health staff is terrorizing the

cases and not giving treatment. 3 cases out of 9 reported had died. 1 family member was bitten by a dog but health officials refused to give treatment and they have to go Gujarat for it.

Schedule : 27th Feb 2007

S No.	Time	Program
1	10.30 to 11 AM	Registration
2	11 to 11.30 AM	Inauguration
3	11.30-11.45 AM	Tea
4	11.45 to 1.30 PM	Parallel Session a. MMR in State causes and suggestions to reduce it b. Sex Selective abortions, MTP act
5	1.30 to 2.30	Lunch
6	2.30 to 4 PM	Parallel Session a. Violence against, women Policies related to women b. Bhopal Gas Tragedy
7	4 to 4.15 PM	Tea
8	4.15 to 6 PM	Parallel Sessions a. Occupational hazards b. Malnutrition among children

28th Feb 2007

S No	Time	Program
1	10to 11.30 AM	NRHM Watch report
2	11.30 to 11.45 AM	Tea
3	11.45 to 1.30 PM	Parallel Session a. Trade related issues in HIV AIDS drugs b. Follow up of NHRC Jan Sunwai cases
4	1.30 to 2.15 PM	Lunch
5	2.15 to 3.00 PM	NHA2 program Participation
6	3.00 to 3.15PM	Tea
7	3.15 to 4.30PM	NHA2 Program participation
8	4.30 to 5 PM	Concluding program

Core group meeting was also constituted to facilitate the process. various district level Jan Samvad was conducted details are given below.

Sl.No.	District Name	Comments, Organised by
1.	Panna	Jan Adhikar Manch
2.	Satna	Anupama Education Society
3.	Sidhi	Gram Sudhar Samiti
4.	Harda	Samavesh
5.	Badwani	Sathi CEHAT
6.	Guna	MPBGVS
7.	Ratlam	MPBGVS
8.	Raisen	Divya Jyoti Sanstha
9.	Jabalpur	MPBGVS
10.	Seoni	Deep Jyoti Sanstha
11.	Chhindwara	Madhya Pradesh Vigyan Sabha

12.	Morena	Madhya Pradesh vigyan Sabha
13.	Indore	Sathi CEHAT
14.	Jhabua	MPBGVS
15.	Bhind	MPBGVS
16.	Rewa	Madhya Pradesh Vigyan Sabha
17.	Katni	MPBGVS
18.	Bhopal	CITU

Resource Mobilisation

To organise budget estimate was nearly 1.13 crores. large part of it was to be mobilised from local resources by participating organisations. Nearly 35 lakhs was to be mobilised from funding agencies.

Apart from funding agencies support contribution from delegates as registration, stalls booking and self organised workshops, was also thought to be resource mobilisation method.

By these ways we could raise nearly 38 lakhs rupees for NHA –2.

Sub Committees for NHA – 2

To perform all the function of NHA –2 in its best manner. A sub committee came into existence. This committee was responsible to look after arrangements at local level. Sub committee was consist to perform Ten major responsibilities like food, accommodation, transport, media & documentation, etc.

Following are the names of Sub-committees and their inchrge.

List of Sub-committees

For NHA-2 (Jan Swasthya Abhiyan)

S.N.	Name of Sub-Committees	Committee Members * Highlighted persons are Head of committees
01	Reception and Registration	*Shafique Rehmani, Johnson, Yaseen Khan, Mubina
02	Accommodation	*Mr Haleem Khan
03	Food	*Subhash Sharma, Mr. Haleem Khan
04	Transport	*Anil Dhiwan
05	Media and Documentation	*Rahul Sharma, Raju Kumar, Mita Ujjain
06	Exhibition and Decoration	*Manoj Kulkarni Ram Prakash Tripathi.
07	Cultural Programme	*Ram Prakash Tripathi, HaleemKhan, Santosh Koushik
08	Control Room	*S.R. Azad
09	Finance	*Ajay Khare, Asha Mishra
10	Stall	*Uma Shanker Sarma
11	Finance	Dr. Ajay Khare, Asha Mishra
12	Medical	Dr. Shoukat Alam,
13	Resource Person Coordination	Amulya Nidhi
14	Coordination with PHM	Mr. Pushan Bhattacharya
15.	Translation	Mr.Shyam Bohre

1.7.4 Support to other States

Organising committee not only organised National Peoples Health Assembly but also supported other states. Dr. Ajay Khare went to Ranchi and, Dr. Shailendra Patne to Jamshed Pur for Jharkhand workshops. Mr. Amulya Nidhi went to Patna and Dr. Ajay Khare to Jaipur for Rajasthan state workshops.

1.7.5 Material Produced

For the organisation of NHA-2, a range of leaflets, folder, wall paintings, posters, and invitations, were produced. Following books were prepared.

1. Globalization and Health.
2. Issues in women health
3. Campaign issue in Child health.
4. Health System in India, Challenges and Alternatives
5. Access to Essential Medicines.
6. New Terminologies in Public Health, Who Pays and Who Benefits.
7. Impact of the Global Trade Regime on Access to Medicine: a CaseStudy of HIV/AIDS Treatment Access.

Based on these books pamphlets on Globalization and Health, Issues in women health, Campaigns issues in child health and health systems in India : Challenges and alternatives prepared in Hindi. They are printed in large scale and used for discussion in various .

Second Peoples National Health Assembly

Venue : Ravindra Bhawan, Bhopal

Day - 1 : 23.03.07

2.0 Opening Plenary

2.1 Inauguration Session- Welcome

For the formal inauguration of NHA 2, all national organisers and network representatives of JSA, dignitaries present, speakers of the opening plenary session and the local organizers were called on stage.

The welcome address was given by Sharadchandra Behar (Chairperson, Organizing Committee).

- He said that with independence in India, people thought there would be a world / country where they matter.
- But the reality of our country today is that most don't have access to basic amenities like health.
- When it comes to the phenomenon of globalization most believe in the TINA(There is no alternative) philosophy.
- But we believe there are alternatives. NHA-2 is not just a congregation but some concrete direction towards a movement.
- JSA has had 7 years of experience since last NHA. (Kolkata 2000) Several issues have been taken up by JSA during this period like patents, social determinants, access, control of private sector. The need of the hour is to work together and fight for health for all.
- Globalization is a major threat and we need to unite to put up a fight against it. He then, thanked all the persons who had been involved in the organizing of the NHA 2.

In his inaugural speech Dr.Ekbal, Convener of JSA argued for a developmental process which is comprehensible to the participants of the process, and which at least informs them that how this process is going to help them. He again argued for a process which does not stand against the cohesion of society, which allows peaceful living of the people in the habitation they live in, so that at least they can continue working, if possible creatively. In an environment in which people do not understand that what is happening and why and how to relate to the happenings, not only lives and livelihood of the people but even the possibilities of sanity become scarce. He emphasized that if the multinational guided agenda succeeds, that implies, that the common sense of the people have been attached and vitiated. Thus the people movement for health is not just a movement directed towards economic aims, although it surely is such, it is as a matter of fact, a movement directed towards preservation of sense of reality. The struggle he said is not just defending this or that system, although it's surely is, as a matter of fact. It is in an effort to safeguard any cohesion and organization that we have, against the forces of disruption.

So he said the people's movement of health is a movement of preservation of common sense, of reason of those systems which have proven their effectiveness for decades, of social and cultural cohesion to the extent it is just.

Task he said is a gigantic task, and peoples movement for health has been able to give its humble contribution to the task.

Citing the history of Kerala Shashtra Sahitya Parishat, of which, he proudly said, that he is a member since its inception, he said that their organization has been able to respond to the times, it is been able to mediate between people's consciousness of their state and the modern developments. Today, he said that any one can see, that their organization has succeeded as the foremost defender of culture and of environment of people of Kerala and this too in a scientific manner. Kerala he said a state where every tree is identified by the people, every village prepares its own plan and every traditional remedy is given its due place.

Concluding his deliberations he said that 3 days are there during which premiere peoples organizations will discuss their agenda, in their own way, therefore it is not right to further speak on the details of the agenda.

After the inaugural programme cultural presentations by MPBGVS team was done. This was dedicated in the memory of Bhagat Singh and great poet Pash .

Testimonies

Industrial Genocide in Bhopal- Jameela- member of the Bhopal Gas Peedit Sangharsh Sahayog Samiti

Jameela Bee, representing the Bhopal Gas Peedit Sanghatan, told that the Bhopal gas victims are still waiting for justice, more than 20 years after the Bhopal gas tragedy that took on 2nd Dec. 1984. There was no proper diagnosis, as the doctors refused to acknowledge the level of toxicity and medical records were fudged.

The poisonous waste of the factory has not been destroyed even today. 25% of actual gas victims have not got their compensation. The Government is ignoring the victims and their problems. There was an out of court settlement in the case on this issue which was before the Supreme Court. The victims do not accept this out of court settlement. The ground water around the factory is getting poisonous, due to heavy chemical waste, and affecting the health of the people living around the factory.

- 1) Attitude of the relief agencies whose treatment of the victims is as if they are culprit and simultaneously the attitude of govt is towards malafying in the facts in the interest of Union Carbide.
- 2) Deficiency of standard treatment protocols and methods and unavailability of facilities.
- 3) Persistence of poisonous waste in the factory premises.
- 4) Improper medical check up and records
- 5) Poor compensation coverage to the most affected
- 6) People feel aggrieved by out of court settlement of the issue
- 7) Reluctance of M.P. government to address the grievances of victims

Her emphasis was on proper information about establishment of units to the people. Information regarding potential hazards, and punishment to the violators of law, and sensitivity in dealing with peoples grievances .

To arrive at a consensus in prioritization of issues, emphasis of many of the

organization was that there should be a four pronged approach to such problems.

- 1) Proper compensation which is important but should not be considered all. Proper recording and justice in distribution of compensations should be ensured.
- 2) Systematic treatment guideline, availability to facilities and proper referral system.
- 3) Punishment to the guilty
- 4) Sensitivity to the grievances of people .

Displacement caused by the Narmada project : Ms.Kamala Yadav, Member of the Narmada Bachao Andolan.

Kamla Yadav from Narmada Bachao Andolan began her testimony, by giving an account of the Narmada project and said that people are being displaced in the name of development, rehabilitation is not satisfactory, and there is improper management of compensation money. The government has a special programme for tribals but it helps in displacing tribals and destroying rich forests which are the source of their livelihood. If there is no water forest land, the world will not exist. Tribal people are facing problems of their livelihood as the forests are disappearing. There is no security of food and safe drinking water. Displacement has a further grave impact on women.

Many problems have been voiced.

- 1) Philosophical problem which on principal do not accept setting up of big hydel projects and argue that for small watershed development in equally viable and people friendly alternative.
- 2) Problems of justice
 - i) Equitable distribution of water and electricity between different areas.
 - ii) Just compensations for the lands procured from the people who have been ousted.
 - iii) Compensation for the loss of livelihood to the displaced
 - iv) Provision for the measures for safeguarding health of the people
 - v) Issue of resettlement of displaced people in a manner which is in closet approximation to the milieu of their traditional life.

Ms.Kamla Yadav's address highlighted personal experience of the displaced people from their own eyes . She raised following issues.

- a. Informed consent form the people who are going to be displaced
- b. Loss of natural habitat which snatched total peoples needs in respect to food, herbs, drinking water and housing.
- c. She reiterated importance of settling of rights over Jal, Jangal and zameen.
- d. Her main focus was on residence , water and food . If not in the traditional habitat than at least in a new habitat that is close to the traditional one.

Emotional pain and frustration could be marked in her deliberations, though she was determined for struggle for the right of livelihood . Issue was opened for discussion that how can the displaced people be provided with a milieu that is as close to their traditional milieu as possible.

Globalisation and its Impact on People's Lives – P. Sainath

New economic policies have curtailed investment in agriculture over the last 10 years (following green revolution) and therefore India is passing through era of agricultural crisis which unfortunately does not find place in our usual parlance.

Mr. P. Sainath, a renowned rural journalist – presented shocking facts of so called development in the era of Globalization. He said that Chikungunya contributed more to GDP than the India fashion week. He said – shining India is not a reality, economy is growing at a pace of 9 % but life expectancy is not increasing. Govt. is spending a big amount of money on HIV/AIDS promotion but is not bothered about 400,000 T.B. patients dying every year. Media and journalists are interested in health selectively, for instance detailed reporting on small diseases of celebrities like Amitabh Bachchan, but do not give sufficient coverage to other issues like farmers' suicides in Andhara and Vidarbha, deaths due to contaminated drinking water, lack of health care services, Malnutrition etc.

He recited an incident in Anantpur in Mallmada district where a farmer tried to commit suicide and his friends brought him to hospital and saved him. He abused his friends for saving him. He already had a debt of 1 lakh debt and this hospitalization had cost him of Rs. 49,000/-. He also quoted an example of the Government's mis-directed efforts in health. In Andhra Pradesh when Chandrababu Naidu was in power, a scheme was introduced whereby Government employees could take health care from corporate hospitals and they would be reimbursed later. The scheme was greatly misused and it cost the government lots of money. Everyone fell ill on same days. Apollo Hospital earned millions of rupees in the bargain. The Government is proposing to introduce Rural Medical Practitioners for providing health care to the rural poor, because doctors do not go to rural areas, these RMPs would then refer the patients to the corporate hospitals and they would be given an incentive for this.

He also spoke of the growing inequities in society, and the withdrawal of the state from sectors that matter for the poor. He spoke of slashing of subsidies, tax benefits for the rich at the cost of the poor, hijacking by multi-national bodies for corporate interests, opening up to the market sectors in which several people are vulnerable, undermining of democracy etc. He said that India is being perceived as a success story, only on economic terms. For instance, we rank among the countries with the highest number of billionaires in US dollars. The billionaires of this country are earning around money equivalent of 1% of GDP, more than the money allocated for health, which is 0.9% of GDP.

But we know that poverty has not reduced in the country. The catering industry has developed immensely after the 1990's, there are many more hotels, catering colleges, etc. But we know that hunger and malnutrition has also increased. Medical tourism has increased, but we know that access to health care has reduced. One in every four rural Indians and one in every five urban Indians, do not seek medical help at all because they can't afford it.

He then spoke about agriculture. He said that 4000 rural banks have been closed down in the last 10 years and the debt has doubled. The import duty on cotton has been drastically reduced, currently it is just 10%, and 6 months credit is also given for paying it. Due to this, more and more cotton is being imported and this greatly benefits the Mumbai textile industry. This translates into reduced demand for the domestic cotton produce, and so while cotton cloth may have become cheaper and more available for the customers, in

Vidharbha farmers are committing suicide. But instead of “understanding” this connection, the Government brought in a team of psychologists, psychiatrists, doctors etc. to Vidharba and they did “research” on the issue. This team went to several places and asked many questions to the farmers. In a village, an old man said to them – “You have asked us several questions, now ask us this – why we, farmers, who generate food, are hungry and starving?”

1. Health can not separated from our and all process of globalization
2. International agencies including world bank , UNICEF etc do not have any restricted national alliance they are actually busy promoting their only objective of promoting multinational agencies world wide.
3. Such agencies are penetrating culture by creating ultra modern idols in the people’s mind so that the economic growth of India can be harvested by selling their product .They are infecting culture and even distorting aesthetic sense.
4. Every fourth villagers and every fifth urban person can not afford minimum treatment facilities due to poverty.
5. New economic policies have curtailed investment in agriculture over the last 10 years (following green revolution) and therefore India is passing through era of agricultural crisis which unfortunately does not find place in our usual parlance.
6. The Govt investment has fallen from that of eighties by more than 30,000 Cr. rupees.
7. There is clear dual standards in America’s prescription for its farmers and for farmers of developing countries . E.g. American cotton Grovers get 100% . Subsidy while the cotton farmers of the Maharashtra had to give their cotton free to mill owners while their prices are paid after 6 months . These discriminate policies are worsening life of cotton growers, other cash farmers of the all areas of the world.
8. The issue of health is not only issue of medicines its also a issue of policies of govt and of big houses.
9. Globalization has affected the governments, has affected the media. It’s accompaniments have mystified science in a different shade, a case study of Chickanguniya serve as an example. Multinational agencies were just interested in selling its diagnostic kits . The media was making chickenguniya a big public health issue but its presentation did not educate people, it just created a sensation, the govt and health machines was busy saving its face. Knowing full well, that as yet there is little that we can do as a treatment Medical profession was busy earning profits. While people spent lots of their money in getting the prescription written.

Thus an elite mentality has been created which is not interested in ordinary heath issues of ordinary people. It is interested in elite health issues, sensational news , and all modes of face saving. This mentality does not allow even the identification of real health issues . It has not allow discussion on realistic solution of these health issues in a realistic manner.

10. Globalization has intensified disparities and social inequalities, It has subjugated any efforts at justice and marginalized real issues of the people . Sainath also emphasized on the fallacy of the allied parlance which has many times totally failed in its appreciation of peoples sufferings, needs and aspirations, as was reflected in the outcome of Lok Sabha elections. Such false presentation of reality (and a matter of fact, creation of false reality which we called environment) even leads to misgivings in the mind of real activist. People’s health movement and its alignment with the people gives it the responsibility to remove all veils

which surround the reality of health situations and to give went to it. As a living moment people's health movement can not prescribe ready made solutions to the problems, rather it addresses the issues in the people's consciousness as they go on arising one after other.

P. Sainath ended his session with the following striking statement :-***“What the mind does not know the eye cannot see. What the heart does not feel, the eye can never see.”***

2.2 Challenges in the Health Systems in the Era of Globalization Dr.Anant Phadke, SATHI – CEHAT, PUNE

Dr. Anand Phadke.s by profession a Doctor, speech was illuminating. He stood in defense of system of health care delivery which according to him were being attacked, eroded and pressurized in way which could jeopardize their very existence

Dr. Anant Phadke.s by profession a Doctor, speech was illuminating. He stood in defense of system of health care delivery which according to him were being attacked, eroded and pressurized in way which could jeopardize their very existence. All capitalist countries have their govt owned system of health care delivery while health facilities in private sector are regularized to a large extent and the expenditure that the people incur on these facilities is largely covered by insurance, not only that social security provisions there are sufficient to provide the people their basics minimum health needs while as a result of globalization and presence of market economy very existence of govt owned health system is jeopardized in India . He pointed out to the regulations in preparation which are likely to snatch away whatever primary or secondary level health service we have, he pointed out various ways by which multinational and big house investment in India put pressure on health system.

1. However, good quality teaching you provide, highly skilled professionals are invariably tapped by rich countries, and private medical establishments in India and as a result the professionals in Govt sector in India are as a matter of fact all the time prepared to leave for international and private sector.
2. Medical teaching and training does not prepare health manpower to take responsibilities in villages and otherwise deprived areas.
3. Multinational and private companies bribe and dump their elite products in govt. owned health system at the cost of essential medicines.
4. Though quality is needed but it is always wrongly defined, good understanding of common problem is not considered quality but rather handling of rare conditions is considered quality and as a mater of fact even medical teaching and is thus corrupted .
5. Though participation and private hands might be needed in certain situation in areas like provision of security, cleaning and maintenance etc. but this participation is once stretched to include areas which only help private investments in the health services like establishment of private investigations, private drug shops in govt premises etc .
6. Govt budgets or health services with being curtailed day by day. Impoverishing govt owned infrastructure which further reduce their public image.

7. Too much of intervention of the private companies are in the affairs of Govt owned health institutions like sponsorship of nearly all workshops, and conferences, use of govt institutions for conducting trials of private products, influencing leading doctors for promoting products of this or that company virtually has converted these institutions as testing grounds for private companies.
8. Apart from these too much pressure by the legislative , bureaucracy, and media in day to day affairs of Govt. Owned medical institutions too has made these institutions weak. Informed and constructive control by well meaning citizens bodies is one thing and uninformed pressure tactics adopted by vested interest is another he added.
9. Anant Phadke said that there are innumerable such practices which have crept into the everyday working of govt. owned health institutions of our country, which have eroded this system, weakened this system and have put this system in disrepute, so that finally whole system may crumble down as desired by vested interests. While in spite of all weaknesses this is the only system which is providing some relief to the common men.

He pointed out that it was only due to public pressure that the govt. could not table the acts in preparation to altogether eliminate primary and secondary level care. He asked for strengthening and streamlining the govt. owned health system in order that the common man can continue getting some relief. Thus he finally said it is not only true of the govt owned health system in India but is rather true of every system. Nearly in India whether they are NGO owned or otherwise, market interests simply don't want these to exist.

2.3 Report on People's Rural Health Watch Facilitator : Dr. Joe Varghese, CMAI

With the view to critically influence the National Rural Health Mission, JSA had decided in 2005 to initiate the People's Rural Health Watch that would monitor, assess and analyse the activities of the mission at state and national levels, providing feedback for further development of the mission. Over the last one year the people's rural health watch has been involved in collecting information about policies and evolving programmes with a focus on 8 states.

An interim report of the first year of activities was presented before the People's National Health Assembly in Bhopal. The report was presented by the national co-ordinating team Joe Varghese and Indira Chakravarthy along with presentations from four states including- Dr. C S Verma (UP), Mr. Dharmendra (Bihar), Mr. Amulya Nidhi (Madhya Pradesh) and Ms. Sulakshana (Chattisgarh).

The session began with a brief account of health scenario in India. Some striking features of the health system of India which denotes its present status were presented:

- Infant and child mortality snuffs out more than 20 lakh children every year
- Indian health system is one of the most privatised health systems in the world. 40% of hospitalised Indians are forced to borrow money or sell assets to cover the health expenses
- A vast majority of the population is at the mercy of private sector, which is unregulated, expensive and often known to take recourse to unethical practice

Other issues highlighted included;

- Historical development of government health services.
- The performance of the health services under the neo-liberal economic policy environments.
- The fact that the public health system remained a low priority in successive planning periods, even though the health care infrastructure found relatively larger attention during the 80's.
- These programs were externally planned and lacked political commitment, and thus led to the creation of infrastructure without the development of the system as a whole.
- It was noted that the state of the public health system further deteriorated under the neo-liberal economic policy.
- The budget squeeze was highlighted where the allocation fell from 1.05 % to 0.88% of the GDP.
- It was noted that not only was the health sector affected directly but the major determinants of health like water, sanitation and food supply were also affected.
- Presently this squeeze is reflected in the meagre supply of medicine and the freeze in new recruitments.
- Along with this came the introduction of strategies like user fees, public private partnership etc. which saw the gradual retreat of the government from the health system.
- It was also felt that the National Health Policy released in 2002 completely ignored the concept of Comprehensive Primary Health Care and instead seemed like an open invitation to the privatization of the health services.
- While the NRHM has many positive as well as encouraging aspects, there are other that seems like invitations to privatization and inspired by the neo-liberal paradigm. It was this specific concern that led the JSA to embark upon the People's Rural Health Watch.
- The People's Rural Health Watch was initiated in 8 states and included surveying rural government health facilities and interviewing the health workers, users and community leaders. It also included collection of information of policies and implementation of NRHM at various levels. Over 2000 people participated across the 8 states in these exercises.

Coming to some of the findings of the overall processes Joe mentioned that:

- Findings about ASHA program from the survey noted that the most of the ASHA's were selected without involving a proper community process. In most occasions it was the health system identified the ASHA. This raised a serious issues related to her accountability to the community and her ability to play the role of an activist.
- Analyzing the caste background of ASHA it was identified that only 15% of ASHA's belonging to SC community were selected as ASHAs. A few of them reported caste based discrimination while at work. One of them reported "Casteism and untouchability in villages causing problem. AWW does not allow me to sit inside the AW; does not even talk to me".
- While almost all the SCs surveyed had ANM posted, more than half of them had no one else posted. So the ANM had to function alone in her area. In others there was either a MPW or a link worker or an ASHA working with the ANM.
- In Bihar of the 1/3rd of the SCs surveyed reported no availability of medicines.
- Nearly half of all SCs surveyed reported erratic supply of medicines.
- The common problems reported are related to lack of proper building, water,

electricity, toilet, no proper supply of medicines and vaccines and lack of facility to conduct delivery, also problems to travel to isolated villages, lack of proper transport. Having to travel and stay alone has been raised as a problem by few of them.

Representatives from four states also presented the evolving NRHM programmes in the respective states.

C S Verma for UP: The main points of his presentation were:

- The polio-eradication drive was taking a poll on the implementation of the rural health mission in the state. He mentioned that the ASHAs were being over-used in the polio program.
- He noted the slow progress in the implementation of the program in UP.

Dharmendra from Bihar: The main points from his presentation were:

- There was an increased attempt to privatize the government health system under the cover of public private partnerships. To support this he provided a list of companies that have been short listed for the running of PHCs on contract. Specifically he pointed out that one of the companies was listed as a computer company from Patna.
- He pointed out that one of the multinationals assigned as an official consultant for the roll out of NRHM in Bihar was issued a show cause notice for their shoddy work in preparing district plans.

Sulakshana from Chattisgarh: The main points from her presentation were:

- Persistent non-availability of medicines and other supplies to rural health institutions. Many essential medicines including chloroquine were in short supply.
- However at the hamlet level the supply had improved with the distribution of drug kits to the mitanins.
- The health situation in Dantewada district because of government's anti-naxalite operations came up for a special reference. In over 500 villages of Usur, Bhairamgarh, Bijapur and Konta blocks of Dantewada district, no health service has been provided by the government for more than one and a half years.

Mr Amulya Nidhi from MP: The main points of his presentations were:

- JSA has conducted the Health watch survey in 15 districts of MP. These districts are Chhindwara, Seoni, Badwani, Bhind, Betul, Jhabua, Satna, Sidhi, Raisen, Sehore, Bhopal, Sehore, Mandala, Dindori, Balaghat.
- It was found that quality of training for ASHA was poor . In some places very large batches are trained together.
- Majority of the CHCs which are surveyed do not have facility for caesarian operation.
- Essential emergency drugs like rabies vaccine for dog bite and anti venom for snakebite were not available in rural health institutions.

- The survey also identified the loopholes in implementation of Janani Suraksha Yojana in the state.

Overall, the people rural health watch initiative has brought few major issues to the focus.

- In spite of the rhetoric of strengthening rural health services, large-scale attempts are being made to privatise the health system across states.
- Lot more need to happen to make rural health institutions to function to a minimal expected level.
- Concerns are being raised ASHA programme, where a strong trend is to make her the lower most functionary of the health system. This is contrary to the original design of ASHA where she is an activist representing the community and accountable to the community.

In general major problem relate to,

- 1) Continuation of dominance of population work in NRHM
- 2) Continuation of domination of disease like AIDS, and Polio in the programme at the expense of common problem
- 3) Deficiencies in medicines , supply, facilities specially labour room, sick child treatment facilities, life saving drugs.
- 4) Non participatory working practices in health functionaries which does not give due place and importance to ground level workers like ASHA
- 5) Lack of proper training support to the health functionaries
- 6) Lack of coordination between different sectors concerned with rural health.

2.4 Representatives from National Networks

The representatives of various national networks which are a part of the National Co-ordination Committee of JSA, spoke to the audience, speaking of their network's allegiance to JSA, and the key focus issues of JSA with which they identify.

Ajay Khare, representing the **All India People's Science Network**, said that the main focus of AIPSN is reaching science to people, in a manner in which they would be able to identify with it. With 500000 membership spread in 28 states AIPSN is network of 40 organisations. AIPSN is working with its full strength for defending health from the on slaught of globalization. We are fully supporting all activities of JSA.

Mira Shiva, member of **All India Drug Action Network**, addressed the audience, saying, that essential and life saving drugs should be made affordable for the poor people. She said that a Rational Drug Policy should be adopted and further said that provisions for free essential drugs should be implemented.

Fr. Augustine, representing **Catholic Health Association of India** was next to address the people. During his speech he said that CHAI, is committed to the goal of 'Health for All'. He said we have to work together to control the forces which cause ill-health and to ensure the availability of health care at reasonable rate. Therefore we should promote community health, with respect to human life and nurture it with full zeal. So, over the years CHAI has focused on doing efforts to

transform universal access to health into reality.

Mr. Vijay Arul Das, representing the **Christian Medical Association of India** (CMAI) said that their organization's objective is to build health society. He pointed out the need for integrating HIV/AIDS programme with the larger health programme. He emphasized on defending health care in the face of the impact of globalization.

Dr. Arun Gupta, member of Breast Feeding Promotion Network of India (BPNI) came and gave the speech on the importance of breast feeding and said that mothers should be encouraged to breast feed their children within an hour of birth. He said that under IMS Act ban had been put over advertisements endorsing and promoting canned milk.

Mr. Balaji Sampath of AID-India expressed his happiness and said that despite having many differences, all the health movements in India have one voice. We are working for priority on health, education and livelihood for all people in India.

Mr. Amitava Guha, representing the Federation of Medical Representatives Associations of India (FMRAI) said while addressing the audience that health right is our birth right and also said that his network would keep raising the questions related with the issue of medical industry.

Ms. Kumud Singh of the National Federation of Indian Women (NFIW) said that if we save the girl, we can save India. She raised the issue of unavailability of clean and fresh water and also highlighted on the need to address the problem of anemia prevailing in women.

Ms. Vandana Bharti of the National Alliance of People's Movements (NAPM) said that her organization is active in Maharashtra and believes in fighting for people's life.

Ms. Sonia Gill of All India Democratic Women's Association (AIDWA), said that from all the corners of country, there should be efforts to prevent discrimination against the girl child, as girls are equal to boys. All they need is the opportunity. She also drew people's attention to the tremendous fall in the sex ratio.

Dr. Vinod Raina, of Bharat Gyan Vigyan Samiti reiterated commitment of Bharat Gyan Vigyan Samiti towards people's health. He said that BGVS is having its network upto Panchayat and block level in many states. Its women wing SAMATA is working on health issues. Violence against women, sex selective abortion and involvement of Panchayats in health are our main area of activity. He gave best wishes for success of NHA2.

2.5 **Indian Women's Health Charter**

Manisha Gupte (MASUM, Maharashtra)

Manisha Gupte, while officially releasing the charter, said that the IWHM charter goes beyond mere reproductive health. It addresses several issues which affect women's lives, eg. sexuality, violence, livelihood, caste, inequity, discrimination.

Demands about women's health usually talk about heterosexual, married women and ignore other groups of women, like girls, adolescents, elderly women, single women, disabled women, transgenders, HIV+ve women, women facing traumatic situations etc. In this charter, we have made an attempt to include the demands of

all these women. We have made the process as inclusive as possible.

I think it was released in both Hindi and English, but need to confirm! The notes below taken by media student – I have doubts that a lot of this comes from the preamble of the charter itself. Somehow I was there and I don't think Manishatai spoke this m

While officially releasing the Indian Women's Health Charter, Manisha Gupte, said that this charter was a result of the efforts of over 2000 women and men. She said that in compiling women's perspectives on health rights and their related demands in the Indian Women's Health Charter, they had tried to squarely address the differences that exist between unequally placed women living in diverse situations in India. In this charter there is a deliberate attempt to infuse a spirit of inclusion of ALL women and a will to eliminate all forms of discrimination against them, particularly in matters of health and care. At the same time, the aim towards equality between men and women has remained.

She said that as the group was giving the final touches to the Charter about two weeks before releasing it in the NHA-II, they realized that the document was still not 'complete'. Even so they hoped that it will help various groups to incorporate women's health and development perspectives within their own advocacy discourses. Rights can only be expanded, and so she expressed the hope that the charter grows over the years, serving as a tool for campaigns and movements to enunciate and advocate for health related rights and demands.

She said that now was the time to ensure that the demands in the Charter truly become more than a wish- list! There is now a need to debate the aspects of the new and unfamiliar demands, to understand them and take them to heart. We need to push the Government to adopt these demands of women in letter and spirit within laws and policies. Likewise, we need to press the Government to ensure enabling conditions for all women in India to attain equal health as well as equal access to comprehensive health care services as part of their basic human rights. In pursuit of these goals, our connection with other movements is crucial.

Today (on International Women's Day), we dedicate this charter to all women living within India. With sadness we remember the women who have needlessly died from lack of health services or from poverty, neglect and violence. We raise our voices against these denials of health right as violation of women's human rights. In salute to all women survivors of individual and structural violence, we pledge to fight discrimination, oppression and marginalization and to move towards peace and justice

2.6 Parallel - 1 **Facilitators Jaya Velankar / Jashodhara**

2.6.1 Focus on Key Concerns **Strengthening and Reforming the Public Health System.**

In this session the first two speakers focused specifically on the public health services – focusing on how to strengthen them at the same time as bringing out reform, while the second two speakers spoke specifically of the Women's Right to Health including the coercive population policies, choice of contraceptives, and similar issues.

Ms. Shrimathi, the Health Minister of Kerala made the following points regarding the analysis of the situation at the field level and the possible solutions that were needed to overcome these problems.

Problems:

- Resurgence of some infectious diseases.
- Health problems of older women.
- Suicide and depression.
- Staff shortage – doctors, nurses etc. unfilled vacancies.
- BPL poor people compelled to use the private sector and forced to take loans.
- Essential medicines in short supply.
- Government not paying attention to government hospitals.

Steps:

- Decentralize to Panchayats and Municipal bodies, strengthen peoples participation.
- Upgradation of hospitals and CHCs.
- Improve public investment.
- Carry out health and sanitation campaigns under NRHM.
- Monitoring health services.

T. Sunderaman from SHRC in Chattisgarh made the following points:

Problems:

- Decline in public investment on health in 90's, weakening of public health system – even now 0.9% of GDP.
- Emphasis on high – tech services for elites and medical tourists.
- Routine immunisation is going down while pulse polio has hundreds of crores being spent on it.
- Drug prices are rising but no increase in medicine budgets for health centers and hospitals.
- Leakage of funds and inability to utilize and absorb resources.
- Primary health system geared to provide immunization and family planning services, is unable to handle comprehensive primary health needs of the people.
- Structure of governance.
- Human resource needs have not been fulfilled. Insufficient number of training institutions..
- The approach paper to 11th Plan suggests privatization as the only solution.

Way forward:

- Acknowledging the role of the public health system, as in NRHM.
- JSA needs to be a watch dog, both at community and policy level.
- Have to find alternatives to the privatization of services – better transfer and posting policies, doctors stay in groups and travel out to rural centers etc.
- Need to offer local girls of rural and tribal areas post – high school training on becoming nurse – practitioners in the remoter areas.
- Decentralization will work if we can build capacities in Panchayats and Municipalities to locally manage health systems.
- Since 80% people are going to the private sector, we have to get into public private partnerships – but equity should be the major consideration.

- Public investment in health MUST be increased considerably.
- Re-look at medical education and skill of doctors.
- This is particularly important to take care of needs like mental health / occupational health / disability etc. as part and parcel of comprehensive primary health care.

2.6.2 Women's Health Rights (Including Focus on Population Policy, Contraceptive Choice etc.)

Objective of the plenary was to discuss state of women's right in our country. During era of globalization women are subjugated to market. She is considered as commodity. Focus of policies is also common on only for reproductive role of women. Women should be considered as whole person not as systems. In many states there are policies which are using coercive measures to control the population. Latest e.g. is imposition of Panchayati Raj which mentions that after II nd child if Panch or Sarpanch become father/mother of third child than they will loose their post. Due to this Act there is increased number of abortions, divorces or allegations of having illicit relationship resulting the III rd birth.

Govt. schemes like Janani Surakhsha Yojana was also restricted up to second child. On third delivery benefit will only be given if she go for permanent sterilization.

Looking the vastness of the issues and affected 50 % of population this plenary was planned. Mrs. Sudha Sunderaman, General Secretary, AIDWA was main speaker and Mrs. Srimati, Health Minister, Kerala also came to gave her own observations and comments on this topic. Dr.Renu Khanna, Sahaj, Gujarat facilitated the session.

Mrs. Sudha Sunderaman said Health is an important sector to establish peoples rights and very important to identify why and what are the reasons behind the present pathetic situation of women's health. While India has signed declaration of Alma Ata which ensures health for all by 2000 AD. But we find that even at this time there is very high percentage of Anaemia and malnutrition among children and women. Indicators related to women health are very high. Malnutrition 33%, Anaemia 56%, Anaemia in pregnancy is 58%, Domestic violence 7.2%. At this time NMR is 301 per 1,00,000. Neo liberal globalization is linked to state policy of privatization. Poverty is very important and it plays role of the grim situation in India. At this time nearly 44.5% marriages are child marriages. Globalization is causing threat to livelihood which is resulting mental health problems to Dalits, Tribal and Women.

In her criticism to govt. she has raised following issues.

1. We are working towards empowerment of women with target audience
2. There is no one accountable for food facility, health or education facility as well as primary education.
3. Abortion
4. Menopause problem
5. Common vaccines
6. Adolescent care
7. Lack of privacy in medical institution because of lack of female doctor in

- the medical sector
- 8. Child marriage
- 9. Lack of proper transport medical facility as mentioned above , for all this there is no money and no policy to the government

Due to the changing scenario following trends are visible.

Misuse of modern technology and opportunities available in the market. MNCs are breaking the rules and trying to make every thing or creating a product / market place e.g Surrogate mother use to sell their womb in return of some money and there are such organization use to sell it to the rich and desired are willing to spent 25 times more money as a result make women right to gave a birth to child as a product in the market . 2500-3000 men and women are working for a consensus document. It is women health policy. 33% women are malnourished and 50-56% pregnant women are anaemic .We propose a nutrition mission and directorate towards target audience and their should be some indicator to make their figure down.. Poor urban ladies need immediate attention .

Mrs.Srimati (Minister of Health Kerala)

Mrs. Srimati is down to earth women activist. She is less known as Minister better known as women working for their rights. She gave gloomy picture of Kerala where infant mortality and crude health rate decreased in past years. She said this is because of strong public health system. Strong public distribution system also helped by maintaining food supply and reducing burden of market. Good infrastructure in education give added advantages. In spite of all these positive sides there are some challenges like

- (i) Communicable disease are coming back
- (ii) New form of diseases are appearing
- (iii) Tendency of suicides increasing
- (iv) 10% of population is of older people which is expected to be 20% up to 2025
- (v) There is shortage of medical staff, doctors in public (Govt.) hospitals are not interested in service. They used to leave the job and join private hospitals. To overcome the situation Government in Kerala decided to appoint qualified team of doctors and nurses.
- (vi) Transparent distribution system of medicine in form of corporation
- (vii) Upgraded women and children hospitals in districts and taluk
- (viii) Coordinated health plans through NRHM
- (ix) Massive health plans specially for Panchayat Nagarnigams, schools and other local bodies .
- (x) Universal health cover programme.

Dr.Renu Khanna, SAHAS, Gujarat started her speech from Human Women's Charter. Nearly 3000 women and men are involved in formation for this charter. This has important main issues. Current estimates suggests that around 30% of urban dwellers in India are poor. Health services of urban poor are as bad or worst as the rural population.

- 1) Malnutrition among women and adolescent girls : In our country nearly 35% women are malnourished . 52-58% women are anaemic during pregnancy . There is need to fight malnutrition like nutrition under this mission there should be some base line indicators.

2) Urban poor women are also suffering from many diseases. This has come as second main issue. As per statistics in comparison to 1961 those who came from villages to city 18% were suffering from health problem but now 2006 it is gone up to 28% . In a survey of 10 urban slums in Vadodara, Gujarat facts came out that these poor are forced to take treatment in private health centers in place of govt. health institutions because there is deficiency of equipments, staff and doctors. Nearly 36% deliveries are conducted at home, 33% in private hospitals, 7% in trust hospitals only 23% are in govt. hospitals. Cost of deliveries in Govt. hospitals is Rs.643/-, Private hospitals Rs.4040/- while home delivery costs Rs.450/-. If Caesarian operation is required in private costs Rs.13000 and Govt. 6750 /- on an average.

3) Older women health needs.

In 2003, there are nearly 60 m women above age of 60 which is expected to become 165 m in 2025. In 1940 average life span of our women was 31 now it has gone up to 65 years. Main requirement of older women are management of malnutrition, osteoporosis, depression, cancers. These need to be diagnosed early and so that proper care can be provided.

4) Women in mental institutions : Approximately 15% of women suffer from mental illness as comparison to men which is 11%. We know that mental health care is a very low priority and mental health institutions are in very bad situations. Mental hospitals are considered as custodian of mental ill patient rather giving treatment and care to them. Many times unwanted women are dumped in to these institutions. Most of the times there are severe violations of fundamental human rights.

Women's health rights should be seen as comprehensive health services available at primary level. It should be incorporated in village, districts health plans. These services should be affordable, accessible and of good quality. There is urgent need of community Obstetrics and gynae and more female health practitioners.

2.7 Parallel Session –2

Venue – Muktakash

2.7.1 Session on Regulating the Private Sector

**Facilitators : Dr.Mira Shiva, AIDAN,
Mr.S.Srinivasan (LOCOST)**

Duggal presented a document with authenticated data on private sector in India, specially, that in the rural areas.

The main data of the document relate to the size , the investment, a patient attendance and profitability of the sector. According to him the private sector in India an investment of Rs.1,30,000 Cr. in comparison to the Rs.32,000 investment in Govt sector. Thus it is more than 4 times in size and investment compare to the govt. sector. Only 20% of the people go to the govt. sector while 70% of the private sector and rest to the other sectors. Thus in case handling also the private sector is 3 ½ times in size compare to the govt. sector. Average charges per episode of illness charge in private sector amount to Rs.400-500.

That is equivalent to 5 days of the prevalent rate of minimum wages. According to him 9% patients are supposed to be catered by the PHC situated in 30000 population area. The real attendance in a PHC is 1/10 of this. Thus according to him the private sector is the main area catered in the need of care in illness. Thus it is evident in private sector is not at all concerned with the primary health care.

The private sector is irresponsible and totally unregularised . but leads to expropriation of the poor peoples money. The 40% of the in hospital patients are reported to have sold their assets including land for treatment purposes.

The private sector is now not only an urban phenomena it has its spread far and wide rural areas in all tahils and towns.

Similar observations were reported also by the groups presenting on planning and monitoring of national health mission , rural health watch, and in other areas. Dr.Anant Phatke reiterated the need for regularization of private sector in alien with Maharashtra state nursing home act which has meet provisions for informed consent , use of vernakulam in all documents given to the patients to make them intelligible. Among other things, Anant Phatke also appreciated the need for regularization of the rate for treatment . But according to him this was only possible with Doctors concern. Issue of consumer protection act and reimbursement cost for illnesses in govt. planning and insurance schemes also brought in.

2.8 Cultural Programmes

In the evening of 23rd March very emotional and attractive play on sacrifice of Bhagat Singh and other martyr was done. Name of the play was 'Gagan Damaya Bajyo' The play was directed by Mr.K.G.Trivedi. Delegates were thrilled and excited by looking the dedicated and great commitment of freedom fighters. It may be mentioned that 23rd March is martyr day of Bhagat Singh so this play was specially planned.

3.0 Day-2 : 24th March 2007

3.1 Parallel Session - 1 : Health and Larger Issue

Facilitator: Ms.Sulakshana Nandi (Adiwasi Vikas Samiti Chhattisgarh)

**Social Exclusions and Health Care; Empowering the Socially Excluded
Session during the NHA 2.**

Right to health care of marginalized groups including health rights of positive women

Overview on Social Exclusion

The overview on social exclusion was given by Annie Namala, a Dalit Rights Activist from the Indian Institute of Dalit Studies Research and Advocacy.

Some of the main points in her talk were:

- That there is an active process of discrimination. It is necessary to see in particular contexts who are the socially excluded communities. These groups face discrimination in all situations including when they approach the public health system.
- The system resorts to victim blaming in order to cover up its own inadequacies. Hence the groups have to go to private health providers.
- She highlighted that caste based discrimination operated in all dimensions of life including social and economic. Thus one cannot only talk about 'physical health' when addressing the health needs of Dalit communities – one has to address other issues like minimum wages etc.
- She mentioned that the first step in this process of addressing the issue was the recognition of such socially excluded groups. With this in mind one needs also to see the geographical location of the infrastructure – for eg. The ICDS centers in the SC and ST hamlets.
- The marginalized groups must be made part of the institutional infrastructure, the excluded groups need to be involved in implementation and monitoring. There need to be specific indicators for the involvement of excluded groups. Highlighting this she gave the example of the fact that there is very little representation from the marginalized groups among the ASHAs selected.

Disabled

Nita Patel from Gujrat who became paraplegic after the earthquake presented the issues of the disabled:She said that the disabled have regular health problems like fever etc. But their access to the public health system for treatment is extremely limited. Hospitals and other public infrastructure are physically not accessible to the disabled.

- More specifically treatment for specific problems like bed sores etc which are common for people with disability is not easily available at public health facilities.. Thus even in case of simple illness, the mortality is very high because of lack of treatment. This problem is much more severe among disabled women who face double marginalization.

- She mentioned that only about 8% of the disabled get any education. This further marginalizes them.
- There are problems of perception towards the disabled which manifests when others plan for the disabled. For example, in providing employment, the disabled are provided with training and work like sewing, embroidery which involves staying inside the house. The disabled can contribute as effectively even outside the home and in regular jobs.

Unorganised sector workers

Subhash Bhatnagar is a member of the National Campaign Committee of Unorganised sector workers.

- He said that 93% of labour is in the unorganized sector and they contribute to two thirds of the GDP. But this group is not provided with any health services.
- He demanded a law providing facilities and essential medicines to the unorganized labour.
- The Government should be under compulsion to provide social security out of their funds.

Salt pan workers

Sakina is a Salt pan and prawn worker from Madia taluka near the Rann of Kutch, an area which produces around 80% of India's salt.

- She complained that the basic health facilities are not available with non-availability of doctors and nurses. This has grave consequences for the health situation of these communities.
- She mentioned that there have been a large number of child deaths due to malaria.
- Specific illnesses due to saltwork also remain largely untreated.

Trans-genders

Revathi is a Hijra and Women's rights activist.

- She spoke about the widespread discrimination and harassment faced by the group. They get laughed at by society and called abusive names.
- She complained that there was no attempt by the government to address these issues instead they are a huge part of the problem.
- As homosexuality is illegal under the law, in order to prevent arrests, Hijras have to pay up to the police in form of money and sexual favours.
- They are subject to humiliation and abuse when they approach the public health system and no one is willing to treat them.
- This complex set of problems results in depression amongst most who then take to drugs.

Sex Workers

Mr. Manohar has been working with sexual minorities and sex workers. He talked of the health issues faced by the sex workers.

- BHe mentioned that they are totally left out of the public health system.

- Health workers don't go to them and hence any disease remains untreated.
- Their whole existence is criminalized hence they have to seek protection from the police. This puts them in a vulnerable situation and results in further harassment and abuse by the police.
- They continue to be left out of all mainstream movements. He demanded that issues of Sex workers be taken up by Human rights activists, women's and dalit groups.

People living with HIV and AIDS

Kaushalya is the President of the Positive Women's Network.

- She first questioned the way the mainstream movements integrate HIV in their issues. While most program have focused on prevention there is now an urgent need to focus on treatment
- One of the crucial lacunae is that there is very little information available to positive people regarding availability of facilities.
- It is essential to involve HIV patients in planning and implementation both in AIDS related programmes and also in the general development programmes.
- It was stressed that HIV and AIDS programmes should be comprehensive in nature and plan for prevention, treatment, care and support and rehabilitation.

Internally displaced communities

Rizwana is from Halol, Gujrat. She is a victim of the 2002 riots.

- After 2002 riots a large number of Muslim families fled from the villages to temporary colonies. Rizwana is currently living in temporary huts put up in a pond. But the Government does not recognize the settlement and many other such settlements.
- Therefor none of the basic services of water, electricity, health, ration cards are provided to them and no compensation have ever been paid to them.
- They are not able to return to their villages and they are continually harassed and threatened.
- They have become refugees in their own country without access to any services.

Mental health patients

Aparna Joshi is from Jan Manasik Arogya Abhiyan:

- She said that mental health has always been meted out a step sisterly treatment. Issues of mental health are always ignored even when talking of health. In development there is no talk of mental health.
- One of the crucial points is that mental health does not figure in any training on health.
- The public health system is totally unprepared to deal with the issue. There is a lot of discrimination against mental health patients. The patients are deprived of the basic human rights.
- The law does not allow them to vote and a marriage can be dissolved on the basis of their mental illness.
- The only model which is available in terms of treatment is a drug

dispensing model which is not enough. There is need for quality preventive services. Any model should necessarily involve participation of the users.

Tribal Groups

Lalita from the Adivasi Adhikar Samiti spoke of the issues of the tribals, especially those of the so called 'primitive tribal groups'.

- The tribals face severe issues of access to the public health system both because of geographical remoteness and because of discrimination. They live on hill tops where no health services reach. Instead of attempting to reach them, they are blamed for their situation and told to come down and live in the plains.
- There is chronic hunger among these groups but the government is not willing to accept this. Starvation deaths are written off by the government by saying that they had eaten rotten meat.
- Child mortality rates are very high. In one study amongst Pahari Korwa tribals of Chhattisgarh, 24 out of 28 mothers had at least one child dead.
- There is rampant malaria and TB rates are much higher than the rest of the population and the number of deaths due to these diseases is very high. The government again is not willing to accept this and hence they don't take any serious steps to prevent this.
- Instead of improving the health services and preventing loss of the tribal's livelihoods, the only way the government is trying to prevent 'extinction' of this group is to ban sterilization amongst the so called 'primitive tribal groups'. This is clearly a human rights violation.
- The tribal groups are now organizing themselves and demanding their rights.

Conclusion

Recommendations for the Alternative Peoples' Health Plan:

- The Plan has to recognize social exclusion, health status of these groups and their issues of access
- Planning has to be done around these socially excluded groups to ensure that their needs are adequately addressed
- The Groups have to be involved in the implementation of the Plan
- The Groups have to be involved in monitoring
- Adequate resource allocation has to be made to ensure the above

3.2 Parallel Session - 2

Ensuring rights to meet basic needs in the era of Globalization: Impact on Right to Food, water and safe environment.

Facilitator : Dr.Vandana Prasad (JSA, Delhi)

Ensuring safe water

Mr. Shripad Dharmadhikari of Manthan Adhayana Kendra, Badwani district, Madhya Pradesh spoke about the issue of safe water for the poorest people and privatization of water sources.

- He said that in the Era of Globalization and privatization, the water sector is under going tremendous change.
- So called reforms, going on in more than 15 states, are pushing the principles of full cost, recovery, elimination of subsidies, rapidly increasing tariffs, dismantling of community water systems and privatization in the

water sector.

- This is throwing lakhs of people out of orbit of the water sector, cutting off their access to water, not only for domestic use but also irrigation. This will have grave impacts on health, food security and employment.
- While speaking on the ideal model of water system, he said that decentralized water harvesting system for rural as well as urban areas and different models for different areas is needed. Finally there is a need for answerability to people for their water rights.

Ensuring the Right to Food

On the issue of Right to Food, Kavita Shrivastava, said That the right to food was inbuilt in the Right to Life which is guaranteed by the Indian Constitution.

- She said that the results of violation of these rights are instances of Malnutrition and anemia, which indicate the apathy of a welfare state towards its people and their basic needs.
- Further elaborating on the Right to Food, she quoted articles 21, 39, 47 (right to life, with dignity, right to education and health) of the Constitution and the order passed by the Supreme Court, explaining and asserting the right to food.

Some key issues which came up in the discussion are as follows:-

- The right to food campaign has to take on along with other organization the issue of finishing 'targeting of the poor. Abolishing the division of the poor in the name of APL and BPL, the Public Distribution System should be universalized and subsidised food should be available to all. She said that in so called developed states of Maharashtra and Gujrat, one on four women and children was found to be malnourished due to inadequate and imbalanced food.
- The National Rural Employment Guarantee Act, which promises 100 hours of work, should also be extended to urban areas, currently it is functional only in rural areas.
- No right to food discussion can happen without seriously taking into consideration, the issue of caste and untouchability. Discrimination in MDMS, ICDS and PDS have to be addressed.
- Accountability of the state towards enforcing the right to food is also central. Gram Sabhas are becoming the platform of accountability for the state.
- If the right to food is not realized, based on the Supreme Court order, one can approach any High Court to appeal in this matter.

3.3 Workshops

3.3.1 Tribal Health, National Health Assembly – 2, Bhopal Organised by Peoples Health Resource Network

For ages the tribals have been continuously neglected socially, economically and politically. Owing to their places of residence in hilly and forest fringed terrains, the access to the formal health system is very much limited for them. At places there are not enough facilities put by the government and there are

not enough human resources to provide the services at other places. Even if they get in to some of the government facilities they are ill-treated. That's why when the tribals get sick the only way remains is to go to the traditional healers or less qualified practitioners (RMPs/quacks). Most industrialization occurs in areas inhabited by the tribals. Since they are unaware (or not made aware deliberately by withholding information) of most government policies and plans, they get displaced easily due to mining, industrialization, irrigation and hydroelectric power projects, without reaping any benefits out of these developments. At places this so called development has brought in diseases like malaria in to some of these tribal communities. They are detached from their natural surroundings, consequently from their livelihoods and sources of food also. The benefits of the government health programs are hijacked before they reach them.

Recommendations:

- Sensitization of all service providers related to health and nutrition on the behavioral aspects of service delivery in the tribal areas
- Program designs to match with ethnical background and lore of specific communities based on formative studies and backed by some institutional arrangements
- Inclusion of ADIVASI network organizations and PRIs for social mobilization and participation
- Document herbal remedies practiced in the area and promote all those validated contents
- Build up an illness protection social security plan for all tribal families linked to the self help groups so that not only the treatment but the invisible costs are also taken care of.

**3. 3.2 Childrens Right to Food
Organised by CIRCUS / BPNI / CID / MPBGVS / Parhit Sanstha /
Foundation for Education**

Action for children under six

Background

- Almost 5,000 children under 5 years of age die every day in India.
- Three fourth of them die before they reach one year of age, and almost half, before they are 28 days old.
- As the recent NFHS survey data show, there has not been much improvement in the situation of children under six in the last eight years. India's performance has been especially poor in reducing malnutrition among young children, with 46% of children under-3 being underweight.
- For decades now, it has been recognised that malnutrition underlies more than 50% of deaths of under-5s. It has also been recognised for years now that malnutrition peaks between 8 and 18 months. More recent understanding however cautions that it starts even earlier, even before 6 months of age, when brain and organ development are taking place. Malnutrition at this age can cause irreversible changes.
- Studies have further shown that exclusive breastfeeding alone provides

the nutrition that meets all the infant's requirements from 0-6 months. It has also been shown that this is the only preventive and the best treatment for the major killers during the neonatal period – diarrhoea, pneumonia and sepsis.

- Recent studies have shown that starting breastfeeding within one hour of birth can help reduce the risk of neonatal mortality by almost a third. And that continued breastfeeding till 2 years of age, along with the introduction of suitable complementary feeding from the 7th month onwards, will reduce the risk of death.
- Policy and programs continue to ignore this important practice despite conclusive evidence of its suboptimal prevalence.
- The National Maternity Benefit Scheme (NMBS) partially addresses maternity entitlements and the nutritional requirements of pregnant women and breast-feeding children. However, this scheme is currently languishing in most parts of the country. Maternity entitlements need much more public attention as an important element of social security for the well being of women and children, and specifically for the food security of very young children.
- The ICDS was supposed to address the health, nutrition and pre-school needs of children below six. However, the coverage of ICDS is quite limited, and the quality of the programme is also quite poor. “Universalization with quality” is urgently required to protect the fundamental rights of children under the age of six. Currently only one third of India's 16 crore children in the 0-6 age group are covered under the supplementary nutrition component of ICDS.
- The coverage of settlements is also highly inadequate: there are about 7.8 lakh operational (about 10.5 sanctioned) anganwadis in the country, compared with an estimated 14 lakh required for universal coverage. An additional 3.5 lakh anganwadi centres must be sanctioned at the very least, and all sanctioned anganwadi centres must be immediately operationalised. The design of ICDS also needs radical improvement if the programme is to achieve its full potential, including the vital component of pre school education as well as effective services for children under three, including ensuring breastfeeding.
- Universalization of ICDS is a core demand – it is not only a core commitment of the Common Minimum Program but is also part of a Supreme Court order that call for universalization by December 2008.

The Integrated Child Development Services (ICDS) is supposed to address the health, nutrition and pre-school needs of children below the age of six. It is, in fact, the only government programme that addresses the rights and needs of this age group.

In this background, the workshop on ‘action for children under six’ was held to discuss ways in which public action can be carried out from the village level to the national level to ensure “universalisation with quality” of ICDS in a manner where starting from breastfeeding, children's right to nutrition is protected. The

workshop was divided into two sections – one presenting the macro and policy level situation and the other where field level experiences from Chhattisgarh, Andhra Pradesh, Madhya Pradesh and Gujarat towards improving ICDS were be shared.

Dr. Arun Gupta of the Breastfeeding Promotion Network of India made a presentation on the importance of breastfeeding for child survival and health.

- He highlighted the lack of focus in the the existing policies at the national and international levels for promotion of breastfeeding including laws such as the Infant Milk Substitutes Act.
- The lack of a separate budget head for breastfeeding and as a result the absence of effective strategies to ensure exclusive breastfeeding upto six months of age was discussed.
- He also talked about the maternity entitlements that are required if exclusive breastfeeding was to be made possible. In this the Tamil Nadu model of giving Rs. 1000 per month for every pregnant woman was seen as a positive development.
- It was felt that the ASHA under NRHM and the anganwadi worker should be trained on counselling and support for breastfeeding, with the ASHA being given incentives to ensure early initiation of breastfeeding.

Sachin Jain, Vikas Samwad, Bhopal presented the macro-situation of malnutrition and hunger among children in India and especially, in Madhya Pradesh.

- The results of the NFHS-3 were presented and also how the governments are not complying with the orders of the Supreme Court on Universalisation of ICDS.
- In Madhya Pradesh itself, thousands of anganwadi centres that were sanctioned two years back are yet to be operationalised. Issues related to improvement in the quality of ICDS were also discussed.

In the second half of the workshop there were presentations on grassroots experiences on ICDS. The following presentations were made – Sujan (Manav Adhikar Samiti, Madhya Pradesh), Samir Garg (Adivasi Adhikar Samiti, Chhattisgarh), Anand (M.V.Foundation, Andhra Pradesh), Shankaraiah (Gram Panchayat Sarpanch, Andhra Pradesh) and Mangu (Anna Adhikar Suraksha Abhiyan, Gujarat). All the presentations talked about mobilising the community for monitoring of anganwadi centres, including the role of women's groups, gram panchayats etc. Details of surveys conducted, meetings held, petitions submitted and the changes observed were shared.

The presentations were followed by a lengthy discussion with the participants on the way forward to ensure Universalisation of ICDS with quality. Some specific action points emerged:

- The Supreme Court order of December 2006 directing governments to set up 'anganwadis on demand' is a powerful one and must be used by all. A draft application form for such an anganwadi on demand in any hamlet where there are 40 children under the age of six was designed and shared with all. It was decided that such demands should be made wherever needed and also that a copy of the application should be marked to the

Commissioners of the Supreme Court on Right to Food. In case the governments do not respond by setting up anganwadis within three months of the demand, this could then be taken up at the Court.

- Some decisions were taken in the Convention on Children's Right to Food in Hyderabad such as conducting an anganwadi diwas, bal adhikar yatra etc. It was decided that this should be pursued.
- Signatures were collected on a banner demanding that the Supreme Court order on universalising ICDS be implemented.
- Issues related to convergence between NRHM and ICDS on malnutrition need to be looked into in greater detail. The Ministry of Health and Family Welfare and also movements on right to health cannot ignore the problem of child malnutrition.

Jean Dreze concluded the workshop by summarising the discussion. Due to lack of time not much time could be spent on discussing future action. It was decided that this discussion would be continued at the Right to Food Convention in Gaya in April 2007. It was seen that many of the participants were new to the issues related to children under six and were through this workshop introduced to the issues and campaign on ICDS.

Workshop Co-ordinators:

Dipa Sinha (Citizen's Initiative for Children Under Six)
Radha Holla (Breastfeeding Promotion Network of India):
Prem Ranjan and Narendra (Action Aid, Madhya Pradesh):

3.3.3 HIV/AIDS

Organised by Positive Women Network

Chair: Dr. B.Ekbal, National Convenor Jan Swasthya Abhiyan

Introductory Remarks

Inaugurating the workshop, Dr. Ekbal mentioned the adverse impact that HIV had on the country and the need for the Health Movement to proactively take up issues relating to it. He pointed out that there was a convergence of several issues such as Gender, Trade and Intellectual Property Rights, Access to Treatment, Health Systems, with regard to the HIV scenario. While JSA has been actively involved in many of these issues the dialogue and involvement of AIDS activists in the larger health movement was limited. This has changed and JSA is looking forward to an active involvement with AIDS activists. As a sign of this the first meeting with Aids activists was held in Chennai and today we are having this workshop to discuss issues pertinent to HIV/AIDS in the country.

Presentations

Journey of Women and Children living with HIV/AIDS in India (Kousalya.P, President Positive Women Network)

This presentation gave a brief overview of the AIDS movement in the country and then touched upon the current scenario. It then the pointed out the broad areas of concern such as;

- Continuing Stigma and Discrimination
- Lack of Information on Services that are available for People living with HIV.
- Health Rights and HIV: A Women's Perspective
- Special needs of Children living with HIV/AIDS.

Each of these points were then elaborate by the speakers who followed

Testimony on Stigma and Discrimination. (Swetha, Delhi)

Swetha shared her experience of how she came to know she was infected with HIV and the result problems she had to face. Even though she was from Madhya Pradesh she had to run away due to stigma and fear that she would be harmed due to her HIV status. Currently she is in Delhi and is working for women and Children who are infected like her. She also touched upon the adverse impact that stigma has on those who are infected and how it prevents them from accessing services due to fear of being identified.

Lack of Information and Services for Women and Children living with HIV. (Madhuri, Maharashtra)

Madhuri was a nurse working in a super specialty hospital when she was tested for HIV as part of the medical check up. When she tested positive she was called and informed that she had AIDS and that she would die in a few months. No information on her rights or the options available to her was given to her. Eventually she found this out through various sources and today works as an activist in Maharashtra. She wondered how if she who was a nurse did not get correct information, how much of information is reaching people who were poor and illiterate and especially those living in the rural areas.

Health Rights and HIV: A Women's Perspective. (Jaya R. Nair, Maharashtra)

The following issues were raised in this presentation

1. City centric approach in most services provided to People living with HIV/AIDS.
2. Need for health systems to be strengthened
3. Discrimination faced by Women living with HIV in the family
4. Economic burden which comes on the women after the death of her husband and the need for support systems to address this
5. Lack of services that are women friendly

Problems faced by Children living with HIV. (Testimony by Latha Tamilnadu.)

Latha a young girl from Tamilnadu has been on Anti retroviral therapy since she was a child. She shared her problems and experiences as a child who had to come to terms with taking lots of medicines everyday. She spoke about the problems she faced at school and the lack of pediatric dosages for children like her till recent past. She also pointed out that while ARVs are available today in certain Government Hospitals, without proper nutrition it is not of much use.

Mr Babul Kumar Adhikary (PHM, Bangladesh)

Mr Babul Kumar Adhikary from Bangladesh who was present then spoke briefly on the HIV scenario in his country. He mentioned that HIV was turning into a major public health problem. However the response was poor and that was worrying. He was happy to note the various interventions being done in India and would be taking back some of the learning's/success stories to be shared with his colleagues in Bangladesh.

Discussions

Discussant (Dr. Manisha Gupte, MASUM)

Dr. Manisha Gupte from MASUM began the discussion by pointing out how the epidemic was being feminized and more and more women were getting infected within marriage. In many places after the death of the husband from AIDS the family and relatives only plan on how to get rid of the women and children. Hence the woman is deprived of any social support and also has to bear the burden of providing for her children on her own. In many parts of India she pointed out that there are large numbers of widows who were being left behind as a result of HIV/AIDS. Dr. Gupte also brought out the importance of moving away from vertical programmes to a comprehensive approach to tackle this serious problem. Also it is important that more options and choices were provided for women if they are to effectively protect themselves from HIV.

Open discussion

Following this there was an open discussion for about 20 minutes during which many of those who were present raised several questions and issues. It was seen that many of those who were present were quite new to there was a lot of eagerness to know more about the issue.

Summing up by the moderator

Concluding the workshop Dr.Ekbal noted that many of the issues presented such as Strengthening of Health Systems, Rights of Women and Children, Access to Care were important areas of work for JSA. He was glad to note that Positive Women Network had participated in the National Health Assembly and this would be the starting point of a fruitful relationship between JSA and PWN.

3.3.4 PRI and Health

Organised by Hunger Project, Sri Lakshmi

Some of the main points that were raised during the workshop include:

- The role of the Panchayati Raj Institutions is crucial not only in making the health care services available but also in increasing accessibility and equity of the health services. This is especially so in the context of the ongoing debate on selective vs. comprehensive primary health care.
- The revolutionary Panchayati Raj Act of 1993 laid the foundation for the effective devolution of power to the people so that people now had more say in their course of development.
- The eleventh schedule (article 243 G) of the constitution devolved 29 subjects to the purview of the Panchayati Raj Institutions.

- Under these 29 subjects – Primary Health Care therefore is now under the jurisdiction of the PRIs. Thus PRIs can plan for the health of the people as not only the primary health care services are under them but also other services like drinking water, minor irrigation, forestry, public distribution etc.
- However the process of such devolution has remained largely on paper.
- Though the functions have been devolved the functionaries are still under the different line departments. There is thus an urgent need for the coordination between these various departments.
- Panchayati Raj representatives have largely become providers at the community level. They have not realized their potential of being community mobilizers and planners to the same extent of being providers.
- Their functioning so far has been seen as interference.
- The seven standing committees that are supposed to be constituted are rarely done and if so the people on them are usually not even aware.

Some of the challenges that lay ahead of us to make health an inclusive agenda:

- The functionaries of the line department have to also be part of the Panchayat Raj institutions.
- The PRI representatives have to be adequately sensitized to become the community mobilisers to go beyond being monitors of health functionaries.
- The PRI representatives have to be technically trained understand the different health indicators (like MMR,IMR, anemia etc) at the community level that they need to take care of.
- The larger aspects like food security and drinking water that directly affect the health of the people have to be seen as part of the health planning.

**3.3.5 Sex Selective Abortion
Organised by JSA-RAJ / AIDWA/ CMAI / MPVHA / HGVS**

The workshop started with Dr. Meera Shiva as the chairperson & Dr. Kalindi from AIDWA, Dr. Jo from CMAS, New Delhi, Mr. Rajiv Kumar From M.P. Voluntary Health Association, Mr. Tejram from Rajasthan, Ms. Kavita from PUCL, Ms. Sonia Gill from AIDWA Maharastra as eminent speaker on the dais. Around 150 participants from all over all India participated in the workshop.

Dr. Meera Shiva highlighted the objectives of the workshop to pinpoint the terrible situation of declining sex ratio or the increasing trend of sex selective abortion in almost every state of India. The objective of gathering is to come out with some sound steps or measures to handle the crucial situation.

Dr. Kalindi from AIDWA highlighted the fact that every female whether a girl or women faces discrimination in all walks of life but there most rigorous is the sex selective abortion.

Dr. Kalindi further discussed that census 1901 reveals that the population of women were decreasing. Later in the census report afterwards it was found that sex ratio is more declining in the age group of 0-6 years.

Though the sex ratio had shown declining trend in almost every state of India but the situation is more worst in H.P., A.P., U.P., Gujrat, Rajashthan & M.P. In this states the sex ratio is between 750-800, which is far below the national average of 922.

And if this trend will continue for some time then it will result in some major problems. There will lesser number of females to marry men thus resulting in trafficking/selling of women & sharing of women by many males at the same time.

In the year 1975, the process of “Amniocentesis” was discovered which is used for knowing the sex of the foetus. The first Amniocentesis center in India was established in Ludhiyana.

Dr. Kalindi said that when the Amniocentesis process came into being various voluntary organizations & women groups opposed it & the government was forced to frame PNDT Act. But then the science has made further progress & the ultra sound technology was invented & resulted in the failure of PNDT Act to a great extent. There are many barriers in the implementation of the PNDT Act. Mass breach of the Act by the doctors.

Dr. Kalindi at last but not least discussed the steps needed to take up by voluntary organization for fighting the vigorous issue is to

- Serious thinking on the issue.
- Mass campaign against sex selective abortion
- Legal awareness of the PNDT Act to the masses.
- Effective monitoring of the sonography centers.
- Ensuring research & right documentation

Dr. Meera narrated the jest of the points focused by Dr. Kalindi.

The issue of sex selective abortion was further taken up by Dr. Jo. He presented the analysis of the trends in sex ratio at birth of the hospital-based deliveries. He commented on the fact that sex ratio is still better in urban areas than the rural areas. His analysis shows that sex ratio is far better in case of educated & working mother in comparison to the illiterate mothers & housewives.

Dr. Jo clarified the fact the CMHO, under the PNDT Act has full right to take action without prior permission against the person & sonography centers denying the condition of the Act.

Mr. Rajeev Kumar from M.P. Voluntary Health Association further elaborated the discussion left by Dr. Jo. He discussed the seriousness of the declining trends of declining sex ratio in M.P. & the major reasons behind practicing sex selective abortion.

He reflected everybody's attention to the question “WHY & WHO?” Why sex selective abortion & who is responsible for it? Is it a mother who was forced to kill the fetus in her womb? He also opposed the so-called social customs

responsible for female foeticide. He further raised the question to everybody that why no rituals having been performed on the death of fetus? Why we all become the silent views.

He further clarified the objectives behind raising all these questions to sensitize every one to stop sex selective abortion. He also discussed the situation of M.P, with regard to the sex selective abortion. The first case under the PNDT Act in Madhya Pradesh was registered in Shivpuri. Recently four foetus was found in the sink in Bhind district.

Dr. Meera in her brief note on the questions raised by Dr. Rajeev said that though the mother are not the criminal to kill her fetus but she is still helpless.

Mr. Tejram discussed the versatility of the issue with special reference to the situation in Rajasthan. Female foeticide & infanticide is very common in Rajasthan.

He also shared his experiences of the collaborative efforts to deal with the culprits of the PNDT act. 64 doctors were caught red-handed practicing female foeticide. Rally & mass protest was organized to ban all these clinics practicing foeticide.

He also reveal the fact that in Rajasthan an additional amount of Rs. 5 lakhs were allotted to the MLAs of declining sex ratio constituencies for awareness campaign.

He also emphasized that a board should be formed including the representatives of the government, NGOs,, women groups etc to review the PNDT Act.

Mrs. Kavita also elaborated the heights of challenges on the issue. It is the high time to fatten our efforts to put an end to female foeticide. District wise data for all licensed sonography centers should be taken up under the RTI Act. Regular audits should be done to all sonography centers by the state Medical Council & the public meetings should be made more transparent.

Ms Sonia Gill shared about the situation of Maharashtra. The census 1991& 2001 shows the rapid decline in the sex ratio. The trends in Maharashtra shows that sex ratio is more rapidly declining in the district place or the urban areas where there is easy availability of ultra sound centers.

Representative from H.P. B.G.B.S at the end put stress on the fact that more legal awareness is needed to handle the situation.

He depicted the 10 major causes of female foeticide as the 10 heads of 'Ravan'.

Awareness campaigns for the PNDT Act should be done through the training of PRIs.

Dr. Meera Shiva concluded the opinions of all eminent speaker's on the dais. She said that there is need to bring more legal awareness & to change the outlook of the masses & to become more sensitive to the issue.

3.3.6 Mental Health

Organised by CEHAT / BASIC NEEDS / BAPU Trust (Kamyani)

The workshop group on Mental health had a fruitful discussion on integrating mental health into the alternative health plan. Salient points are given herein. We propose that a detailed review of the health plan from a mental health perspective will be submitted to the JSA NCC by 24th April 2007. The Maharashtra JSA/JMAA charter of demands can be referred to for specific points of integration into the alternative health charter.

- Mental health should be integrated into the people's alternative health plan at every step. Mental health is a concern for everybody and should not be treated from a purely disease perspective.
- There is a need to advocate and develop comprehensive, rights focussed state level and national level mental health policies. There must be Greater budgetary provisions, especially for community care, and rational utilizations of budgets.
- Greater participation by users, communities and all stake holders at all levels of mental health planning, implementation, and monitoring.
- Mental health is a developmental issue, not just relating to health. It should be linked to all sectors of development, including disability, economics, law, food and security, housing, poverty, employment, education, women's empowerment, and other.
- The mental health services should move away from curative to preventive and promotional; from hospital based care to community based / de-centralised approaches; from bio-medical services to a whole range of psychosocial and other non-drug based interventions.
- The vertical and expert driven community mental health care model (DMHP) of "identification, early treatment, drug treatment and referral" must be challenged. An alternative model including non-drug, psychosocial services at the door step must be provided.
- Edit language in the alternative health plan charter: Reference to "mentally challenged" (e.g. p.31, second paragraph) "disadvantaged", etc. must be removed. The correct nomenclature (Persons with psychosocial disabilities) must be used when reference is made to mentally ill people.
- Research, documentation and information relating to mental health, distress, illness as well as services must be collected in a systematic and sensitive manner, across all groups, capturing diversity of needs.
- The mental health strategies should be based on social determinants and life cycle approaches, and an interdisciplinary approach should be adopted. The connection and vicious circle between social vulnerability and mental distress should be recognized.
- There must be a greater number as well as diversity of services and service providers in mental health care, and adequate training facilities must be created.

- There must be mechanisms of regular monitoring of human rights violations concerning persons with psychosocial disabilities in all sites (family, community and mental health services, including hospitals, all custodial institutions). Laws must be reviews for positive assertion of rights of persons with psychosocial disabilities.
- Persons with psychosocial disabilities must be beneficiaries under all laws, policies and programs under the Disability sector.

3. 3.7 Environmental and Occupational Health Organised by CHC Bangalore

Introduction

Rakhal welcomed all the participants, as well as the four groups participating as coorganizers and presenters. Commenting on the Democracy Now video being screened just before the commencement of the workshop, Rakhal noted that while it seemingly was disconnected with the topic of the workshop, in reality the roots of the problem of today's situation in environmental and occupational health clearly rest with corporate led globalization, which was the topic of the video

It is important to understand that today's scenario of environmental degradation and weakening of worker rights and occupational health is clearly linked to the corporate led globalization, increasing greed based consumption, and loss of control of communities over natural resources. This is leading to an increased vulnerability of communities dependent directly on the natural resources for their lives and livelihood – this includes the poor and marginalized communities in all countries

Today's scenario is characterised by 4 phenomena:

- Communities that are weak and marginalized, due to the erosion of livelihoods and direct impacts on health of the degraded environment and working conditions.
- Increasing corporate power that is leading to a complementary weakening of the state – especially in terms of its powers of regulation and taking the side of the worker – both in the formal as well as in the informal sector.
- A medical fraternity that is ignorant of the issues.
- An academic and scientific community that ignores the issue.

Rakhal also mentioned that one of the main objectives of the workshop was to mainstream the issues into the agenda of the Jan Swasthya Abhiyan.

He requested the speakers that while sharing their experiences and struggles, they should also try and distill out the main learnings and action points, so that people coming from all over could go back with a sense of the possibilities and various strategies. He also pointed out that the main points that were raised at this workshop would also feed into the evolving People's Health Plan.

PRESENTATION 1
CHINTAN – DELHI'S INFORMAL RECYCLING SECTOR

- The presenter gave information on the number of people involved in this waste picking trade and its various levels.
- He mentioned the fact that while there was very little or no segregation at the home level, nearly 15 – 59% of segregation of waste produced was segregated by the informal sector. This translated into a daily saving of nearly Rs. 6 lakhs daily.
- He also showed through a map of the area covered by an individual waste picker. One of the important points highlighted was that the waste-pickers actually sorted the waste in the dump sites itself.
- Moreover most of the waste-pickers were children and women of child bearing age.
- He then shared the findings of a health survey done on a group of children waste pickers. The survey findings showed a high morbidity among the children with widespread anemia and a shocking prevalence of children who had actually handled mercury.
- Nearly 6% of children were also addicted to charas and smack.

He then shared some of the main fears that the waste pickers faced:

- Despite the fact that their livelihoods depended on the dumps – they really had no security as they had no rights over the waste, neither was there any legal recognition. This led to no basic amenities as well as the absence of social security.
- All these problems were being compounded by the recent moves to privatize the whole waste disposal sector.

While describing the work of Chintan

- He highlighted the provision of identity cards to all waste pickers.
- Andsensitization of the police and policy makers

Both these have led to a reduced harassment of the waste pickers.

He also called for support / lobbying for the inclusion of the recognition of the informal sector in the newly introduced Municipal Solid Waste Rules.

After this Anees a waste picker from Delhi shared his experience of the harassment by the police, the living and livelihood conditions as well as the way in which working with Chintan has helped him and many others.

During the discussion some of the participants wanted to know about the interaction between Chintan and the police, about the health facilities for the waste pickers, and about the hazard of medical waste being mixed with municipal waste for the waste pickers and the role of science and technology in reducing the hazards.

PRESENTATION : 2

PEOPLE'S TRAINING AND RESEARCH CENTRE – STRATEGIES FOR PREVENTING SILICOSIS IN THE GEMS AND JEWELLERY INDUSTRY

Jagdish Bhai who has been working on silicosis for many years made the presentation.

- He started by explaining that the people getting affected by silicosis is not limited to only those working in the industry, but includes children of the workers as well as people living in the neighbourhood.
- With regard to the impact of silicosis he mentioned the effect of the death of the male member on the family, apart from the destitution and risk, other effects included the bonded nature of many of the workers, the impact of such work on the people of the neighbourhood, alcoholism and the high cost of treatment – which is eventually more symptomatic than curative.
- While describing the early strategies of attempting to reduce dust exposure by exhaust systems etc.
- He pointed out that while the various strategies were aimed at increasing awareness about a particular intervention, there was a failure to organize the workers and make them own the process, and there was no element of direct welfare to the workers. He felt that these two were important reasons for all the efforts to translate into very limited gains.
- He also reported on the international level advocacy that they undertook with groups of affected workers from different parts of the world. The network also attempted to raise the issue by trying to block the participation of the merchants at international fairs etc.

Learning from the limited impacts of the earlier strategies, more recently the People's Training and Research Centre started a new program, but this time actively including a component of welfare as well as support to the affected families. Such programs included:

- Day care centres,
- Child Activity centres,
- Respiratory physiotherapy,
- Working with widows and
- Organizing and advocacy.

Despite the project and various efforts, the project has seen limited impact especially in the introduction of cheaper machines / interventions that will reduce dust. Moreover there seemed limited scope for litigation and representation from among the various stakeholders.

He mentioned that now the Center had decided to continue with the present work, but in addition also work on the sensitization of various government departments, promoting alternate employment, facilitating compensations and insurance as well as lobbying with the Export Promotion Council of India.

PRESENTATION - 3
JSA DELHI – SILICOSIS - THE LAL KUAN CASE

There was another presentation by Yashpal from Delhi on silicosis. He explained the process of the work with people living in Lal Kuan area of Delhi. Here many persons were living with chronic respiratory illness, however they were all being treated for Tuberculosis till a detailed medical examination was arranged and it was discovered that it was infact silicosis. Once the appropriate diagnosis was made there is now a struggle for compensation and rehabilitation.

PRESENTATION - 4
SAKHI – MINING

The stark reality of mining in the Bellary district of Karnataka was highlighted. Apart from this findings of a study on mental health of miners were shared. And the little recognized mental health affects were highlighted.

Recommendations of the Workshop

- It is very important as a strategic point that in every movement / program / intervention aimed at improving occupational health we need to work actively with the various arms of the state. This work will include awareness building, lobbying for appropriate policy and sensitization regarding the plight of the people working etc.
- One of the most important components of our work towards better and better environmental and occupational health is the organization of labour.
- Program limited to mere awareness building without cognizance of the complex set of problems the worker / pollution impacted communities face very rarely succeed. Programs need to be comprehensive, and directly meet some of the 'welfare' needs of the community before one can develop any sense of community ownership.
- It is very important to move towards increasing community ownership of the process right from the beginning.
- All our advocacy needs to be research based.
- We urge the government to ratify section 155 of the ILO charter.
- We would like to make the plea that given the seriousness of the situation, the amount of impact on the health of the people and the urgent need for action, that environment and occupational health be made core issues in JSA's work.

3. 3.8 Gujarat Public Health Act
Organised by JSA Gujarat at NHA-II

The workshop was conducted to disseminate and discuss the draft Gujarat public health act and to get feedback from public health experts to strengthen the Act. The draft Act was sent to the panelists few days in advance so that they could go through it in detail.

To begin with, rationale, process of formulating the Act and its broad contents were shared after which the three experts gave their suggestions to make the Act more effective.

Panelists' observations

Manisha Gupte

- She welcomed such an Act and appreciated the effort put in drafting it.
- However she raised concerns about the implementation of the Act. She said that sometimes best can be the enemy of good and the government might refuse to implement it on the pretext that it is too vast to be implemented.
- She was especially concerned as the government in question is the same that committed extreme violation of people's rights in the 2002 communal riots in the State.
- One of her suggestions was to have a one-window crisis centre in hospitals to help women who have experienced violence either at home or elsewhere. Such a facility would help women deal with not only their physical injury but also provide the necessary emotional and legal support.
- With respect to mother to child transmission of HIV, she observed that ARVs are given only so long as the woman delivers which protects the newborn child but the mother is again left unattended after the delivery. Therefore the Act should recognise a woman's right to health care and free medication including ARV as an individual in her own right and not just as a mother.
- She raised a question whether every pregnant woman who is HIV positive should be given ARVs even if her CD4 count had not fallen just as a precaution to protect the child.
- She also suggested that health care facilities be made accessible to people with disabilities.
- She said that physical and mental disabilities are very related to poverty and pregnancy and necessary steps should be taken to prevent disability.
- Finally the question of budgetary allocation was raised as there is no mention of it in the Act. In the absence of adequate and timely funds the implementation of the Act could be in jeopardy despite the best of intentions.

Mr. Narendra Gupta

- He appreciated the effort saying it's a historical step.
- Though NRHM talks of the concept of a public health act but no State has as yet initiated it. He observed that the Act would ensure cheap, effective and easily accessible services to prevent people from falling sick as well as provide treatment in case of sickness.
- A suggestion was to include a prescription audit system to check the medicines and diagnostic tests being advised to the patients so that unnecessary expenditure and exposure to invasive procedures/ radiations can be avoided.
- In the section on 'registration of private establishment', he said that the statement 'supervisor should be qualified' was not clear as it could mean that the other staff could be unqualified.
- Regarding committees – it was felt that a village level committee would be better, that the committees should meet monthly rather than once in three months, Anganwadi worker or the ASHA could be the member secretary of

these committees and do the record keeping.

- He observed that decentralisation has not been clearly spelt out in the Act. Public health service providers are very caught up in centralised procedures and have little administrative and financial powers.
- Field based providers like ANMs, medical officers can be authorised administrative powers along with untied funds that now they are getting as part of NRHM so that they can take decisions according to local and immediate needs of the community.

Thelma Narayan

- According to her the Act should have a public health perspective, particularly to reduce inequalities.
- An evidence gathering mechanism can be established, which need not be totally quantitative, to analyse whether the provisions of the Act are reducing inequalities.
- She emphasised upon the need to address the social determinants of health and suggested that the work being done by the WHO's commission on social determinants of health be referred in drafting the Act.
- She said that strong community based monitoring and surveillance systems are needed to ensure that the Act is implemented in its true spirit.
- Quality assurance at different levels of care should be ensured.
- The Act should integrate the urban municipal bodies with the health department, which is not happening right now and therefore there is no coordination between the two.
- She stressed upon the need for adequate funds which should be made available at the right time.
- She felt that the biggest challenge in the implementation of the Act would be training the staff, changing their mindset and getting them to understand the Act and their role in its implementation.
- Finally she said that regular review and assessment of how the provisions of the Act are actually being carried out would be very crucial without overlooking its shortcomings and failures.

Discussion

- One of the delegates suggested that the existing Acts be incorporated in the Gujarat Public Health Act. For instance there is Waste Management Act whose provisions can be included in the Act without having to write that section again.
- He said that operational definitions should be clear like what is meant by 'adequate space', 'recognised service providers'.
- While AYUSH practitioners are recognised service providers as per the

government regulations but CHWs and ASHAs are not recognised providers.

- He informed that the Central government is about to put up a legislation to the Cabinet with respect to regulating the private sector. All private clinical establishments, diagnostic centres, laboratories, day-care centres would fall under the purview of that legislation. He said that it is very difficult for a legislation to decide the cost of services for an entire state or country as there are no uniform standard treatment guidelines. Therefore making it mandatory for each facility to put up its charges openly would be more feasible and useful.

3.3.9 Micronutrients Organised by JSA

Resource person : Dr.Veena Shatrughna (Biraj Patnaik could not reach on time as his train was delayed and Dr Yogesh could not make it from Jan Swasthya Sahyog) Attended by about 20 persons Facilitated by Dr Vandana Prasad and Dr Venna Shatrughna spoke for about an hour and a half to establish certain facts regarding malnutrition and micronutrient deficiencies. She used data from NHIS and NMBS to illustrate these points. Some of the points she emphasized were as follows:

1. There is a large calorie gap in the diets of poor children and adults at all ages
2. Most of the calories poor and malnourished people are able to achieve is through carbohydrates (cereals) alone
3. In particular, there is a huge deficiency of protein and fats in their diet
4. Not all supplementary programmes also only add carbohydrates as supplements rather than proteins and fats.
5. This is quite against the principles of balanced diets and probably done as a result of the notion that SNPs are more charity than a genuine attempt to solve malnutrition
6. There is a huge (according to her, upper caste) propagation of the myth that Indians are culturally non-vegetarian and this is untrue.
7. The addition of foods of non-vegetarian origin such as milk, eggs, meat and fish, could do a lot not just to fill the calorie gap but also the micronutrient gap.
8. Children should be getting 40% of their calories through fat yet this is currently at a dismal 5%.
9. The main deficiencies in micronutrients are to do with iron and Vitamin A.
10. Iron absorption from vegetables is highly enhanced by the addition of just a little non-vegetarian component to the food, such as a small bit of meat added to dal or vegetables, like a stew.
11. Iron supplements can actually harm the intestinal lining in persons who are malnourished and predispose them to further malabsorption and diarrhea.

Zinc deficiency was only discussed during the question-answer session. Dr Shatrughna said that existing research needed to be examined carefully for the so-called beneficial effects of zinc, even in cutting down the duration of diarrhea. She explained that the benefits being shown were of reducing duration of diarrhea by a few hours only, and wondered whether that was worth the costs and side effects incurred at the same time. She also felt that there was a risk that the emphasis on zinc could set back the use of ORS even further.

It was decided that the research on zinc and iron needs to be shared and

analysed further from the public health perspective and that a follow meeting would be organized by jsa on these issues.

To include all micro-nutrients in our daily diet, it is essential to be a non vegetarian. This was the message which Veena Shatrugna, Deputy Director, National Institute of Nutrition imparted while giving her presentation on this issue.

She said that weight and height are important indicators of health of a child, and for proper increase in both these, it is essential to have a nutritious diet. Daily diet should include eggs, milk, moong dal and other nutrients. These three are important sources of proteins. We should not ignore either gender when it comes to balanced and nutritious food. Through milk necessary amount of zinc is received by the body. Consumption of non-vegetarian food gives zinc, iron and calcium to the body.

3. 3.10 The Mirage of Polio Eradication in India'. Facilitator : Indira Chakravarthy

Presentation on Poliomyelitis were done in the following manner :-

- Epidemiology by Dr. Rajib Das Gupta
- Economics of Polio by Indira
- Critique of the polio eradication programme by Anant Phadke
- Campaign against polio by Satyamala.
- Polio was initially a disease of cold countries.
- It was later spread in the tropical countries like India, Pakistan etc.
- The Pulse Polio campaign, also known as the mass vaccination or vertical programme, started in the 1940's. In India, Uttar Pradesh and Bihar are the worst affected areas.
- It can be seen that Polio is reported in bulk, i.e. a lot of cases, after every three years. This phenomenon has been a trend in India.
- The main reason for polio in India is the unhygienic conditions that most people live in. They don't have proper sanitation, access to clean drinking water, education etc., all these factors make polio even more severe in India.
- However, despite this, there is no emphasis on hygiene, health, diet, or avoiding intramuscular injections during monsoon season etc., in the entire pulse polio programme.
- Intramuscular injections often lead to paralysis in a person already afflicted with polio, and hence should be avoided especially in monsoon for young children.
- Transmission of polio virus is high in rainy season, at least 5 folds higher risk than any other season.
- Cases of polio are reported in children after the age of 2-3 years. At this age they are not fed on mother's milk, which builds antibodies to fight polio virus.

Detection of polio is not easy. There are 4 clinical types of polio - asymptomatic, aseptic meningitis, minor non CNS illness, paralytic (1% - 2% of the total cases).

Once the polio virus enters the body, it affects the nervous system. Its effect can be seen after 2-3 days. Polio virus can even cause death of the child, which is not highlighted in mass vaccination. The goal to eradicate polio from earth till 2000 has not been achieved, for the following reasons:-

- Oral polio drops are not 100% effective.
- 100% protection can be achieved only after 7 polio drops.
- On an average 12-13 polio drops are inhaled by the child till age of 5 years.
- OPU is considered incompatible with polio free world.
- Injectable polio vaccines are much expensive about 100 times the oral drops.
- 80% of Polio cases have no symptoms,
- 4-8% complain of vomiting, while 1-2% complain of laziness. Only 0.5% suffer from paralysis.
- It is believed that polio virus only infects children, but the fact is that even adults can be infected by polio. Polio is a serious problem but other epidemic diseases like TB etc cause more death.

With regards to the funding

- The total expenditure on pulse polio around world has been US \$ 4.5 billion, till date.
- Supplementary vaccination has been imposed in India and other third world countries by WHO. In the initial stages of pulse polio Indian govt. received some grant to cover the costs for polio vaccination. But today about 46% of the total costs incurred on the polio eradication campaigns is incurred by the Government.
- While America's host governments and communities have contributed about 80% of total eradication costs for polio, now, since the polio campaign has not achieved its target, thus all of the major funders are withdrawing. This creates funding gap for 2007-08.

The Critique

- Polio eradication is not possible with vaccination because at least 5-7 doses of OPV is required to each and every child throughout the world.
- It needs very high degree of awareness among people. It needs high enthusiasm, integrity among health staff.
- Society should be free from social conflicts.
- And it requires strict compliance with cold chain requirements.
- OPV is much less effective in tropical countries. Even after repeated doses of OPV, every vaccinated child will not necessarily develop immunity.
- Sabin virus vaccine reverts back to virulent virus within a month. This can cause Vaccine Associated Paralytic Polio (VAPP).
- OPV can be compared to a mechanism which on the one hand provides a mask to protect from pollution, but which on the other hand simultaneously also adds the pollution.
- Polio in India, breaks out every three to four years despite the campaigns.

Steep rise in AFP cases have been reported. It has been claimed by the govt, that this rise is due to increased sensitivity of their surveillance system. But the data from UP shows something else - in 2005, out of 10,264 cases of AFP, 209 were polio or compatible with polio. Out of the remaining 10,055 only 2553 cases were followed up of this 217 died and 898 i.e. 39% out of 2326, had residual paralysis. This shows actual rise in paralytic cases.

3.3.11 Health of the Urban poor Organised People's Health Resource Network

Urban poor includes daily wage labourers, domestic helpers, small service providers, drivers, beggars etc. Some of them work in factories or are even government employees at lower scale with wages that barely meet their needs. Most of them are migrants who have come from rural areas to cities in search of employment opportunities.

Dr. Chander, speaking at the workshop on Urban health, spoke at length about the Jawaharlal Nehru Urban Renewal Mission,

- He opined that the JNURM was a futile and unsuccessful programme.
- The 7 year plan, which started in 2005 with 60 cities, is said to be for urban poor, yet there are no policies for these sections within the scheme.
- No fixed criteria for identifying the poor have been defined yet. In this scheme, 35% of the funds will be given by the Central Government, 15% funds would be given by the state governments and 50% would be contributed by the Municipal Corporations, but the Corporations have no source to get the funds.
- Important factors like education, health, employment are totally neglected. The implementation of the Mission lays down the condition that user fees would be charged for any service being provided, and this will make the service out of the reach of the poor.
- There are more of investor friendly schemes rather than people-friendly health plan.
- Quoting a study done on people living in the Resettlement Colonies in Delhi, he said that within the poor, there are three distinct categories of very poor, poor and semi-middle class, all of which have varying degrees of health. As level of poverty increases, Death rate, infant mortality rate and maternal rate also increases.
- He described the Resettlement Colonies as mostly being Minority Colonies, and said that there was no access to health services there.
- He said that 80% of the poor women deliver at home, as they are misbehaved with in hospitals.
- Also, they are asked queries about family planning in a humiliating manner.
- The hospital which was to be built for these colonies, has been built in the middle class colonies, hence the poor have no access to health services.

Dr. Prabhat Jha, while presenting a report about health services in Indore, said that,

- The number of urban poor is increasing at a fast pace.
- If we consider children's health, health status of poor children in Urban areas is worse than that of poor children in rural areas.
- Poor hardly have any access to health services. Among the child births every year, 10 lakh children in slum areas are born at home. 2/3rd of the Urban poor do not have access to clean water and sanitation.
- 27.8% of total population of India lives in urban areas. That means about 285 million urban citizens. 31% of the urban population is poor. By 2025 the number of urban poor in Indian will be about 200 million.

Most of the urban poor live in slums and have been living there for more than 5 years. While 30% lived in villages before moving to slums, another 20% slum houses did not possess any document like ration card or voters ID card.

5. 3.12 Alternate health practice and sustainable development

Organised by Medical Mission Sisters Organisation

This session was facilitated by Sr. Molly Vadaken of the Medical Mission Sisters Organisation. The meaning of holistic health was discussed by the participants as a way of life which was connected with everything in nature. It was understood as a harmony with mind, body and spirit. Food was also a form of medicine.

Some relaxation exercises and yoga were demonstrated by trained activists at the workshop. There was also discussion on postures. The organising team then presented a drama on water. This was followed by a presentation on sustainable development and on how to include people in decision making. The need for all development works to include the needs of the poor and need people was discussed.

3.3.13 Human resources for health care Organised by CMAI / CHAI / CHC

The main points raised in the workshop were:

- Meeting urgent health challenges, especially with an equity focus requires the availability of appropriate composition of health workforce in terms of their level of training and skill categories and also of perspectives and attitudes.
- The present health care system suffers from a severe shortage of trained personnel.
- The problem is more severe in rural and particularly in remote rural / tribal areas.
- This shortage affects public health care system in the following ways:
- Hampering service delivery and reduces reliability and credibility of the health system.
- Facilitating the back door entry of the private sector.
- Recent policy initiatives to tackle this shortage include:
- including practitioners of AYUSH to participate in the public health system.
- Providing additional training to nurses to function as nurse practitioners.
- To create a separate cadre of rural doctors.
- Another crucial issue is that a number of vacancies exist in the posts of the allied health professionals like pharmacists, lab technicians, radiographers etc.
- One of the solutions suggested to this problem includes the creation of multi skilled workers at the rural hospital level.
- The issue of health human resource is not only of non-availability but of relevance and appropriateness of the training.
- The growing recognition of the need for public health skills in the health system.

3.3.14 Violence against women Organized by CEHAT / MASUM / AIDWA / BGVSM

The speakers of the session were introduced by Sangeeta and facilitator Renu Khanna From Masum, Archana from Cehat/Dilaasa: Matron Khade, Sister Gore, Mrudula (Bombay Municipal Corporation Pramila, and Tabassum from AIDWA: Sandhya. First presentation from Ms. Archana - Masoom

She shared that this is to highlight that the issue of domestic violence has to be looked at going beyond the traditional intervention strategies like counseling sensitization of police and judiciary. We want to say that it's a public health issue and women's human rights issue.

- We want to see the linkages between health and violence on the background of the politics of violence.
- The domestic violence occurs inside the home but the very patriarchal structure and values of the society give courage and social sanction to the violence against women. On the other hand it makes women internalize guilt and feeling of being responsible for the violence being inflicted.
- There are well set norms about the responsibilities and role of a married woman. Being a new member of the family she is the most powerless person. Till she becomes mother of son and mother-in-law she remains at the bottom of the family hierarchy. She is economically, physically and emotionally dependent on the other. That makes her vulnerable to all kinds of violations and violence.
- It is a weapon against those women who challenge social norms. The violence perpetrated on the mother teaches a lesson to the daughter. She learns not to break family norms. The consequences of the violence are borne not only by the victim but by her subgroups too.
- Single, deserted, widowed, divorced, homosexual men, lesbian women, transgender, people whose belief system and political convictions are different from the majority are not safe within their homes also.
- Natal home is responsible for the violence against a woman in her matrimonial home. Not only that but many times the parents are more violent than the in-laws. (When it comes to exercising right to choice by the daughter. In case of married woman speed of the violence cycle is fast when she doesn't get parents support.
- Violence is normal is much internalized concept. But it is not fact. We are taught to accept violence.
- Higher the class and caste of a woman, the forms of violence become more and more complicated and remain hidden. It becomes more difficult for her to leave the violent home.

In violent situation remaining healthy is just not possible for anyone. WHO emphasizes the same thing in its definition.

1. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. (Art 12 of ESCR tells The right to the highest attainable standard of health)
2. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, human dignity, life, the prohibition against torture. Thus violence free life is a precondition for a healthy life.

Now a days ANM's are given instructions that they have to gather data on the survivors of domestic violence in their villages. But no she is not aware of the purpose behind it also not aware about her role in the scenario. It just remains an order to follow.

Preventive activities like Awareness creation, immunization, and cleanliness drive then early detection and treatment and promotion of health of people is the role the health system is expected to play.

The same manner the state should be obliged to prevent domestic violence. Give emergency support to the survivors of violence (like an extra 24 hrs vacant bed for survivors of domestic violence in every health set up) and strive for promotion of human rights of woman.

- Violence results in physical and emotional hurt, injuries, bruises, fractures, burns, vaginal tears, psychiatric problems such as depression, distress, self harm or suicide attempts, miscarriages or repeated abortions, sexual assaults, infections- including HIV/AIDS and unwanted pregnancies are a few examples.
- In case of TB or HIV/AIDS stigma and marginalization worsens the problem. Due to the stigma attached to the disease a woman is reluctant to disclose her complaint. Because being thrown out of the home will be the consequence of it.
- Unfortunately violence has been steadily emerging as one of the main reasons of the death for women in the reproductive age group world wide including in India.
- Child marriage results in early childbirths, miscarriages difficult labor, early tubectomies, unnecessary hysterectomies at an early age, workload and other family tensions at early age results in anemia, weakness, and early aging amongst women.
- She is nowhere in the decision making in reproduction. Lack of negotiations in sexuality, also not able to negotiate at time of marriage – whether or not to marry, whom to marry, when to marry etc. Most of the survivors filled complaint at the Samvaad counseling center of MASUM.
- As ill health and disclosure of illness increases the element of violence in women's life.
- Women with tuberculosis, mental illness or HIV/AIDS are likely to be thrown out of the house and therefore they are reluctant to disclose their disease to their families or get their illness diagnosed. If a woman has white discharge she may be accused of sleeping with other men. If she repeatedly falls sick she may not get medical attention. Thus women are more vulnerable to illness because of their low status in the society and low access to food, rest and recreation. This in turn increases the possibility of violence in their lives. Being dependent on husbands and in-laws for health care silences a woman.
- If at all she gets to the health centre notions of family honor and the consequences of speaking out may keep her silent about the violence in her life. A vicious circle thus set in motion.

MASUM is a community based organization working in two districts of Maharashtra for empowerment of women and children with a feminist, democratic, secular and human rights perspective. Taking into consideration the linkages between violence against women and their health MASUM works with an integrated approach on these issues.

The health professional is the first and in few cases may be the only and last

person to whom she can approach for help. Seeking health services is the only socially sanctioned opportunity for the survivor to come out of her home. MASUM's health worker screens the woman who comes to the centre in order to find out the root cause of her illness. If it happens to be domestic violence or an other mental stress the health worker gives medical treatment to the woman also gives her support and encouragement to work on her problem.

If the woman is willing to seek legal support she is referred to the Sathi center. Conversely in Sathi center, in case of emergency help from health workers is easily and immediately available to the survivors.

- As strategy to prevent violence at early stage the couple get together proves to be very effective. It's serves as an opportunity for the couple to get to know each other and remain away from the stereotypical role models traditionally set in the society.
- Right to health is very closely linked with right to housing, food, livelihood etc. In case of domestic violence it is the women who have to leave her home. Safe home is the first requirement. So MASUM had initiated a campaign for registration of home on joint name of husband and wife, where the right of the wife who is forced out of husband's family was also emphasized.

For a woman to enjoy her human rights role of police, doctor, lawyers, judges is much important. Often it is seen the state machinery dismiss domestic violence as normal.

Second presentation from Cehat/Dilaasa Team

Pramila spoke about Dilaasa.

- She said that Dilaasa is the first hospital based crisis centre in India designed to respond to the needs of women facing violence within their homes and families.
- It is a joint initiative of the Public Health Department of the Brihanmumbai Municipal Corporation (BMC) and the Centre for Enquiry into Health and Allied Themes (CEHAT), research centre of Anusandhan Trust.
- Dilaasa is the first attempt in India to sensitise the public health system to domestic violence. The goals of this partnership between CEHAT and the BMC are- (1) institutionalize domestic violence as a legitimate and critical public health concern within the public hospital system and (2) build capacity of hospital staff and systems to adequately and sensitively respond to the health needs of the victims.
- Dilaasa provides social and psychological support to women survivors of violence and helps them rebuild their lives.
- We believe that women facing any form of abuse are more likely to seek treatment for their injuries or symptoms resulting out of DV.
- In such cases, Health care providers (HCP) are the first contact. Only a public health setting can provide medico legal evidence to a woman which

a woman can use in case she decides to pursue legal action.

- And that is why we say that health care providers are in a unique position to offer not only medical care but probe in to the reasons for the injury/symptoms.

Learning's of Dilaasa

In the last five years, Dilaasa has supported over 1200 women. Through its ongoing training activities, it has trained over 80 hospital staff as trainers on gender and violence issues, out of which 35 have formed a training cell. In 2006, the BMC has set up another crisis centre at Bhabha Hospital Kurla which also has trained counsellors who provide the required counselling services to survivors.

- We have been able to screen woman at an earlier stage of abuse.
- Women find the space at *Dilaasa* as non threatening because of its unique location in hospital.
- The number of women coming to *Dilaasa* has gradually increased (more than 1500 women)
- This led to setting up one more hospital based crisis centre in a central suburb in Mumbai

Skit on the role of health care providers:

After this presentation *Dilaasa* team i.e. Matron Khade, Sister Gore, Pramila and Tabassum presented a small skit on the role of health care providers. The objective of this skit is to show that health care providers can sensitively respond to woman coming to hospital facing domestic violence and it is the responsibility of health care providers to respond sensitivity (Script is attached to the report). In this skit there was an involvement of BMC staff, the core group members of K.B. Bhabha Hospital, Bandra, Mumbai and they are also the trainer who conducts trainings at their hospital level on the awareness of domestic violence and the role of the health care providers.

Cehat's Presentation ended with a small presentation by Mrudula on protection of women from domestic violence act. She shared important features of the Act, emphasizing more on the role of health care providers specified in this act.

Third presentation by Sandhya from AIDWA:

Sandhya shared five cases of girls who were either orphans, dalits and adivasi girls who were staying in government hostels and in villages they were raped either by their care takers in hostels and upper caste people in the village. And they were denied help by police and government machineries because police and government machineries themselves were the part of these heinous crimes. And finally with the intervention of AIDWA they tried to get justice for them. Sandhya said that these big people are the main culprit and we need to hold these forces accountable.

Response and questions came from the participants:

1. One participant shared that there are many cases of sexual harassments by Doctors and we need to address this issue.
2. Another participant shared that U.P. government has appointed some representatives of the state machinery on the post of probation officers, there are women approaching these probation officers they are not able to

take their cases further as probation officers have not given any budgetary allocation for it. They do not even have money to pay for stationary like papers and pen.

3. Third participant raised a question saying that nowadays MP government is doing Group *Kanyadan* which is again imposing a patriarchal values on us, do any state has authority to run such programs officially in the state?
4. How to work on the issue of gender discrimination?
6. One participant asked that breaking a joint family system can be a reason for increasing domestic violence cases?

Archana responded to this saying that no government has right to run such programs but the in the kind of patriarchal society we are in it is more acceptable by the people. She also responded to one of the question about breaking of joint family system as the reason for domestic violence by saying that we all know that women and children are no safer even in joint family system. She also shared that when we are talking about unmarried girls are coming in hospitals for abortion this is showing that there is need to have sex education amongst the adolescents but we don't want to speak about it.

3. 3.15 Bhopal Gas Tragedy- Genocide continues Organised by M.P.JSA

During National Health Assembly a workshop on Bhopal Gas Tragedy: Madhya Pradesh Jan Swasthya Abhiyan organized Genocide continued.

BACKGROUND

- Bhopal Gas Tragedy is the biggest man made industrial disaster occurred in the history.
- On 2nd – 3rd night of December 1994 nearly 50 tons of gas leaked from Union Carbide Factory in Bhopal.
- Because of non-working of scrubbers and non-functional flayer towers this whole toxic material reached in the atmosphere of Bhopal.
- The main component of this gas was Methyl Isocyanides (MIC), which is lethal to all living organisms used to prepare pesticides. Due to cold weather prevailing all the gas which was at a higher temperature settled over colonies, slums areas and affected five hundred thousand persons.
- Nearly 3-5 thousand persons died on the same day and many have continued to die even after years have passed.

THE EFFECTS

- The organs mainly affected by gas are eyes, lungs, liver and gastrointestinal system.
- Psychological disturbances due to disaster and deaths of close relatives as well as suffering have also resulted.
- Majority of the persons recovered who had mild exposure but those who have moderate or severe affections are still having symptoms like diminished visions, watering from the eye, breathlessness, easy fatigability,

and post traumatic mental disorders.

- These sufferings could not be reduced because of anti people attitude of Union Carbide. Till now Union Carbide has not informed about composition of the gases leaked, anti dote or treatment of the injuries.
- Govt. had agreement with Union Carbide to pay compensation for 3000 deaths and 1 lakh injured. This meager compensation could not provide relief to the damages caused by disaster. Bhopal gas affected people are continuing to suffer.

In this background the workshop was organized to focus the issues and raised the demands of Bhopal Gas Tragedy affected people. In the chairmanship of Mr.S.R.Azad, General Secretary, MPVS this workshop was organized. Mr.Abdul Jabbar, Convener of Bhopal Gas Peedit Mahila Udyog Sangathan, Mr.Balkrishna Namdev, Convener Bhopal Gas Peedit Nirashray Pension Bhogi Sangathan, Mrs.Sadana Karnik, Convener, Bhopal Gas Peedit Sangarsh Sahyog Samiti and Mr.N.D.Jayprakash, Delhi Science Forum / Bhopal Gas Peedit Sangarsh Sahyog Samiti, New Delhi.

Mr.Balkrishna Namdev said

- The Bhopal Gas Tragedy was one of the biggest genocides and many thousands had become disabled. But govt. has not supported them substantially. Thousands of people died and lakhs are still suffering. They are still suffering and will remain disabled for life.
- The tragedy requires a detailed assessment of damage, injury and losses.
- Responsibility of this tragedy is mainly Union Carbide but Government is also equally responsible. He said 1st action plan came in 1990, which had allocation of Rs. 2.88 b but after, that there is no plan for relief or rehabilitation. Even with this plan economic rehabilitation could not be achieved. Even after decision from Supreme Court neither state government nor central govt. Gave attention towards these Bhopal Gas Affected people.
- Earlier there was Rs.750 per month pension to gas victims but it has been closed much earlier. Now they are not getting enough pensions to for survival, which is not enough to manage food for two times. Only 150 Rs are given as pension, which is insult of them.
- Widows are not included in below poverty line survey. It is necessary to change parameters for BPL list. Condition in gas-affected area is very bad.
- There is need for safe drinking water and proper treatment.
- There is no regular system of employment.

Mr.Abdul Jabbar said

- Gas tragedy is very big issue.
- It is due to faulty policies of Government and multinational companies.
- It is must that such policies be framed which result in such a way so such disaster does not occur nowhere in world and never. We are conscious and worried for some tragedy just after it happens but later we forget it to remain alert. We remain inactive till next tragedy. Just after tragedy Rs

5000 was given.

- Till now more than 22000 deaths has occurred due to gas tragedy.
- He raised question mark on check up and investigations of gas affected people. He said proper investigations have not been performed. Compensation based on these investigations and check ups are not justified. During government of Mr. Motilal Vora as Chief Minister some work was done but later no appreciable work is done.
- Presently in hospitals patients are not treated properly, medicine is not given many times and equipments are not working.
- Government does many post of specialist doctors lying vacant from very long-time but no serious efforts.
- He said monitoring committee set up by Supreme Court has submitted more than 5 reports and advisory committee 3 but no action is taken on the reports.
- There is toxic chemical waste in campus of factory earlier government has hidden this fact but due to concerted agitation and intervention of court it has come to surface.

Mrs. Sadhana Karnik said

- That this government seems to be deaf and blind.
- It is not listening to the suffering or struggles of Bhopal Gas Affected people.
- She said due to globalization many multi national companies are playing with the life of general public.
- Due to influence of these company's health checkups has used as instrument for cheating and befooling.
- Many patients have given category without proper investigation and check up.
- Compensation given on this categorization is faulty and insufficient.
- We need to have common forum against globalisation.

Mr.N.D.Jay Prakash spoke about the legal fight of gas affected people.

- He said government has created obstacles for extradition of Warren Anderson, the then Chairman of Union Carbide.
- He said Govt. has surrendered its peoples right in the interest of multinational companies.
- He hoped that in due course of time gas victims receive justice.

Dr Ajay Khare raised issues related to research done by ICMR

- He noted that these were later stopped due to pressure of Union Carbide to remove from the struggle from scientific facts.
- It is necessary to start research again so at least long term effects can be monitored.
- He also said about merger of gas hospitals in state health system, which

will reduce access of gas victims to treatment and good care.

Mr.S.R.Azad in his Presidential address focused on health issues.

- He said discontinuation of ICMR research has weakened the case against Union Carbide.
- It has disarmed the gas victims against legal struggle.
- The gas victims are continuing to suffer due to exposure to MIC which is still causing pain and misery to gas victims.
- There is need to have comprehensive plan for social, economic and health rehabilitation.

Recommendations:

Following recommendations have come after discussion on effects, condition of victims and future strategy for action.

- Research projects stopped by Indian Council of Medical Research should be started.
- Long term genetic studies should be started to find out long term effects and any carcinogenic effects of MIC and other gases released on 2nd 3rd Dec 1984.
- There should be central registry of patients, centralized documentation of patients including Bhopal Memorial Hospital and Research Center to avoid duplication of records, treatment and better follow up.
- Efforts of merger of Gas hospitals in state health department should be stopped. Responsibility like medico legal cases, post mortem should not be given to doctors working in these hospitals, it will affect their availability for gas patients.
- Rogi Kalyan Samiti in gas hospitals should be stopped immediately as they are causing discrimination among gas exposed and unexposed patients. Staff and doctors are giving more attention towards paid patients and neglecting Gas affected patients. Doctors are also getting perks for treating private patients so giving more attention towards them.
- Facilities in Gas hospitals are utilized by Gandhi Medical College doctors for non-MIC patients, which cause neglect of patients and damage to equipments. It should be stopped.
- Doctors for all specialties should be appointed immediately to provide proper treatment to gas affected patients. Space for this specialty is given to establish cancer ward of medical college it should be taken back.
- Special attention should be given to old and disabled patients they require immediate attention.
- Severely affected area should also be taken first.
- There is change in disease pattern in moderately and mildly affected areas detail study is required to understand phenomenon and causes to tackle it.
- Hundreds of tones of toxic waste is still dumped in campus of Union Carbide factory which is polluting under ground water, It should be removed immediately and persons affected due to poisonous water should be treated and paid sufficient compensation for this.
- Social security pension should be given to widows without any support, disabled old persons. It should be raised to minimum Rs 400 /month from Rs 150 / month. They should get benefit of Antyodaya scheme also their treatment should also be totally free.
- Gas affected old persons and widows should get separate compensation from gas relief department.

3. 3.16 Patents and IPRs Organised by JSA

Intellectual Property Rights are rights obtained by Governments, which are given to a person or commercial/business group which has invented a new thing/process. This helps to maintain the equilibrium between the inventor and the society. But the existing patents laws, are giving more importance to companies. This is because the earlier laws granted the patent for a limited period of time, but today any inventor is being granted life long patent for the invention. This is because companies are creating a pressure in this direction. Almost 92-95% of the patents are currently with America. This has a negative impact on the availability of essential drugs and research on useful drugs. Instead of giving preference to medicines required for curing the illnesses faced by common persons, companies are paying more attention to other non-essential medicines, keeping in mind the interests and “needs” of rich people. More than half of the global medicine market has been captured by just 10 MNCs.

Research on medicine is a very expensive endeavor. But actual production of drugs not expensive. If the profit margin is reduced even by 1-3%, all people can have access to cheap medicines. The latest drug on TB was invented 28 years back, after which there has been no innovation in this medicine. American companies make use of research done by Universities, as there, the Universities and Corporate sector are together and have shared interests.

Patent laws are actually taking science backward in time, as the Corporations do not share their research with others for wide usage. So in effect the patent laws only serve the interests of the MNCs. The interest of humanity lies in undertaking co-operative development rather than competitive research.

3. 3.17 Sexual Minorities and Sex Workers Organised by SANGMA

Geeta's presentation focused on problems of Kinner. She mentioned the mythological and cultural root of the terms. It is a Jathi in Himachal Pradesh having particular attitude and which workshop a particular god. It has by tradition its own cultural rights. It needs to differentiate from Hijara which does not have any right . She complained against media and politics for term and commenting without the knowledge of the effects.

She narrated for personal plight. Married at very young age she was brutally dealt by her husband on the basis of false allegations and was socially castigated which prompted her to work amongst sexual minorities. Even after I have become member of the committee working for sexual minorities the castigations has not ended indeed it has become amplified. She said there are NGOs working for commercial sex workers but their activities are limited to them only, they do not include sexual minorities on their work.

Amongst the major problems faced by sexual minorities she indicated

1. Social castigation
2. Mal treatment by anti social elements
3. Mal treatment by police
4. Discrimination with their children
5. Misbehaviour by facility providing agencies including the health agencies

This has resulted in the need of organization there were presentation of CSW's the points raised in the discussion are already familiar.

3.3.18 Disability Organised by CHC, Bangalore, CBR Forum, Ashagram Trust, Badwani

Discussion was intimated by Shri C.Mahesh of the community based Rehabilitation forum was incorporation of the disabled in the main stream of society. There were presentations of Dr.Aneeta Ghai, Psychology lecturer from New Delhi, Shri Victor John, Kediro of Sasal Action Aid and Mr.Vijay Swain of Ashagram Trust Badwani and others .

Surprisingly the focus of presentation was that disability is not the problem the problem is social dis acceptance of disability . The theme slojan was not pitty but warm with equality and justice. According to presentations every body has some disability in one sense or the other, than why to look down on them who has less or one other faculty working. Presentation and discussion dealt on the meaning and implications of terms handicapped, empowerment, disability, differently abled etc. They also dealt on the development of concepts and programmes regarding disabled. Major observations and the recommendations as follows.

1. It is not the social welfare department but the health department which should look after problems of disabled.
2. Prevalence of handicapped has been estimated to be 5-6% and according to one sample survey done in 2002 it is 18%
3. NRHM does even does not mentioned disability.
4. There is dearth of institutions working of disability.
5. Disable are more prone to assaults including sexual assaults.
6. Their was a demand for more facilities to the disabled.
7. Vocational training health facility, employment and social acceptance are key issues.

3.3.19 Community Based Monitoring of National Health Mission Organised by SATHI – CEHAT and PRAYAS Rajasthan

Presentations emphasis was participation in planning process of NRHM as NRHM envisages a community which participates in planning process.

Planning process there experience has been done to procure community participation in planning process in 8 states which include. Assam., Orissa, Rajasthan, Tamilnadu, Maharashtra, M.P.Chhattisgarh, Gujarat and Jharkhand. This participation has to be at all levels of planning process right from Panchayat to National level.

Main ingredients of strategy of NRHM are as follows.

- 1) IPHS standard (Indian public health standard)
- 2) Expansion of nursing staff
- 3) Multi skilling of existing staff
- 4) Private participation and hospital development committee
- 5) ASHA programme
- 6) Urban health facilities
- 7) Communities to interview health organization.

As understanding of the issue and proper communication are the key issues in programme planning therefore NGOs and health organizations are expected to participate widely in the planning process. It is also important to critically influence the NRHM.

There was less discussion on monitoring part of the issue.

3.4 JSA organizational session Towards a peoples health plan Facilitators : Dr.T.Sunderaman & Mr.Sanjeev Sinha

Dr.Sunderaman presented alternative peoples health plan. This is developed on the basis of peoples health charter adopted by JSA. In this health plan various issues related to women health, children health, marginalized sections, health systems and possible approaches for implementation of health programmes are included (Alternative peoples health plan draft is annexed)

In response to Dr.Sunderaman's presentation AIDWA supported the plan and expressed its commitments. She said that health should be fundamental entitlement which is already discussed in last two days. She was happy that preventive and curative measures for domestic violence is included and action emphasized. She is worried about RCH –2 frame work. She also said Panchayat should be given more responsibility to develop funds and authority to strengthen health delivery systems.

Ms.Suhas Kolhekar from NAPM emphasized that training of health workers and professionals to understand the people's problem and increase sensitivity is required. Rights of villagers, tribals, displaced dalits, minorities, urban poor should be respected. We need to develop strong links with other movements and campaigns such as right to food and land. We need to involve people especially women in planning decision making and implementation of the programme. It should be two way process.

Dr.Ajay Khare from All India Peoples Science Network said health should be fundamental right. We need to have special plans for marginalized sections. Convergence should be at all levels from state to Panchayat. Modalities should be developed to ensure health professional in rural areas. Corruption in health should be checked. Public health system should be strengthened and privatization should be stopped. We need to change patent act so drug prices may be lowered down.

Dr.Habeen Mohamad from KSSP said health should be all not only for the poor. AYUSH is not practiced properly. There should be family Doctor concept. Private institutions need to be regularized. 30% resources should be allocated to women and child. NRHM is becoming IAS Raj. We should look in PPP, user charges etc.

On behalf of NFIW delegates suggested to have NRHM committee up to mandal and district level through JSA. She also expressed need of proper sanitation, fluosis control and provision safe drinking water. JSA should act as watch dog in the case of corruptions etc. Peoples committees should be formed to increase accountability. Tribal personal should be trained to work in their areas. District Collector may be made incharge of PCPNDT Act.

Dr.Vandana Prasad said there should be guarantee of water and it should not be privatized. Ground water utilization should be regularized. Caste is important way of social exclusion which should be taken care of in alternative peoples health planning. There should not be any scheme for target groups or BPL basis. It should be for all. Environmental strict regulations are required for pesticide production. There must be guarantee of safe food.

Satya Sri reported on behalf of workshop on sexuality minority and sex workers that they endorse the peoples health plan and want to act following points.

1. Criminalization is the primary impediment for health of sexuality minority and sex workers as it pushes them underground where human rights violation against them thrives. Therefore section 377 of IPC and ITPA (Immoral Traffick Prevention Act) should be repealed.
2. Criminalization coupled with moralistic social constructs make sex workers and sexuality minorities vulnerable to HIV/AIDS. We ask for a nation – wide public campaign to fight myths, stigma and discrimination linked to various sexualities, genders, sex work, sex etc.
3. Transsexuals should get comprehensive Sex Reassignment Surgery (SRS) facilities / procedures including psychiatric assessment, endocrinological and surgical procedures.
4. Universal access to HIV/AIDS treatment (ARV, OI treatment, care and support) with a special attention to sexuality minorities, sex workers, IDVs and people living with HIV/AIDS.
5. We need to resist USAID policies of forcing its partners outside the US to sign 'Anti-prostitution pledge' and 'not do any work for supporting rights of sex workers'. This provision is an attack on the human rights including health rights of sex workers.
6. Health rights should be viewed in different context of marginalizations based on class, caste, gender, sexual preferences, gender expression, disability HIV status, ethnicity, race, religion, region, language, migration status, political affiliations, nationality, and occupation.

Dr.Joe Verghese from CMAI said issue of health human resource is not linked to non availability. This is largely due to urbanization of medical systems. The bio medical training and present trend make them unprepared to work in rural areas.

Kamayani from SATHI-CEHAT said mental health should be integrated including peoples alternative health plan . There is need to advocate and develop comprehensive, right based state and national level mental health policies. More budget should be allocated. Language in Peoples Health Plan should be edited to suit to the JSA philosophy. There is need to have regular monitoring mechanism of human right violation.

3.5 Cultural Programmes

On the second day cultural programme from various states was performed. Team from Kerala Sashtra Sahitya Parishad performed a play on Bhopal Gas Tragedy. Teams from Orissa performed on Health Issues. Cultural teams from Uttaranchal, Rajasthan, Gujarat, TamilNadu, Chhattisgarh, M.P. and Delhi presented various scripts and songs . Bangladesh delegation also performed a very good drama.

- 4.0 Day - 3 : 25.03.07**
Venue : Rabindra bhavan
4.1 Session : Tri-continental dialogue (9.00 am to 10.30 am)

Meeting the Challenges in Africa.

- David Sanders (PHM south Africa)
- India is leading South Africa to the global health Movement and we will try to emulate that.
- Between 1970 to 2002, African countries borrowed 504\$ billion foreign debts.
- Globalization is the unequal growth of different countries and unequal distribution of income.
- Ethiopia spends 22% of its national budget on health and education.
- In South Africa out of 45 million people around five and half million are HIV positive.
- Dr. David from South Africa told that, in South Africa the Primary health system has improved in comparison to past years. But still there are some areas which still require work. As far as child birth is concern, the neo-natal mortality rate has declined; and safe delivery has been taking place.
- But in the 1990s due to neo-liberal globalization, the health sector had been used as commodity. The rate of TB, Malaria, STD and HIV / AIDS is increasing.
- Many women have been found to be HIV positive during this period. People didn't have enough awareness about such kind of diseases or infections.
- In the 1970s there were many debt crises in the developing countries. People committed suicide because they could not pay back. There was unequal distribution of income. The poverty rate was very high due to political crises.
- But due to our strong effort, the whole scenario has been changed. People became more aware, the rate of mortality decreased, 4% to 5% decrease was recorded for HIV/AIDS. Good health is the right of the people of any country.

Edelina De La Paz (PHM- Philippines)

- Globalization has increased poverty and it is the greatest illness of world.
- According to reports 51% of population in Philippines lives on \$2 per day.
- WTO has given lift to unfair trade and the work force of Philippines continues to receive low wages.
- 68% of doctors work overseas.
- Medical tourism has emerged as a business and meant to attract foreign tourism.

Latin America

- Armando De Negri (PHM – Brazil)
- We are trying to develop strong public health movement.
- Brazil is the biggest country in Latin America with a population of 190 million people.
- In 1984 it finished 21 years of military dictatorship.
- In Brazil health is included in social security program.

- In Brazil access to health is the basic right of every Brazilian.
- Health system in Brazil is much better than any other part of the world.
- Described the social control of policy making that has been achieved in Brazil. In all decision making bodies there is at least 50% representation from the community. This ensures a certain social responsibility / accountability even at the decision making level.
- He highlighted that this was a constitutional process. The constitution of Brazil ensured the presence of the community in all such bodies.
- While the constitutional recommendations were in place for a long to get the constitution to work in the way intended was and continues to be a continuous struggle.

QUESTIONS / COMMENTS FROM THE FLOOR

MARGARITA

- She felt that organized people are the only way to bring about social change in today's day and age and in today's context of the increasing power of the trans-national corporations and the weakening of national governments..
- She said that there is no need to be afraid of Trans-national corporations. When people / communities get together trans-national corporations are afraid of us. Our strength lies in our collective power.
- We need to raise our collective voices against privatization, and say a strong and resounding "NO" to militarisation.
- It is up to us to get up, get together and struggle as the empire is in control of our lives.

REPLIES BY THE SPEAKERS

ARMANDO

- Globalization can be seen as a doctrine / an ideology that naturalizes poverty in the landscape of the world. It states that poverty is necessary for capitalist development. In this ideology the only option is to go ahead in terms of individual / economic gain – with no concern / connection to ethical thought / community thinking necessary. Thus a resistance to the concept of globalization will be the doctrine to provide life / well being and solidarity and a harmonious life.
- Globalization is not just a trade and economic problem alone – in fact it is a paradigm that is allowed to dominate by hegemonic acceptance by communities.
- In Brazil there is people's participation at all levels of governance. There is direct election of people from pre-defined social territories. From these higher and higher levels are democratically elected. At each level there is 50% representation from the community.
- Such participation is achieved only after a lot of conflict – conflict with the state – the institutionalized nature of the state.
- Despite constitutional ratification there is a daily struggle between competing interests.
- Brazilian government supports people – by enabling / facilitating the

municipalities to transfer money to deprived groups.

- Replying to a question on the coverage and effectiveness of the Anti-retroviral therapy in Brazil, Armando said that the very impressive results was due to the pre-existing strong National Health Service. This enabled the distribution not only of ART but also antibiotics for various Opportunistic Infections and enables PLHA to access both IP and OP and emergency care.
- Such a program cannot be successful merely as a vertical program. He stressed the importance of the presence of medical professional to cover these specialized services and said that neighbors treating neighbors is an oversimplification of the ground realities – especially for PLHA.

DAVID SANDERS

- Commenting on the impact of water privatization in South Africa – he said it was important to understand that water privatization was being pursued in South Africa first and foremost because of the availability of a market for privatized water. He said that there were numerous examples of epidemic outbreaks – especially cholera – that can be linked to the privatization of water. In Kwazulunatal there was a cholera epidemic that was linked with the introduction of user fees, this led to the people turning to the polluted river water for their requirements. Similarly in Soweto the cholera epidemic was linked to a drop in washing of hands in communities that had privatized water.
- Commenting on the observation that debt / alcoholism and mis-communication are some of the major effects of globalization at the community level – he felt that these three were direct effects of the following the principles of globalization at the community level.
- He pointed out that Health Sector Reforms were an ideological attempt to legitimize the health impact of globalization. We need to analyse this carefully, we need to question technical interventions, as these undermine our struggles for freedom, by suggesting a charity based approach by Aid and targeted interventions. This all occurs while the basic structures that cause inequity in the first place are ignored.

DELEN

- Delen noted that in Asia we as communities are victims of globalization – she stressed that community action needs to be strengthened and protected from the onslaught of globalization.

MARIA

- She noted that the dream of Health for All which in fact started much before Alma Ata is still a dream – we need community action to actualize this.
- She said that the present health system is merely a 'medical repair system' – we need social reform in and through health. We need to focus on empowerment at all levels. There is an urgent need for the skill and the will for people to become social creators of health and welfare.

- Health is politics and politics should be health – she felt that the health movement in India is the conscience of this. While this is a difficult role India needs to recognise this and become a cumulatively energizing cornerstone of the movement.

SESSION II – CLAUDIO / IMMAMUDDIN IMMAMUDDIN

This session focuses on the various issues taken up by the PHM over the last 6 years or so.

CLAUDIO

- Claudio mentioned that one can't be an effective activist unless you know what is going on in other parts of the world.
- It is thus crucial to keep in touch with what PHM had been involved in at the global level.
- The World assembly did not consider health as an end, but as a means to the 'end' of human development.
- All over the world (the present developed world) social aspects / change preceded economic aspects of development.
- Experience has shown that mere economic development invariably leaves out / creates a large section of people who are poor. But if people can contribute to social development – ie. When people are socially productive then the benefits of economic development are more equitably distributed.

PHM AND THE WSF – LANNY SMITH

1. While it is important to protest – it is also important to get together in positive ways – to say that another world is possible.
2. It is not enough to merely say no. We have to get together to say a YES to an alternative.
3. The seeds of a PHM / WSF alliance was initiated by the ALAMES (Latin American Social Medicine Society) when feelers were sent to the PHM around 2002.
4. It was felt that PHM could provide the action and the evidence base to WSF.
5. We need to act – not only to think.
6. We need to use the space within WSF to contact with people not directly related to Health – gives PHM the opportunity to meet new people and new groups.
7. Lanny felt that PHM should integrate more within WSF groups – we can be the central node of health in the WSF.
8. WSF is a great opportunity to go towards action for PHM.

RIGHT TO WATER – JEFF CONANT

- There is a growing water crisis.
- However water is crucial for dignity.
- The question is not of merely coping with water scarcity but to move towards water justice and equality.
- We must realize that scarcity is due to lack of political will – we must struggle for a right to safe and sufficient water for all.
- We must fight against water privatization / mining and all agencies (UN?) that promote these – to protect our fundamental right to water.

- We need to hold the governments and corporations accountable for water scarcity.
- We need to study the example of Uruguay where 2/3rd of the populace voted for the right to water and voted a resounding no to privatization and profit.
- There are similar examples from Canada.
- From Bolivia.
- From Argentina.
- We must recognize mining / large dams and water privatization as the triple threats for all developing countries.
- We must realize that the privatization of water has begun to erode into public health.
- It is ironical the even though Europe and America improved their public health because of the public supply of water – that they are in fact spearheading water privatization.
- The upcoming American Social Forum in Atlanta, Georgia – there is going to be a big demand for Water for All.
- This is a historical site as here suez had to leave the city within a year – they had to break the contract and the mayor is in jail – suez had to leave.
- Atlanta is also the head office of Coca Cola
- We need to realize that the water companies all over the world are failing.
- The goal of the movement is not to cope with water scarcity – but to end it.
- We see health as an entry point to politics – and social change.

CLAUDIO

- There needs to be an increase in the social and political conscience of the health movements around the world.
- We need to destroy the myths of scarcity and see it for what it really is.
- We need to expose the present interventions of the various international agencies – as a mere masking of inequity.
- We must consolidate our struggle to counter privatization.

JIHAD MASHAAL (PALESTINE)

Jihad described the extreme suffering of the Palestinian people at the hand so the Israelis, he described the gradual land grabbing by Israel, the building of the wall, the health effects of the wall including the number of deaths and deliveries at the gates.... he also mentioned,

- The disintegration of the Palestinian society.
- There is a total loss of social cohesiveness .
- Thanks to the Israeli occupation and building of the wall the very ability of the Palestinian people to mobilize resources is seriously affected.
- We need to see the PHM as a global movement of solidarity.

SALAM ISMAIL (IRAQ)

He described the horrendous situation that is presently there in Iraq. He mentioned how the hospitals had been systematically looted and even destroyed in the bombing. He mentioned the extreme conditions under which doctors are now working.

- Problems are not solved by humanitarian acts but by political action.
- There is an almost systematic destruction of infrastructure.

- Huge corruption and misplanning.
- Privatization.
- Brain drain – for example there are no professors in the department of Radiology in the University of Bhagdad medical school.

MAJIA KAJIS

Majia described the movement in Canada of the formation of the Community Health Centers. She described how that when the government decided to introduce Medicare the doctors went on a strike, it was during this strike that the demand for community health centers emerged and these centers were born. This was essentially a movement for the prevention of privatization, this basically means working with trade unions and political parties.

- PHM needs to be involved in attempting policies preventing siphoning of health resources from developing countries.
- PHM also needs to concentrate on the health of the first nations – especially the social determinants of health.
- There is a campaign for the Right to Health by Canada for the first nations.
- PHM needs to be an integrating movement of the peoples health, an organization to make this possible.

4.2 Panel Discussion with Members of Other Campaigns Alliances for Health for all – Now, Venue : Muktakash Facilitator : Dr.Amit Sen Gupta

Dr.Dinesh Abrol from WTO Virodhi Abhiyan blamed the govt. for following neo liberal policies under agreement of WTO. Under WTO commitments it is forced to withdraw support for social sector resulting in increase of poverty, reduction of expenditure on health causing increased cost of health and education etc. are becoming very costly. Change in import / export rules, patent laws are affecting adversely. He extended his full support to Jan Swasthya Abhiyan for its efforts to mobilize masses and working towards health for all.

Mr.Jean Dreze from Right to Food Campaign gave very detailed picture of PDS in our country. Due to decrease in allotment of PDS and withdrawal of support from Govt. Right to Food campaign has to file PIL in Supreme Court. With this initiative commissioners are appointed and monitoring of PDS and Anganwadi is possible. He said BPL families in very bad condition and malnutrition and hunger is increasing. He expressed his concern to work with JSA on hunger watch and other issues.

Ms.Annie Naamala from NCDHR emphasized the condition of Dalits in our country. She said unless special focus is not done on marginalized sections it is difficult to improve their conditions. Social and economic exclusion as well as increasing cost make unaccessible health facilities to Dalits and poor. Civil societies and organizations need to focus on these sections.

Ms. Razia Ismail Abbasi from IACR and representative from Right to Information also gave their well wishes and shown commitments to JSA and its cause.

**4.3 Main Session: Building on the Past: Future Campaigns and Alternatives
Parallel Session at the National Health Assembly, 23rd-25th March 2007,
Bhopal.**

**4.3.1 Peoples Rural Health Watch and Intensifying the Right to Health
Campaigns including private sector regulation.**

Chairperson : Narendra Gupta

Facilitators : Dhananjay Kakde and Indira Chakravarthi

The session began with Narendra Gupta introducing JSA's proposal regarding community monitoring of public health systems, and that it had been made a part of the NRHM. He also informed the audience about the implementation of this on a pilot scale in certain states.

Indira Chakravarthi gave a brief background to the People's Rural Health Watch. It was conceptualized in the context of the promises made under the NRHM to strengthen and improve rural health services.

- She mentioned that the PRHW was not meant to be limited to doing 'facility surveys'; rather the findings of the survey of the health services had to be disseminated at the district and state level, as well as made an integral part of the community monitoring process in the pilot districts as well as in the other states where the PRHW survey had taken place.
- It was expected that during the session concrete suggestions would emerge regarding how to carry on the PRHW activity at the district and state level, and as a part of the community monitoring process and the right to health care campaign of JSA.

Abhay Shukla spoke about the next phase of JSA's Right to Healthcare Campaign.

- He recalled that in 2003-2004 JSA had organized a series of public hearings on denial of health services at the state level, culminating in the national level health hearing and the release of national and state level guidelines by the NHRC.
- Meanwhile the NRHM had been implemented in April 2005. The NRHM had provisions for guaranteed services at all levels of healthcare. Such as - by 2007 guaranteed services would be available in 30 % of the SC's, PHC's & CHC's.
- He proposed that in the coming months JSA could document, through community monitoring process, whether or not such guaranteed services were available. Further, JSA needed to take up the issue of patients' rights in the private medical sector.
- He proposed that *jan sunvais* may be organized to document *denial of emergency services in the private health sector*.
- He concluded by suggesting that this round of public hearings at district level could lead up to a National Hearing in April 2008, to coincide with completion

of three years of NRHM.

Following these brief laying out of issues for discussion, Dhananjay Kakde called for comments and suggestions from the audience.

The following were the issues that emerged from the audience's comments:

Regarding PRHW

- Replicability and sustainability of the activity; whether it was being done by motivated/sensitized people?
- Need to make it flexible, and incorporate the state specific schemes.
- Need to look at the district level planning processes.
- Need to look at the Infrastructure/Facility Surveys that the government was conducting

Regarding Community Monitoring –

- Need for capacity building at district level to use findings of survey.
- Need to involve community in coming up with relevant questions.
- Practical problems such as of time, of indirect costs to community, have to be considered.
- Accountability and Redressal mechanisms must be in place. If there are no appropriate redressal mechanisms, then the entire community monitoring process can be pushed back.
- Not to document just cases of denial; but also document instances where people's monitoring has led to people getting services.
- To take up the community monitoring issue beyond the PHC level, right up to the district or state level. For instance: regarding availability of medicines – if PHC MO says there are no supplies then to follow it up with the district level officials, rather than merely confronting the MO on the matter.
- In some states PHCs are being handed over to NGOs or RKS. Need to look at this.
- PPPs need to be made focused upon – guided research into private sector to get information.

Other Issues of concern that were raised

- We should not use the term PPP – rather call it public-private interaction. JSA should take initiative to enlist who to interact with in the private sector.
- Need for struggle based on knowledge.
- Campaign against sex-selective abortion (SSA)
- JSA needs to take a position on shortage of medical personnel, and in this context on medical education.
- Social Audit of Rogi Kalyan Samitis.
- No coherent system for the urban poor.
- Need to document patients' views - what happens to people when they get into hospitals to access care? About affordability of private healthcare. Need for hearings on this issue and a Task Force.
- Regarding NRHM – Focussed on curative aspects; no preventive measures; Immunisations (the only preventive) also being incentivised.
- The 0-6 month group does not figure anywhere; need for norms in private sector for 0-6 months group;

- Need to look at family-level interventions, such as breast-feeding.
- Basic Mental Health Services not available at PHC level; family not interested in taking care of mentally ill; such people on the streets not taken care of.
- Regarding needs of disabled people – not just a matter of providing ramps for physically disabled; need for integration of services for disabled with public health systems.
- Prescription Audit indicates that all medicines prescribed are not available. Why prescribe medicines that are not available?
- Role of Students in the present scenario

4.3.2 PARALLEL 2

Effective campaigning for women's health, campaigning against coercive population policies

Facilitators : Ms. Deepa (SAMA, Delhi)

The following are the main points / issues that were raised during the session. While some were issues around which campaigns could be planned by JSA, others were specific ideas / plans for future action / campaigns.

Womens health should not be viewed as 'separate' and should be mainstreamed. Therefore whatever the issue, should be seen / analysed / considered from women's perspective. Coercive population policies should not be seen as a 'women's' issue alone.

Campaigns, Strategies, Action suggestions

- Campaign to ensure that justice is done for Bhopal survivors, ensure access to various determinants of health – water, food, livelihoods and access to health services and compensation.
- Campaign to abolish coercive population policies – to revoke the 2 child norm.
- Campaigns on issues of mental health, focus on disability (physical and mental), issues and concerns of sexual minorities.
- Campaign against violence against women – violence within home; state violence eg. Gujarat Carnage, including policies programs which violate womens rights (girl children and adolescent girls); or cause / exacerbate violence against women.
- Campaign on women's, girl children and adolescent girls nutrition. May require long term follow up. Monitoring nutritional status towards advocacy.
- Women's health concerns / issues should not be a mere tokenism. People's Health Plan has separate sections; instead women's perspectives / concerns / issues should be 'mainstreamed' incorporated throughout the plan.
- Campaign to implement Supreme Court order on sterilisations; ensure compensation in case of failures / violations. Also ensure conditions / quality of care so that failures are prevented. March 3rd every year could be designated for this campaign as the SC order was made on this day.
- Indian Womens Health Charter raises several issues and has emerged from

an indepth and inclusive process. IWHC should be acknowledged and given legitimacy in JSA. People's Health Plan should incorporate / refer to the IWHC.

- Campaign towards ensuring implementation of PCPNDT Act. There is a PCPNDT advisory committee, which JSA should try and be a part of.
- Laws and acts related to women should be monitored and ensure their implementation. eg. Domestic violence bill.
- Campaign to ensure care for women and prevent violations in institutions including institutions for mental health. Public hearings could be organized to document experiences of women in public institutions, towards advocacy. (Concern was raised re: lack of follow up of public hearing process)
- Action / campaign to ensure health services for poor women in urban areas, which is an urgent need due to lack / absence of services and increasing migration.

4.3.3 PARALLEL 3

Realizing the Right to Essential Drugs and Ensuring additional drug use

Chairperson : Mr.Amitava Guha (FMRAI)

Facilitator : Mr.Naveen, CHC.

A. ISSUES DISCUSSED

Pharmaceutical Policy:

The Govt. in order to formulate new policy had constituted two committee- Pronab Sen Committee and a Joint committee on Draft National Pharmaceutical Policy. Based on the reports of these Committees, the Ministry of Chemicals and Fertilisers had forwarded a note to the Cabinet of the Ministers on 27th December, 2007 and enclosed a 'National Pharmaceutical Policy draft.

1. The draft policy contains certain new and valid decisions but left many area uncovered which needs to be discussed. Certain such areas are-
 - Weeding out of irrational and hazardous medicines.
 - Compulsion for production of medicines by the large and medium sector companies
 - Importation of expensive medicines
 - Consumer awareness
2. Apart from the concept of counting all medicines in the National List of Essential Medicines under price control all other recommendations in the policy on pricing are not acceptable. There is no reason to enhance mark-up up to 200 percent replacing present limit of 100 percent.
3. No measures had been proposed for controlling the unethical marketing practices.
4. No concrete proposal for strengthening the public sector medicine companies.
5. Promoting rational medicine use is absent.

Action

Alternative pharmaceutical policy in the line of Kolkata declaration should be prepared.

Issues Regarding EMR application:

- Recent court case by Novartis on Gleevec has challenged the sovereign right of the Govt. to change its domestic law and the right of the Patent Office to reject patent application.
- Tied up with the interest of the multinational medicine company, Govt. appointed committee chaired by Dr. R.A. Mashelkar had reported against the Patentability under frivolous claim.
- The scope of availability of medicines at cheaper price manufactured by the national companies are also endangered. The Govt. has not yet shown required prompt action in defending its sovereign law in the court.

Data Exclusivity:

- Post patent amendment issue which yet remains unresolved is data exclusivity permitting the generic medicine makers to produce off patented medicines relying on the test data from the patentees.
- The Govt. Committee appointed for the purpose has not yet reached to conclusion. Multinational lobby is highly active in this area.
- It is apprehended that most stealthily the Govt. determine data exclusivity period which would help prolonging the patent period beyond 20 years.

Production Outsourcing:

- In absence of any compulsion on the companies to manufacture medicines within the country, the multinationals are taking advantage to manufacture bulk medicines by the Indian companies and re-exporting them at a very high cost beyond the limit of price control.
- Large Indian companies are shifting towards this direction since they apprehending that being unable to market patented medicines this contract manufacturing would provide their industrial activity.
- The production profile of Indian company would surrogate from domestic consumption to export may lead to shortage of essential medicines.

Other issues of concern:

New drugs for reproductive therapy,

- Formation of the Drug Regulatory Authority,
- Essential drug shortages,
- Irrational and hazardous drugs, rational drug use with focus on antibiotics and drugs in national health programmes.

Many other issues were highlighted, but due to lack of time, it could not be taken up. They include:

- National AIDS drugs programme – phase 3 had been started;
- A task force on safety of food and medicine had been set up;
- Code for ethical marketing needed to be looked into;
- Issues of pricing vs. the industry;
- Profiteering by the drug industry;
- Monitoring of drug prices;
- Complete utilisation of flexibilities under TRIPS, including compulsory licensing,
- Availability (production and access) of essential medicines;

Dr. Zafarullah Chowdhry, shared about the experience of drug policy in

Bangladesh and said that higher price of drugs was not a guarantee for quality. He said that, even developed countries have drug price control directly or indirectly.

B. FUTURE ACTIONS

At the Ministry Level

1. People's Pharmaceutical Policy should be prepared and presented to the Govt as a demand from the people.
2. Meeting with selective Parliamentarians, political parties can be held for pursuing the demands.
3. Campaign booklet should be published in several regional languages.
4. State Campaign Committees should be formed to popularise the demands and local actions.
5. To pursue code of ethics to be formed by the Govt. to regulate promotion of medicines.
6. Public interest litigations should be filed against violation of code, inaction by the state drug control on fake medicines.
7. Meeting with the medical students to popularise demands and for rational use of medicines and to develop appropriate medical curricula, guideline for local ethical committees, preparation of hospital formulary, etc.
8. National Convention at Delhi by end of 2007 on the demands.
9. Coordinate activity for production and procurement of medicines by the civic society initiatives.
10. Action required on Drug Regulatory Authority with focus on essential drug availability, irrational and hazardous drugs and rational drug use with focus on antibiotics.
11. Contribution to the work of national task force on safety of food and medicine.
12. Focus required on issues of pricing, profiteering by the drug industry, monitoring of drug prices;
13. The issue of complete utilisation of flexibilities under TRIPS should be taken up, including issuing of (or applying for) compulsory licensing.
14. Kolkata Declaration should be revisited and widely publicised.

4.4 Dialogue with Policy Makers

Chairperson : Dr.B.Ekbal

Facilitator : Dr. Abhay Shukla

Issues raised by Jan Swasthya Abhiyan

We would like to know the position of the organisation you represent regarding:

- Making the Right to health care a fundamental right under the constitution; enacting a model Public Health Act at the national level and State Public Health Acts, to legally enshrine health rights of all citizens
- Ensuring a significantly higher rate of increase in health budgets of Union and State governments to make public health spending reach 3% of GDP by 2009 (required an overall increase of at least 35-40 % annually).

Increase in budgetary allocations to ensure comprehensive universalisation of ICDS by 2009.

- Major expansion of guaranteed health services, to ensure availability of all services and conditions required by various groups with special health needs (details in People's Health Charter, Indian Women's Health Charter and various JSA documents)
- Enacting at National and State levels comprehensive legislation and operational mechanisms to regulate the private medical sector, including quality standards of care for the entire health care sector, ceiling on fees and ensuring patients rights
- Binding national norms on Public-Private partnerships to ensure no dilution of public responsibility, while bringing private providers to fulfill public health goals. Abolition of user fees at all levels in the Public health system (except nominal registration fees)
- Ban on any further capitation fee medical colleges, formulation of a National Health Humanpower and education policy along with time-bound investment in training facilities and processes to ensure adequate trained healthcare personnel at all levels
- Including all essential drugs and their analogues under Drug Price Control, ban on all irrational combinations and formulations, utilizing available flexibilities to prevent the new patent regime from restricting access to essential drugs
- National review of vaccine policies (review of Pulse polio strategy, universal free availability of rabies vaccine without restrictions)
- Making available as a right - safe drinking water, comprehensive food security and nutrition, and effective environmental protection for all by 2009

Amarjeet Singh's reply

- He noted that a model public health act is already in the process of evolution and it will be circulated very soon.
- He noted that the concerns regarding PPP and the introduction of user charges had been raised on numerous occasions by pro-people NGOs. He assured the audience that there would be no non-transparent PPPs.
- He also said that a draft clinical establishment act was ready and will be circulated soon.
- He said that regarding the Rogi Kalyan Samitis they did not function only on the user fees collected. In fact the government is actually allotting these committees special money for the development of the hospitals.
- He reiterated the governments commitment to increasing the budgetary allocation.
- He called upon JSA to mobilize a dedicated cadre of rural doctors in the context of doctor shortages.
- He also noted that regarding the pharma policy there is the need for a unified department to look into the matter.
- There is the need to look at different socio-cultural models of health.

Hon'ble Minister Mr.Sujon Roy, Member of Parliament from CPIM broadly supported the issues raised by Jan Swasthya Abhiyan. He said We are in full conformity of realizing Right to Health for All . He specially mentioned the need for reducing drug prices. Availability of essential drugs at all levels at affordable prices should be priority of the govt. He said due to globalization and privatization cost of health and treatment is increasing. Under NRHM Govt. Should focus to improve the system. From his party he has assured full support.

4.5 Closing Ceremony

Closing ceremony was presided over by Dr.K.S.Tanwar, Secretary BGVS and Ms.Sudha Sunderaman, Secretary AIDWA .

Facilitator : Dr.Rahul Sharma , MPBGVS.

Ms.Sudha Sunderaman expressed great satisfaction and commitment for the decisions taken in NHA2 . She gave very dismal picture of women not only in rural areas but also in urban and elite classes. Malnutrition, anaemia and high MMR shows apathy of Govt. for improving health condition of women. She appealed to the audience and all the participants and the organizations to come unite and work for health for all.

Dr.K.S.Tanwar, said economic policies are also need to be changed to provide health for all . Privatisation of health services should be stopped. Unless we all work together this conditions will not be changed. On behalf of BGVS he assured to be a part of health movement at large.

Dr.Ajay Kumar Khare gave vote of thanks . On behalf of organizing committee he is thankful to national coordination committee to give an opportunity to hold National Health Assembly at Bhopal. He is especially thanked to all funding agencies- WHO, NRHM, UNICEF, UNFPA, UNIFEM, Dorabji Trust, and ICCHN. He expressed his gratitude for all members of organizing committee and volunteers for their tireless dedicated commitment and day and night work to make NHA2 a success. All support organizing committee received from various state committees, organizations supported for workshops, cultural groups and all the resource persons. He also thanked the state govt. for its full support and cooperation. Electronic and print media was especially thanked for their very good coverage and spreading the message.

In the end Mr.Vinay and Mrs. Charu from Gujarat gave emotional and appealing cultural programme on communal harmony.

List of organization participated in NHA2

Sl.No.	Organisation
	Madhya Pradesh
1.	Vikas Samvad
2.	Yug shati Mahila Mandal
3.	Pushp Kalyuan Kendra Sehore
4.	Jan Adhikar Manch M.P.
5.	Socio legal information center
6.	Catholic Relief Services
7.	Ekta Parisad
8.	Jan Sachas Sanstha
9.	FDRA Bhopal
10.	Mahila Vikas Samiti
11.	Royal Mahila Kalyan Samiti, Vidisha
12.	Gandhi Medical College ,Bhopal
13.	Pahal Jan Sahayog Vikas Sansthan
14.	Samaj Kalyan Samiti
15.	Samarpit Sewa Sastha
16.	Adarsh Yan hit gram vikasamiti
17.	Govt. Benazir Science and Commerce College,Bhopal
18.	MYK
19.	Dehat Samaj Sevi Sansthan
20.	Abhinav gramothan Samiti Dabra
21.	Prayas M.P.
22.	ANWC Bhopal
23.	Urban Health Resource Centre, Indore
24.	C.E.Rowc Bhopal
25.	Voluntary society
26.	Deep Jyoti Sanstha Sivani
27.	Sanghmitra Narishikhan Santhan
28.	Institute for study research development
29.	WRRC Bhopal
30.	Sewa Santha
31.	M.V.Foundation
32.	Bundel Khand Gramin Janothan Samiti
33.	Gram Sudhar Samiti Sidhi
34.	Vikas Samvad fellow
35.	Ambedkar Indian Club
36.	CARE Bhopal
37.	Gurukul Sanstha PSM
38.	Zilla Panchayat Guna
39.	CAPART
40.	Asha Niketan Welfare Centre
41.	Asha Gramothan Sanstha
42.	AITUC Bhopal
43.	Marco, Vikas and Kalyan Samiti Bhopal

44.	AIDWA
45.	Seed Bhopal
46.	CMAI Jabalpur
47.	CMAI Indore
48.	Christian Hospital
49.	Sambhav Samaj Sevi Sanstha Shivpuri
50.	Rachana Sanstha Gwalior
51.	Khadi andgramodhan Sangh Morena
52.	CID Sanstha Shivpuri
53.	National Centre for Dalit Organisation
54.	Lok Mangal Sewa Kalyan Samiti
55.	Parhit Samaj Sewi Sanstha
56.	Sahriya JanGathbandhan
57.	Jagrati Samaj Sewa Samiti
58.	Gram Vikas Parishad
59.	Asha Niketan Kalyan Kendra
60.	Narmada Bachao Andolan
61.	Manthan Adhyangan Kendra
62.	Adiwasi Mukti Sangthan
63.	PRS welfare society Sagar
64.	Emmanuel Hospital Association
65.	JanSahas Sanstha Dewas
66.	Jarat Adiwasi Dalit Sangthan
67.	Samadhan
68.	Seevika
69.	Nav Ankur Manav Kalyan Sanstha
70.	SATHI CEHAT
71.	Shilpi Kendra Indore
72.	Kripa Social Welfare Society
73.	AWARD
74.	Kisan Khaadigramdhogy Sansthan
75.	Rupcha
76.	Asha Niketan Socieity
77.	Private
78.	Nivetita Education Society
79.	Family Planning Associatino of India
80.	KDSS
81.	AES
82.	Vikas Anusanthan Avm Pragati Sansthan
83.	Devamatha Hospital
84.	Do Uglas Church PGVT
85.	Rural Environmental Developmental Society
86.	MPSS CHAMP
87.	Christian Medical Association of India
88.	Human Right Law Network
89.	Center for Integrated Development
90.	Sewa Sanstha

91.	Bhaya Aur Bhook Se Mukti
92.	Green Earth Social Development Consulting
93.	Gas Peedit Sangarsh Samiti
94.	Debate
95.	Vikalp
96.	CITU
97.	NCHSE
98.	Jagaran Samajik Sansthan
99.	Vigyan Sabha
100.	Kisan Sahayog Sanstha
101.	Samavesh
102.	Udthan Vikas Sansthan
103.	Other
104.	Ratan Welfare
105.	Samaj vikas seva samiti
106.	Rahul Mahila Bal Vikas Samaj Kalyan Samiti
107.	Janadhar Advocacy Kendra
108.	Ambika Shiksha Prasar
109.	Pratik Mahila Samiti
110.	Sachi Sanskar Sod Samiti
111.	Kalpak Vikas Samiti
112.	Paryavaran Sansthapak Samaj Kalyan Samiti
113.	Shiv Vikas Evm Shiksha Samiti
114.	Moti Shiksha Samiti
115.	Kavita Shiksha Prasar Samiti
	Uttar Pradesh
116.	WBCHA
117.	FMRH
118.	Nirantar
119.	BGVS
120.	Mahila Swasthy Adhikarmach
121.	SAHANOG
122.	Gramya Sanstha
123.	Gramin Purn Nirman Sansthan
124.	Baba Ramvarandas Gramin vikas Samiti
125.	Holly Cross Sisters
126.	Jeeradaya society
	Chhattisgarh
127.	Adivasi Ahokar Samiti
128.	Voluntary Health Association
129.	Community Health
130.	Animith Health Centre
131.	Jila Saksharata Samiti
132.	Rupantar Sanstha
133.	Yug Shakit Mahila Sangathan
134.	SHRC
135.	Mukti Morcha

136.	Mitanim Programmme
137.	Janchetna
138.	Pahari Korva Mahapanchayat, Sarguja.
	Uttarakhand
139.	Kamna Social Service Soceity
140.	BGVS
	Kerala
141.	KSSP
142.	CHRD
143.	CHAI
144.	KPWND
	Bihar
145.	BGVS
146.	KHS,
147.	ASHRAM
148.	MASOOM
149.	Najrat Hospital
150.	Community Health Centre
151.	SSK
152.	Mahila Vikas Kendra
	Delhi
153.	All
154.	Dan
155.	Aman
156.	CMAI
157.	JSA
158.	CRAW
159.	Matri sudhacharitable trust
160.	CISRS
161.	Council for Social Development
162.	DSF
163.	SATHI
164.	PNDP
	Himachal Pradesh
165.	BGVS
	Haryana
166.	BGVS
	Punjab
167.	BGVS
	Maharashtra
168.	The Hindu Press
169.	AIDWA
170.	MASOOM
171.	JSA
172.	Manav Foundation
173.	Korku Development Project
174.	Manta

175.	CHAI
176.	Institute of Health
177.	Radha Social Society
178.	CMAI
179.	Satyajeet Mutual Health Centre
180.	Sneha
181.	MFG
	Tamil Nadu
182.	Sister of SPN
183.	CHAI
184.	CHC
185.	KPWNT
186.	AIDWA
187.	JSA
188.	TNSF
189.	Federation of Consumer
190.	Sagma
	Gujarat
191.	Sandhi
192.	BGVS
193.	JSA
194.	SEWA
195.	Deepak Foundation
196.	Samarth Trust
197.	Anaohi Rajkot
198.	Devegad Mahila Sangthan
199.	Mahila Gram Vikas
200.	NDS
201.	Chetna
202.	Prayas
203.	Handicraft international
204.	Ansar
205.	FMRI
206.	Lok Sangharsh Morcha
	West Bengal
207.	FMRAI
208.	RRE
209.	Health for all association
210.	Vikas Rural Development organization
211.	CHAI
212.	NESA HAFDL
213.	CMAI
214.	Navjewan Hospital Rural Health Care Centre
215.	JSA
216.	Sohaj
	Andhra Pradesh
217.	JUV

218.	APD
219.	AIDWA
220.	DSSWS
221.	NMSRA
222.	Federation Consumer Organistion
223.	NFIW
224.	AIDIN
225.	FEDCOL
226.	Ragrot to Food
227.	CHAI
228.	Basic Needs India
229.	MV Foundation
230.	RDSS
	Karnataka
231.	JAKK
232.	APD
233.	BGVS
234.	CEHAT
235.	Sanathi
236.	SANADA
237.	NEFA
238.	JSA
239.	Jabroli women foundation
240.	Amravati Health Centre
241.	Suraksha
242.	Gramin Mahila
243.	Sakhi
244.	SamooH
245.	Najewan Mahila Ekta
246.	Jevika
247.	Apna Log
248.	Khoj
249.	CHAI
250.	JMS
251.	FMRAI
252.	Domestic Women Association
253.	Sangama
	Orissa
254.	The Humanity
255.	OCHA
256.	BAPTA
257.	BGVS
258.	Vishva Yuva Kendra
259.	JSA
260.	The Mother
261.	CHAI
262.	Parastuti

263.	VHIP
	Rajasthan
264.	Siv Shiksha Samiti
265.	JSA
266.	SHRC
267.	Nav Nirman
268.	Sikoi dirom
269.	Handi Craft International
270.	Puel
271.	BGVS
272.	SWERA
273.	Prayas
274.	Amulya Sansthan
275.	Lokshiksha Sansthan
276.	Majdoor Kisan Shakti Sangthan
277.	SPANN
278.	Prey
279.	CECOEDELON
280.	HREDL
	Jharkhand
281.	Population Foundation
282.	Lok Sewa
283.	Sansthan Kendra
284.	Sarvodaya Viklag Samiti
285.	CHABIJ
286.	SANCALP
287.	CIM
288.	BGVS
289.	Child in Need Institute