7. Proposed Health Districts
8. Modus Operandi of Health Corporation
9. Proposed engagement policy by passing PSC
10. Proposed Government and Private Medical Colleges
11. Functioning of MCI, WBMC, Joint Monitoring Mission etc.

Considering our previous experiences we should be alert and should pledge:

1. We will not work for personal gain, name, money, power and prize as well as fractional profiteering
2. Whatever minimum we contribute, contribute honestly, sincerely and in a transparent way and all contributions will be accepted with honour
3. We should be respectful to others and should not blame, ridicule, taunt or be humble others and their initiatives
4. We may propagate but cannot force to include our ideas, morals, plans, programmes etc. if it is not accepted by the house
5. We may have differences which we will resolve through discussions democratically
6. We should not dilute, deviate, delay or jeopardize the rudimentary initiative by unnecessary talk, debate, blockade etc.
7. We should have mentality to learn from others and work for the community
8. We should talk less and work more and work resolutely and persistently

UNITED WE, ACCOMPLISH WE MUST
[Unit Effort Document II]

Present Situation and our Programmes and Demands

PRESENT SITUATION :

In 1978, at the Alma Ata Conference (formerly in USSR, now Almati and located in Republic of Kazakhstan), ministers from 134 member countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of third world population has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterized by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalization which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor. Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma Ata has significantly aggravated the global health crisis. Governments and the international bodies are fully responsible for this failure.

To cover up their inefficiencies, the international health and social organizations, mostly funded by US and its allies of first world and who have imperialist and hegemonic interests in second and third world countries, in 2000, initiated **'Millennium Development Goals' (MDG)** within 2015, which essentially is an 'old wine in a new bottle' manipulation. Similarly to hide their complete failure to cater basic health services to people at large and inability to develop a need based effective health system and structure throughout the country since independence from British Raj in 1947, Indian ruling classes and their governments launched **'National Rural Health Mission' (NRHM)** in 2005 with loud fan fare. But due to their in-built weaknesses and distortions, half-hearted attitude, red-tapism, corruption, nepotism, delayed response, poor motivation, poor work culture, lack of co-ordination and other faults NRHM has not been properly implemented like previous health policies and programmes.

Essentially these maneuvers accelerate the shift of health orientation from a sovereign people's democratic health system to a global capital based, highly privatized, highly profit making, city and curative-centric health industry. In course of capitalization and privatization of health system most of our population, particularly the peasants, workers, artisans, other rural and urban poor, minorities, dalits, adivasis, nationalities, middle income groups like common service providers, small traders etc. have been deprived from their fundamental constitutional rights. Now big capitals are dominating the health and pharmaceutical industries and virtually treatment becomes so expensive that common people cannot afford it. **National Health Policy** first declared in 1983 vowed to encourage private curative centres with a view to

reducing government expenditure. Moreover, in 2002, the **NHP II** solicited for levying reasonable user charges for certain secondary and tertiary public health care services. All these came in the wake of directives attached to the World Bank-IMF loans to curtail government expenditures in public utility services. Later GATT and WTO added flavour to these. Again in 2012, on the eve of finalization of 12"' Five Years Plan, the Government of India, conspired for outsourcing remaining health care services including primary health care to NGOs and private players.

Central government's all time budget allocation on health remains less than 2% where real health budget is practically around 1%. From malaria control to tuberculosis control most of the **national health programmes** have been declared futile officially with adaptation of revised or plus strategies guided by infamous World Bank, IFID etc. monetary and other overseas agencies. Though Indian rulers sometimes express their pride for having a large economy and hosting leading industrialists and entrepreneurs, the real picture tarnishes their pseudo-images. According to human development and health indices India scores pathetically 134th and 172nd positions and India becomes the capital of tuberculosis, MDR & XDR tuberculosis, HIV-AIDS, polio, kala-azar, malaria, filaria, dengue, chikungunya, leprosy, diabetes mellitus, ischeamic heart diseases, strokes, blindness, carcinomas, psychosomatic disorders, denerative bone diseases, road traffic accidents and others. Now US tilted policies of Indian government are facing catastrophe after massive hike of crude petroleum by OPEC, conflicts in oil-rich Middle East countries and after chain of crashes in global capitalism (sub-prime crisis, failure of global finance capital and investment agencies, fall of share-market, bankruptcy, liquidation of large industries, massive retrenchment and unemployment, massive cut of state subsidiary etc. which resulted in Wall Street Collapse in the USA, failure of economy in Iceland, Greece, Spain etc.). In the backdrop of global food crisis India is also adjudged 66th hungriest country out of 88 hungry countries.

From different national surveys we came to know that West Bengal became topper among Indian states on hunger and death due to hunger. The abysmal socio-economic-nutritional conditions of tribal inhabited western parts of West Bengal (Parts of Paschim Medinipur, Bankura and Purulia districts); tea gardens of Terai region of North Bengal (parts of Darjeeling and Jalpaiguri districts); river-erosion and flood affected areas of Maldah and Murshidabad and cyclone and high-tide affected Sunderban of two 24 Paraganas and Purba Medinipur districts are known to all. After 30 years rule by Congress, 34 years rule by CPIM led Left Front and more than one year rule by TMC, West Bengal becomes the front runner on closure, retrenchment, unemployment, lawlessness, social unrest, violence, infiltration, eviction, migration to other states for livelihood, crimes against women, trafficking of women for prostitution and sex-slavery, child labouring, non-implementation of social projects, collapse of public distribution system etc. LF ruled WB ranked 19th and 10th places respectively in infra-structure and economic development among Indian states and TMC government still cannot come out from its first agro-industrial promise the `Singur imbroglio'. Due to faulty agricultural policy, over-dependence on bureaucracy and fall of residual self-governance in rural Bengal the agriculture sector, the major sector and major employer, deteriorates further in TMC rule.

State-sponsored organized genocide occurred at Marichjhapi, Karanda, Nanur, Nandigram and Netai in LF Rule. After failure of land reform and stagnation in agriculture the rural economy has been throttled. The **Panchayeti Raj Institute (PRI)**, government co-operatives and rural banks, which could bail out from this situation, rather became inert due to petty party politics, non-working, nepotism and corruption on the behest of ruling parties, kulaks, middlemen and lumpens. Factory and mill owners in connivance with ruling leaders, ministers and union leaders shifted their profit, capital and assets to more profiting sun-rise industries in Western India without modernizing the existing tea gardens, jute mills and other industries. After plundering and siphoning all the properties they declared closure or lock-outs depriving pays and dues of workers and in this process ruined thousands of workers and their families. Now the mill owners with the help of above mentioned politicians started promoting multi-storey apartments and shopping mall business in the precious factory lands. Again the LF government brought some big capitals who were trying to grab thousand acres of best alluvial lands evicting rural and urban poors in the name of industrialization and development. Now TMC government is repeating the same

drama from Nonadanga to Howrah. 2216 km long Bangla border is practically unmanned and becomes the epi-centre of narco, flesh and arms trades and other illicit activities. Armed forces are being spoilt and they became a high-risk group for contracting HIV-AIDS. Citizens' lives become troublesome due to 'syndicate raj', poor governance, unplanned development, digging of roads, water-logging, rocketing price rise, environmental pollution, noise pollution, pollution related and vector borne diseases, transport problems and obviously for the highhandedness of leaders-promoters-hoodlums and prevalence of mall - pepsi - IPL - lotto - liquor - Bollywood culture. You cannot admit a seriously ill patient in a government hospital in Kolkata without bribe or 'catch'. Services in government hospitals are plan fully disrupted to pave way for privatization particularly for the 'health hubs' developed by businessmen - politicians nexus at EM Bypass, Kolkata, Siliguri etc. Private hospitals are not providing emergency services. Peoples are either thronging to South Indian hospitals or to the quacks for treatment of common ailments.

The government health system in West Bengal has been on the verge of collapse vis-a-vis booming of private hospitals, nursing homes, clinics, diagnostic centres, insurance companies, TPAs, touts etc. Their beloved government even waived tax from these money and profit making organizations in the name of 'research'. Government has no will to thwart the unethical and corrupt activities either of these private institutions like excessive and false billing, unnecessary investigations, negligence in patient care, irrational use of ventilator, ICU etc. or mal and unethical practices of government doctors inside and outside the hospitals. There is resentment against the **Medical Council** also as it was captured by CPM doctor leaders earlier and now by TMC doctor leaders who are always weak to the highly corrupted and grossly negligent doctors. Among Indian states West Bengal floats middle rank in Infant Mortality Rate (IMR) and topped on anaemia in children. World Bank funded **SHSDP-II**, to develop middle tier hospitals (rural to sub-divisional hospitals) and a proper patient referral system, was a failure though a huge extra-budgetary transaction was noted. Again West Bengal government is bringing a huge extra-budgetary fund from DFID, GTZ, JICA etc. donor agencies to develop primary and tertiary hospitals and other set ups. GTZ built asbestos-shaded hospitals in tribal-inhabited Bankura, Birbhum and Purulia was a complete failure. Cow-dung covered village health centres give births juicy jokes whereas the Health Mafiosi, consisting of corrupted party leaders - corrupted administrators - contractors - corrupted doctors and health staff, are draining the money. In their pockets L.F ruled West Bengal government has been starting privatizing of government health services in full swing since early 2000 following the footsteps of neo-liberal Central Government. important programme components of **NRHM, RCH-II, NACP-III, RNTCP-II, NLEP, NVBDCP** etc. are assigned to NGOs in the name of **public-private-mix (PPM)**; all district level health activities have been transferred under **District Health & Family Welfare Samity** controlled by Zilla Parishad Savadhipati, District Magistrate, representative of MPs etc.; low-paid contractual workers are engaged in all spheres instead of recruiting regular staff and transforming the entire health service to an corporation. Sagar Dutta hospital of northern suburb of Kolkata was planned to donate to Apollo Glenagles and vast land of K.S. Roy TB Hospital of southern suburb was donated to a NRI who started a profit making private medical college flouting all government norms on admission in MBBS course, fees structure and teaching modules. Same things were happened in private Medical & Dental College at Haldia owned by a CPM leader. Lucrative ambulance and diagnostic services were opened to Private players who were also invited to take over the vast land of TB hospitals located at Dhubulia, Dubrajpur and Chandrakona Road. Rampant corruption was practiced regarding purchase of medicines and logistics; tenders for medicines, instruments, reagents, diet, scavenging etc. and engagement of contractual workers and ASHAs. All these were happened with full support of ruling CPM party and ruling LF government. On the other hand official oppositions were silent on these important issues related to public health. Now the TMC government is trying to sell the precious land of government hospitals and profitable diagnostic services to private players directly or indirectly through **PPP, fair price shops** etc. modes and engaging cadres by-passing PSC. And present official opposition, the erstwhile ruler, remains completely mum. The present government, whose Health Minister is the Chief Minister herself, cannot run the existing hospitals and medical colleges, but always announces for establishment of **super-speciality**

hospitals and medical colleges here and there including a 500 bedded hospital for Muslims in Muslim dominated Bhangar, 24 Paragans South, to woo populist votes in panchayet and other elections. Again to undermine its ally cum competitor INC, who has dominance in Muslim majority North Dinajpur, Maldah and Murshidabad, it is neglecting the process of establishing **AIIMS** at Raigange and proper functioning of Maldah and Baharampur Medical Colleges.

It has now become essential to build up a concerted individual, community, village or ward, block or borough, district, state, national and international efforts to put the goals of health for all to its rightful place on the development agenda. Genuine, people-centred initiatives must therefore be strengthened in order to increase pressure on decision makers, governments and the private sector to ensure that the visions of Alma Ata, MDG NRHM and UHC and promise of primary and essential health care to all become a reality And for this **all pro-people health initiatives should be united - to protest and change, - for formulation and implementation of genuine people's health policies and programmes.**

PROGRAMMES :

1. Development of a pro-people, scientific, reasonable, effective and sustainable State and National Level Health Policy with special arrangement for challenged areas and population, both organized and unorganized industries, migrant and landless laborers etc.
2. Extensive propaganda for the urgent demands of the people both inside and outside the campus, unification of all pro-people individuals, groups and organizations for common essential issues; mobilization of mass of the people and launching a strong people's health movement particularly on basic and primary or essential health care.
3. Removal of corruption and mismanagement in government health facilities and ensuring transparent billing, adequate infra-structure and medical rights in private health set-up by direct intervention.
4. Opposing privatization, commercialization, corporatization, insurance-ization and NGO-ization of government health system.
5. Developing, supporting and coordinating alternative health models and innovations where government health system is absent or deficient or weak and / or defunct and / or corrupted.
6. Fight for a scientific, rational and pro-people syllabus and curriculum in medical education and involvement of medical, nursing, pharmacist, medical technology students in the pro-people health movement.
7. Regular inter-personal and inter-organizational sharing of experiences with family building among all pro-people health initiatives.
8. Pooling our efforts, energy, time, resource and creativity to publish a popular, easily written, vernacular and sleek health bulletin and to distribute widely among mass of the people.

OUR DEMANDS

1. Completely free treatment in government hospitals up to medical colleges including all necessary investigations. No need of RSBY, Medical or other health insurance.
2. Out Patient Departments (OPD) of all hospitals from Primary Health Centres to IPGMER and specialist clinics from sub-divisional hospitals to medical colleges are to be remain open from 9 am to 4 pm from Monday to Friday and 9 am to 2 pm on Saturday throughout the year except Sunday and ten notified holidays as per government norms and Medical Specialists, Medical Officers, Nursing Staff, Pharmacists, Technicians, Attendants and Sweepers, attached to the OPDs, clinics, laboratories, X-ray, ECG, USG etc. should be available throughout the period. Private hospitals should also abide by these norms.
3. **Emergency treatment, investigations** and **medicines** should be available from Primary Health Centres to tertiary hospitals round the clock and 365 days with presence of Medical Officer and other support staff. **Private hospitals and nursing homes** should have emergency clinics and emergency arrangement mentioned above and no private hospital and nursing home can deny emergency treatment including accidents and injuries.
4. As per '**right to information act**' the plan, methods and prognosis of treatment including expenditure should be clearly informed to the patient and / or patient party day to day basis. **Help desk**, along with 24 hours manning, with prominent vernacular signage is to be installed.

Arrangement of **meeting between attending doctors and patient parties** is to be arranged twice daily in a fixed time.

5. Prominent **display of available services** with timing, staff position, name of doctors and their dates of OPD, OT & admission days and availability and status of beds, drug stock, blood stock etc. in all health centres and hospitals.
6. Availability of following basic facilities in government health centres and hospitals : **(i) At village level** – establishment of Drug Depot Holders with primary management of fever and diarrhoea and primary health education on hygiene, immunization, disease prevention, family planning, environment, sanitation and safe drinking water by **ASHA/Dais/CHG Gram Sevak or any trained volunteer and arrangement of a van-rickshaw/country boat for transfer** of serious patients or pregnant women to nearest PHC; (ii) **At sub-centre (SC) level** – availability of 1st and/or 2nd ANMs round the clock (9 am to 3pm from Monday to Saturday at sub-centre and after that at adjacent quarter or residence) with arrangement of normal delivery and a mini-ambulance (Matrijan) to transfer complicated cases; arrangement of treatment of minor ailments and accidents, fever, diarrhoea, malaria, kala-azar, tuberculosis, leprosy, filaria & chikungunya and arrangement of immunization & family welfare services, availability of pregcolor, rk39, RDK, H2S, Cary Blair, Iodine detection kits and strips, availability of sufficient delivery kits, ORS, Halozen tablets, bleaching powder etc.; arrangement of quarters of 1st and 2nd ANMs and a garage for the ambulance. In flood prone areas SC and other health units will be functioning from 1st floor. (iii) **At Primary Health Centre (PHC) level** - Full- fledged running of OPD in presence of Medical Officer, nurses, pharmacist, medical technician and MT (optometry); sufficient medicine stock; arrangement of normal and assisted deliveries; arrangement of general and emergency treatment of respiratory and gastro-intestinal systems, skin, eyes, ears, accidents, snake-bite, dog bite, drowning, burn, electrification, poisoning etc. common ailments and minor operations; arrangement of resuscitation kits, gastric lavage, oxygen, drip, AVS, ARV, life saving drugs and ambulance (Nischayjan); arrangement of habitable quarters for doctors, nurses and other staff; (iv) **At Block Primary Health Centre (BPHC or CHC) & Rural Hospital (RH) level** – (iii) plus availability of gynaecologist, anaesthesist, paediatrician and dentist; AYUSH clinics; ANWESHA Clinic; ICTC; DMC; 24 hours service for emergency management, admission, emergency operation & caesarian section, laboratory, ECG, X-ray, blood storage unit (BSU) & NRC; arrangement of vasectomy, tubectomy & moderate operations, at least two ambulances (Nischayjan) and generator; provision of isolated beds for infectious diseases, (v) **At Sub-division (SDH) and State General Hospital (SGH) level** – (iv) plus presence of physician, surgeon, pathologist, radiologist, orthopedic surgeon, eye surgeon and ENT surgeon; facilities of USG, FNAC, Blood bank, peritoneal dialysis, respirator, ICU, SNSU, ART link centre, physiotherapy, post mortem, fixed dated board for physically challenged persons, isolation ward and burn ward; (vi) **At District Hospital (DH) level** – (v) plus presence of cardiologist, pulmonologist, oncologist, microbiologist, dermatologist, psychiatrist and dietician; facilities of ICCU, SNCU, ventilators, CT-Scan, micro-biology & histopathology, dialysis, PP unit, PPTCT; cancer, thalassemia and haemophilia day care centres; ART centre, geriatric ward, trauma centre and public health laboratory having tests for arsenicosis, fluorosis and others.
7. Arrangement of **adequate infra-structure** and availability of **proper number and trained man power** in private clinics, nursing homes and hospitals as per norms.
8. Immediate **repair** and **renovation** of **health centres** and **hospitals** including **residential staff quarters** which are in dilapidated state with proper annual maintenance.
9. Arrangement of investigation and treatment of **Acute Encephalitis Syndromes, Nipah viral fever, SARS, Avian influenza, Swine flu, Dengue Hemorrhagic Fever** etc. emerging and re-emerging infectious diseases in all medical colleges and apex hospitals including the School of Tropical Medicine and IDBG Hospital.
10. Sufficient and steady supply of **vaccines** and **medicines** at **sub-centres** and **hospitals**.

Inclusion of JE and penta-valent vaccines in routine immunization schedule. All posts of **Multi Purpose Health Workers (MPHW), Auxiliary Nurses cum Midwives (ANM) and Accredited Social Health Activists (ASHA)** are to be fulfilled immediately and all sub-centres, catering primary and basic health to 5000 population in villages and 3000 population in tribal and hilly areas, are to be made viable and functioning. Similar efforts are to be given on **urban health centres** and **clinics** in Corporation and Municipal areas.

11. Proper implementation, functioning and spending of **NRHM, RCH II, IDSP** and **National Disease Control Programmes** and immediate launching of **National Urban Health Mission** and publication of month wise status and expenditure reports of these programmes both in display of Zilla Swasthya Bhavans and web sites.
12. Repealing of **West Bengal Medical Services Corporation Ltd.** and taking over of private KPC Medical College at KS Roy TB Hospital Campus, Jadavpur and Haldia Medical and Dental College by the government.
13. Establishment of **North Bengal Medical College & Hospital** and **North Bengal Dental College & Hospital** as complete and functional medical college and dental college as per **Medical Council of India (MCI)** guidelines and commissioning a Medical College at Coochbehar. **Nursing and MT training institutes** with all medical colleges.
14. Establishment of **mini directorates and secretariats** of Department of Health and Family Welfare, Government of West Bengal, at Siliguri, Maldah and Durgapur.
15. Full-fledged functioning of government **medical colleges** at **Maldah, Baharampur, Kalyani** and **Sagar Dutta Hospital, Kamarhati.**
16. Review of **"West Bengal Medicare Service Persons and Medicare Service Institutions (Prevention of violence and damage to property) Bill 2009"** with inclusion of commitments and transparency of medical communities and institutes and health and civil organizations are to be included in the process of finalization of the bill.
17. Oppose 'hire and fire' policies on contractual health staff and will support the legitimate demands of confirmation, pay hike, maternity leave, medical and accidental benefits, provident fund and an congenial working atmosphere by **contractual health staff, RNTCP & NACO staff, trained dais, CHGs, NRHM link persons, vaccine carriers, spray workers, ASHAs, AWWs, Gram Sevaks, IPP-VIII & CUDP workers, Midday Meal Workers** etc.
18. Immediate and appropriate, integrated and down-to-earth implementation of **'Janani O Sishu Surakswa Karjakram'**, **"Ayusmati Prakalpa'**, **School health** and **nutritional supplementation programmes** to protect and strengthen mothers, neonates and growing children.
19. Democratic election and functioning of **'Rogi Kalyan Samities'** with representation of community and hospital staff.
20. Banning of extremely harmful **sponge iron factories** and opposing indiscriminate construction of rice mills and brick kilns in rural Bengal and erection of **mobile towers** in academic, playing, residential and working areas.
21. Review of **'US-India Nuclear Treaty'** and also demands for repeal of **'End-Use Monitoring Agreement (EUMA)'**. Oppose proposed Haripur nuclear plant and Nayachar chemical factory.
22. Involvement of health, science, civil, workers' and peasant organizations for preparation of proposed `Health Rights Bill.' and `Universal Health Coverage' and immediate implementation of them.
23. Formation of **'Rapid Response Team (RRT)'** with training and equipments up to block level to combat disasters. Inclusion of **Disaster Management** from secondary school level.
24. **Fixation of consultation, treatment, operation, investigation, bed and other charges and packages for all private hospitals and nursing homes** with proper monitoring.
25. Involvement of health, science, civil, workers' and peasant organizations for formulation of scientific, rational, beneficial, effective and sustainable **"Clinical Establishment Rules"** and **"Food Safety Rules"** and stringent implementation of them.
26. Case specific **audit of all death and referral cases.**
27. Supervision and monitoring of implementation of **Standard Treatment Guidelines** by doctors

from PHC to Medical College as well as private practitioners.

28. Strengthening **Rain Water Harvesting** in agriculture and other water related works to prevent leaching of micro elements in aquifers and thus preventing arsenicosis, fluorosis etc. and encouraging **Solar Panels** to consume energy and to prevent burning of harmful fossil fuels. Linking up of **MGNREGA** with viable landscaping, road and check dam building, water bodies and canal digging and their reform etc.
29. Increase the slab and make ease the procedure of sanctioning of **Illness Assistance Fund** for the poor.
30. Till attainment of free treatment to all, allow **poor certificate** (economically weak) issued by elected people's representatives, government servants and teachers in stead of ambiguous BPL certificate.
31. Arrangement of **regular mobile and outreach camps** for challenged areas like forest and island areas of Sundarban; Jangal Mahal of Paschim Medinipur, Bankura and Purulia; 'Khadans' (mines and quarries) of Bardhaman and Birbhum; erosion affected and island areas of Maldah and Murshidabad; 'Chitmahals (corridors inside Bangladesh); remote hilly areas of Darjeeling and tea gardens and forested areas ('Banabastis') of Jalpaiguri.
32. Engagement and fulfillment of vacant posts through regular (yearly) conduction of **PSC** examinations and formulation and implementation of a reasonable and time-bound transfer and promotion policies for all.
33. **Same pay scale and other benefits** in central, central-government undertaking, ESI, state, corporation, municipalities, government sponsored autonomous bodies as well as in WBHS, WBMES, WBPH&AS, NRHM, Adhoc and contractual services. Abolition of all adhoc and contractual services.
34. Enhancement of the work for establishment of an **AIIMS** at Raigunge; establishment of second campuses of **NICED** and **STM** at Siliguri; establishment of **ESI hospitals** at Asansol, Siliguri, Kharagpur, Kalyani, Siuri and Jangipur; revival of **Satyabala ID Hospital** in Howrah and modernization of **TB, leprosy, mental** and **AYUSH Hospitals.**
35. Inclusion of management of diarrhoea, fever, respiratory tract infection, worms, common skin problems, unconsciousness, foreign body inhalation or impaction, injuries including gun shots and blasts, asthma, epilepsy; snake, dog and insect bites; drowning, lightening, insecticides and other poisoning, burn, shock, stroke, road traffic accidents etc.; exclusive breast feeding for first six months of birth; child, adolescent, antenatal, lactating and geriatric care; hygiene, nutrition, addiction etc. **common problems and ailments of our country** in the curriculum with adequate importance.

[Unity Effort Document VI]

উত্তরবঙ্গে যৌথ উদ্যোগ

সুদীপ্ত মুখোপাধ্যায়

উত্তরবঙ্গের শিলিগুড়ি, কালীঝোরা, রায়গঞ্জ প্রভৃতি এলাকায় 'শিলিগুড়ি ওয়েল ফেয়ার অরগানাইজেশন', 'ফোরাম ফর পিপলস্ হেলথ্', 'APDR', 'PUCL' সংগঠনগুলি যৌথভাবে কয়েকটি আলোচনাচক্র আয়োজন এবং কয়েকটি রুগ্ন চা-বাগান পরিদর্শন করেন। বিশিষ্ট বুদ্ধিজীবীদের ও সাধারণ মানুষের ছিল উদ্দীপনাময় উপস্থিতি। ডা: বিনায়ক সেন, ডা: অনিতা মজুমদার, ডা: দেবাশিস দত্ত, অভিজিৎ মজুমদার, ডা: প্রবীর চ্যাটার্জী, ডা: জয়ন্ত ভট্টাচার্য্য, ডা: সুদেব সাহা প্রমুখেরা আলোচনা ও ক্লিনিকে অংশ নেন। দুঃস্থ চা-শ্রমিকদের সহায়তা, সাধারণ, মানুষের স্বাস্থ্যের দাবী নিয়ে আন্দোলন এবং বিভিন্ন এলাকার 'জনস্বাস্থ্য কমিটি' গড়ে তোলার সিদ্ধান্ত হয়।