

**Report to the National Human Rights Commission, New Delhi on the
Complaint from Mr. K. Yerran Naidu regarding death of Girijans in Agency
Areas in Andhra Pradesh due to a major epidemic breakout of Malaria,
Anthrax, Dengue, etc.**

20th August 2005.

Sub: Complaint from Mr. K Yerran Naidu regarding death of Girijans in Agency Areas in Andhra Pradesh due to major epidemic breakout of Malaria, Anthrax, Dengue, etc.

Ref: Case No.214/1/2005-2006 NHRC (Law Division-IV) dated the 27th July 2005.

In the complaint cited above it has been stated that there is a major epidemic breakout of Malaria, Anthrax, Dengue, J.E. etc. in the Agency areas of the State of Andhra Pradesh and more particularly in Visakhapatnam District of Andhra Pradesh, that such an occurrence of epidemic is normally expected every year during rainy season, especially in the Agency areas but that, quite surprisingly, the State Government did not wake up and take any preventive or curative measures to control this epidemic in time. This negligence on the part of the State Government and its inaction has claimed several innocent lives in the Agency area.

2. While a copy of the Complaint petition has been forwarded to the Principal Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department for a response, I have been requested by the Commission to visit the affected areas, more particularly Visakhapatnam District, and submit a factual Report.

3. The basic points made in the complaint are that -

- (i) The health sector has been grossly neglected and health conditions of the common people have been dismally deteriorating.
- (ii) There has been no Minister exclusively for an important subject like medical and health for the past 14 months.
- (iii) Several Doctors and Para Medical Staff who were recruited by the earlier Government exclusively to serve in the Agency areas have managed to get transfers

to other places of their choice in the present Government throwing many more posts vacant in the Agency areas.

- (iv) Innumerable posts of Doctors and Nurses are lying unfilled in the health sector.
- (v) Even basic medicines are not made available to the poor and common public who are suffering from various health problems and
- (vi) The situation now in the Agency areas is far worse and more deplorable than before.

4. It has also been stated that as a result of this callousness of the State Government, 809 people have been affected with highly infectious epidemics and succumbed to avoidable deaths in the Agency area of Visakhapatnam district. Most of them are children. There has been no response even to the representations made by several Girijan Organizations and Shri L Raja Rao MLA, Paderu. This constitutes callous indifference on the part of the State Government, gross violation of the fundamental rights and the directive principles of State Policy of the Constitution.

5. It has been stated in the Complaint petition that even after the notice sent to the Chief Secretary to the Government of Andhra Pradesh as early as 30th June 2005 by the National Human Rights Commission, only minimal attention has been paid by the State Government to the deteriorating conditions of the Girijans. The Chief Minister has not cared to visit the epidemic affected areas. The local Ministers started visiting certain areas in Visakhapatnam very late. There is a lack of basic medical facilities that is compounded by the negligence of Government. Contradictory statements are being issued by different Ministers of the State Government about the intensity of the epidemics, more particularly the incidence of Malaria.

6. The Complaint petition encloses a list of 936 names who are victims of the epidemics in the area and refers to the Leader of the Opposition in the Andhra Pradesh Legislative Assembly Shri N Chandrababu Naidu demanding the declaration of a "Health Emergency" duly providing all out help and relief to the victims of the epidemics in the epidemics-prone agency areas. The Complaint states that the persons in the list died due to "communicable diseases owing to the out break of epidemics in the current rainy season". The Complaint has expressed appreciation regarding the decision of the Government to declare a Health Emergency though belatedly and at least now planning for the deployment of medical staff, provision of medicine etc., in the affected areas. The Complaint petition demands that the

State Government should further gear up preventive and curative efforts on a war footing without giving room for any further loss of lives and demands the following steps:

- (i) All the vacancies of Doctors and Para-medical staff in the Agency areas may be filled up immediately with clear instructions for the staff to stay at the Head quarters of PHCs so as to make themselves available all through.
- (ii) Additional Staff may be diverted from other areas and deployed in the epidemic infested areas to meet the emergency situation.
- (iii) All the essential health and medical services be mobilized to help the affected areas so that such lethal epidemics like the present ones do not recur.
- (iv) An immediate relief package may be provided to all the families in the Agency areas of the State that may include, per family
 - 30 Kg. Rice,
 - 3 Kg. Dhall,
 - One Rug and one bed sheet,
 - Two mosquito nets.
- (v) A sum of Rs.1.00 lakh be given as ex-gratia to the next of the kin of the victims of the epidemics, and
- (vi) A judicial enquiry may be ordered to bring out the factual situation of the incidence of epidemics and also of the irresponsible, inconsistent and contradictory statements made by the Ministers at different times.

7. I have proceeded, as desired by the Honourable Commission, to the Paderu area of Visakhapatnam district, visited a number of villages personally and spoken to the people there; heard all concerned individuals; and held discussion with the Collector and all officers concerned with medical and health matters and development work in the area. Before proceeding to Paderu I had two meetings with the Principal Secretary to the Government of Andhra Pradesh, Health at Hyderabad and a third one again after my return from there; a meeting with the Commissioner of Tribal Welfare, Government of Andhra Pradesh and his senior officers on my return from the area; and a meeting with the Director of Health Services, Andhra Pradesh. I have also had the advantage of interacting with Dr S K Patnaik, Deputy Director, Regional Office of the Department of Health and Family Welfare, Government of India, Hyderabad. During my tour I have taken notes of the information gathered by me from the tribes at the village level and gathered information considered by me

relevant to this investigation from the Project Officer, ITDA, Paderu. In fact, I had made an informal memorandum of all the information I needed prior to my visit to Paderu and made that available to the Principal Secretary, Health and the Project Officer, Paderu as also the Sub Collector, Paderu. They, the Director of Health Services and the Commissioner of Tribal Welfare have made available quite some information to me that I had asked for. I am grateful to them for this.

8. I am most grateful to Dr. I. V. Subba Rao IAS, Principal Secretary to the Government of Andhra Pradesh, Health for sparing his time for detailed discussions on the situation in the Agency area. I am grateful to the Director of Health Services, the Commissioner of Tribal Welfare, the Collector, Visakhapatnam, the Joint Collector, Visakhapatnam, the Project Officer, ITDA, Paderu as also the Sub Collector, Paderu for discussing with me freely the issues involved and furnishing me with the information sought for by me. I am grateful in particular to Dr. Mohan Kanda IAS, Chief Secretary to the Government of Andhra Pradesh for issuing instructions to all the officers to provide me with all the assistance required by me to conduct my investigation in to the Complaint.

9. Based on all these efforts made and information gathered at the State Head Quarters, the District Head Quarters and at the grassroots level in the villages I have formulated my report, which is given below in 4 parts.

10. I reached Visakhapatnam early on the morning of the 4th August 2005. Before proceeding to the Agency area, I received a delegation of the Telugu Desam Party at the Government Circuit House, Visakhapatnam as previously arranged and heard from them again the various points made in the Complaint petition to the Human Rights Commission. I also had a brief preliminary meeting with Shri Praveen Prakash IAS, Collector, Visakhapatnam, Shri Sandeep Sultania IAS, Joint Collector, Visakhapatnam, Shri. Siddharth Jain, IAS, Project Director, Integrated Tribal Development Agency (ITDA), Paderu and Dr. Rama Rao, District Medical and Health Officer (DMHO), Visakhapatnam to get an idea of their perceptions of the developments in the Paderu Agency area.

11. Accompanied by the Project Director, ITDA, I arrived at Paderu early in the afternoon and held detailed discussions with a group of senior tribal leaders of the area consisting of Smt. Machiraju Mani Kumari, former Minister in the Government of Andhra Pradesh, Shri. Lake Raja Rao, MLA, Paderu and Shri. Chitti Naidu, former MLA, Paderu in regard to the

developments in the Agency area. All these three leaders belong to the Telugu Desam Party, on behalf of which party the present Complaint has been presented to the Human Rights Commission. I also consulted them on the villages that could be visited by me, especially the remote ones.

PART – I

I stayed and worked in the Paderu Agency area from the afternoon of the 4th August 2005 to the afternoon of the 6th August, 2005 and visited the following 5 villages:

1. Kujjali Village of Kujjali Gram Panchayat in the Paderu Mandal.
2. Pantalachinta village of Teegalavalasa Gram Panchayat of Hukumpeta Mandal.
3. Sappiputtu Village of Vantadapalli Gram Panchayat of Paderu Mandal.
4. Jogulapuram Village of G. Madugala Gram Panchayat of G. Madugala Mandal and
5. Champaguda Village of Madaguda Gram Panchayat of Arakuvalley Mandal.

2. In selecting these villages, I tried to cover representative ones from among the Mandals mentioned in the Complaint petition, where the largest number of deaths had been mentioned. In the case of Champaguda, my decision to visit this village was prompted by the very large number of deaths reported in this village as seen in the Complaint petition to the Human Rights Commission.

3. I night halted on the 4th August 2005 at Paderu and on the 5th August 2005 at Arakuvalley. I was accompanied to Kujjali, Pantalachinta and Jogulapalli by all the three senior tribal leaders mentioned above and to Sappiputtu by Smt. Mani Kumari, former Minister and Shri. Chitti Naidu, former MLA, Paderu. The Project Officer, ITDA, accompanied me to Kujjali, Pantalachinta and Champaguda. In addition, the Sub Collector of Paderu also accompanied me to Champaguda village.

4. In all these villages that I visited I sat with and among the people, spoke to them at length, and enquired about all matters relating to their life, health and livelihoods. The subjects of my discussions with them included their land holdings, availability of work for them when they did not have work on their own fields or in their own villages, the prevailing market wages and wages which they generally were able to earn per day, wages for men and women

separately, their nutritional status based on their hunger levels, their drinking water sources and their hygiene and safety, when was spraying of insecticides done for their homes and in the village, how and what number of deaths have taken place recently in their village, etc. I invariably asked for and spoke to the Community Health Worker (CHW) of the habitation, unless she was away from the village at the time of my visit. All this information was elicited in the full view and hearing of all assembled people including the leaders who had accompanied me and the press who invariably seemed to be present in the villages visited by me.

5. It is important for me to record here that if I have not visited more than 5 villages during this tour of three days that was because it was not physically possible to do more, consistent with the amount of time required to travel into the interior areas and to speak in a leisurely, reassuring fashion to the tribes to elicit the required information. Of the full 48 hours spent by me in the area, I may have slept for a maximum of 8 hours, on two different nights together.

The following are my findings in the above villages:

1. Kujjali Village: 3.20 p.m. to 5.30 p.m. on the 4th August 2005.

In this village 11 people had died in the last 6 months of whom 6 had died in the course of the last one month. The following are the names of those who died in the last one month:

(i) Tamara Syamala	W/o	Chellaiah	28 years.
(ii) Tamara Chellaiah	S/o	Apparao	25 years.
(iii) Vongerri Chandrammma	W/o	Bhaskara Rao	30 years.
(iv) Gabbada Ramanna	S/o	Kothanna	25 years.
(v) Tamara Lakshamma	W/o	Puttanna	40 years.
(vi) Killo Chittibabu	S/o	Bojjanna	30 years.

The following had died in the village about 5 months ago:

(i) Bonda Machamma	W/o	Subba Rao	30 years.
(ii) Arla Karamma	W/o	Endanna	40 years.
(iii) Supuru Ganapathamma	W/o	Jogulu	30 years.
(iv) Gammala Appamma	W/o	Ramanna	30 years.
(v) Gabada Chinna Balanna	S/o	Ramanna	40 years.

2. The villagers first told me that 8 persons had died in the village of “malaria” and later on, when we discussed and I wrote down their names, the number actually turned out to be eleven and not eight. This is because, as I found out in the other villages as well, the tribal villagers are not able to conceptualize the numbers all at one time when questions are asked. Only when we patiently write down the names and keep speaking to them would they be able to recall all the names one by one. Also, sometimes they could conceivably confuse 3 months as 1 month. For example, they told me that Chellaiah had died 3 months ago to begin with but while giving me the names of those who died in the last 1 month, they gave Chellaiah’s name as one such. This may be also because Syamala and Chellaiah belong to the same family. These are not contradictions but the difficulties that an interlocutor would face in the area. Excepting for these difficulties, truth itself is not a problem with the tribes living in these areas.

3. The villagers told me that all the persons who had died this year had died of “malaria”. The common expression used by them to describe malaria was either *Chali Jwaram* or *Visha Jwaram*. In Telugu, *Jwaram* means fever. *Chali* means shivering, in this context. *Visham* means poison. The point they seek to convey is that the victims died of killer fevers or “poisonous” fevers, which were invariably accompanied by shivering or rigor. So, the symptoms that were seen by the close relatives and the villagers in all these cases of deaths were high fever and rigor. Some times head aches, as well.

4. All those who died in this village of fever were scheduled tribes and none of them was a non-tribal. It is important to make this point here because, despite the law relating to land transfer being in existence for over more than a century barring non-tribals from acquiring immovable property in the scheduled areas, much of the land in this village is owned by non-tribals. That is the status to which the scheduled tribes have been reduced to in their own abode. I, therefore, specifically asked them if any of the fever deaths were those of non-tribals. The tribals reaffirmed that all those who died were scheduled tribes only because, as they put it, “rarely do non-tribals die of *Visha Jwaram* for they have the capacity to acquire better medical treatment than the tribes. They go to the 3 or 4 private hospitals in neighbouring Paderu town (headquarters of the Paderu Mandal), which provide better and more effective treatment than the Government hospitals do”.

5. I discussed the case of Syamala in detail with the villagers. Immediately she got the fever, she also got the shivers. She went to the Community Health Worker (CHW) who gave her

some “tablets”. These were consumed for 3 days continuously. In the meantime, on the second day of her fever, she was taken to the Government Hospital (actually the Community Health Center or CHC) situated at Paderu town, 9 km from this village. She was treated there for 1 day, including that night. She was administered an injection and drip. Her condition worsened and it became “serious” the next morning. Because of this, her family brought her away from the hospital back to their village where she died. Asked by me as to why they brought her away when she must have been kept in the hospital, the reply was that if she had died in the hospital the family would have been put to a lot of trouble to bring her body to the village as they had no money to engage an auto rickshaw to bring it home. Or they had necessarily to go to the Project Officer who alone had the authority to order the hospital authorities to allow a vehicle to carry the dead body back to their village. Anticipating her death and being certain of it they had got her back to the village for her to die there.

6. Discussions relating to their every day lives brought out the following information:

- (i) There is extreme poverty in the village amongst the tribals and they are keenly aware of it and feel helpless about it.
- (ii) The tribals have very little land of their own and about 50% of the lands are in the hands of the non-tribals, who, prima facie, are barred from having them as far as the law is concerned.
- (iii) The daily wages they get as agricultural labourers are Rs 20.00 per day, for both male and female. When they get some work in neighboring Paderu town, which is 9 km away (usually it is in construction work), the wages they get are Rs 35.00 for a male and Rs 30.00 for a female per day. However, work availability is very limited and lasts for a few days only.
- (iv) The tribals here go to the bed hungry for 25 days in a month for 5–6 months in a year, because of lack of work opportunities and food.
- (v) Tribals have necessarily to borrow from moneylenders for many purposes including buying food grains. The prevalent rate at which they borrow is Rs 5 per month for Rs 100. In other words, they borrow at an interest rate of 60%! Tamara Appa Rao who lost his son Chennaiah and daughter-in-law Syamala this year because of ‘fever’, has a total debt of Rs 16,000, – Rs 10,000 borrowed from the Union Bank, Paderu at 4% interest against hypothecation of the title deed of his land for agricultural operations, and Rs 6,000 from private money lenders.

- (vi) Their heavy indebtedness and inability to pay their debts back force them in to bondage under the non-tribals, who are both landowners and moneylenders. About half the agricultural lands in the village (and most of the land elsewhere in the tribal area, according to the tribals here) are in the hands of the non-tribals. Almost all masters of bonded labourers are non-tribals.
- (vii) The Domestic Requirement Supply Depot (known as D.R. Depot) that should supply the monthly entitlement of subsidized rice to the tribals at any time they are in a position to buy during a month insists that the tribal household lift its entire monthly allotment all at one time, in one installment. Since the tribals do not have the wherewithal to do so in one go (this means 20 kg x Rs 5.25 = Rs 105.00) they are forced to buy their food grains from other private shops or are forced to borrow from the moneylenders to buy their quota of rice from the Government D.R. Depot!
- (viii) There is just 1 bore well here for drinking water purposes, catering to 80 households.
- (ix) This village is an electrified village. However, 70% of the huts have no power, as they are too poor to pay for electricity.
- (x) The tribals constantly live with mosquitoes but their situation becomes worse in the rainy season.
- (xi) The authorities did no spraying at any time during the past 3 months. Spraying done prior to that was confined to the houses and cattle sheds. No spraying was done elsewhere in the village such as nalas, drains or stagnant pools of water. The tribals had not seen any disinfectants spread in any part of the village.
- (xii) The tribals in this village believe that an evil spirit living in an abandoned hut in the village was the cause of all these deaths occurring on account of 'fever' in their village. This hut is next door to where I sat and did my inquiry. This hut where I sat belongs to Supuru Jogulu, a tribal who has lost his wife because of 'fever'. The neighbouring hut belongs to a tribal Gabbada Malanna, who left the village 5 years ago on migration. The villagers want that hut demolished, as they believe that the evil spirit, living in Mallanna's hut, is causing all the *visha jwaram* deaths. They have made this request also to the Sub-Collector, Paderu.
- (xiii) The Community Health Worker (CHW) Krishnaveni was not available at the time of my visit to the village, as she had gone to do transplantation work to earn her own livelihood.

The above facts speak for themselves.

**2. Pantalachinta Village of Teegalavalasa Panchayat in Hukumpeta Mandal - 6
P. M. To 8 P. M. on the 4th August 2005**

This village is at a distance of about 18 Kms from Paderu and involved also a short walk of about 1 ½ Kms up and down from the road. The Kondh tribe, a Primitive Tribal Group, inhabits this village. About 30 men and women gathered around me to furnish me with information to the questions asked of them.

2. The following are the details of the seven deaths that occurred in this village of fever or *visha jwaram*:

(i) Pangi Rama Rao	S/o	Appa Rao	8 years.
(ii) Pangi Burushanna	S/o	Bennu	45 years.
(iii) Korra Bujji	D/o	Babu Rao	5 years.
(iv) Korra Suri Babu	S/o	Babu Rao	3 years.
(v) Sidheru Sita Kumari	D/o	Nageswar Rao	4 years.
(vi) Marri Lalitha	D/o	Jagga Rao	5 years.
(vii) Sidheri Rani	D/o	Appa Rao	3 years.

They all died in June 2005. Excepting for one, the deceased are all children.

3. The other facts relating to the socio-economic indices that determine the life and livelihoods of the tribals in this village as elicited from them are:

- (i) The wages that they earn per day by way of agricultural labour is Rs. 20/- for male and Rs.15 for female workers. When there is Government employment on works taken up under the SGRY the daily wages are Rs. 35 for male and Rs. 30 for female.
- (ii) Indebtedness is common. An articulate Kondh Sri Nageswara Rao who lost his daughter Sita Kumari in June 2005 has a debt of Rs. 2,000, incurred for buying food grains.
- (iii) Nageswara Rao's family goes to bed hungry twice in a week. This is the case with all the families that lost their members to the 'fever'. The other households in the village also go to bed hungry for 2 or 3 days in a week.
- (iv) The source of drinking water for this village is a spring ('KUNDI' in the local language). It is in a state of constant pollution with waters from the surrounding fields,

in rainy season especially, draining into it. Chlorination of this KUNDI had been done 9 days ago.

- (v) Not a single house (hut, really) has anything like a toilet.
- (vi) Mosquitoes are present in the village all through the year but intensity increases during the rainy season.
- (vii) Bandho, the Community Health Worker (CHW), whose honorarium is Rs 400 per month, had not received her honorarium for 5 successive months, at the time of my visit to the village. She earns her livelihood as an agricultural labourer. She goes to bed hungry often, so often that it could be 4 days in a week when 'she did not light the cooking fire', to put it in her own expressive language.
- (viii) Spraying was done in April 2005, on the outside of the homes as also cattle shed. However, no spraying had been done in any other part of the village. Bleaching powder was spread in some slushy areas in the village the previous day.
- (ix) In the year 2004, 5 deaths had occurred in this village of fever or *visha jwaram*. The year previous to that - 2003 - saw 3 deaths by *visha jwaram*. Such deaths have occurred in the area for the past several years but were more this year.

**3. Sappiputtu Village of Vantadapalli Gram Panchayat of Paderu Mandal -
10.40 A.M. To 12-40 P.M. on the 5th Of August 2005.**

This village is one of the more remote ones in the Agency area involving a travel of 16 Kms from Paderu by road of all descriptions followed by another 5 Kms of walk on difficult terrain. It took me all of 100 minutes to reach this place, accompanied by Smt Machiraju Mani Kumari, former Minister and Sri Chitti Naidu, former MLA, Paderu. Even as I went past one of the first huts in this habitation in slush and mud, I could see a young boy of about 10 sitting all by himself on the *pyal* of his house, shivering. It was the *shandy* day today at Paderu and the tribals were carrying their produce such as ginger and vegetables to the Paderu market several kilometers away. On my reaching this habitation, as many as 75 men and women gathered around me and they patiently gave me all the information I needed.

2. The total deaths in this village this year were 8, including one that had occurred just 3 days earlier on the 2nd August 2005. They had all died of fever or *visha jwaram* and following are the details.

- (i) Pangi Madhavi D/o Manju 8 years.

(ii) Korra Divya	D/o	Korra Siknu	8 months.
(iii) Marri Kondamma	W/o	Marri Krishna Rao	25 years.
(iv) Marri Anandam	S/o	Poolnaidu	5 years.
(v) Marri Roja	D/o	Nukharaju	7 years.
(vi) Marri Vishnu	S/o	Mallu Dora	1-1/2 year.
(vii) Marri Chanti	S/o	Musiri	2 years.
(viii) Marri Srinu	S/o	Sombanna	12 years.

Of the total deaths in this village this year of 8, as many as 7 were of children.

3. The following further facts highlight the condition in which the tribes here live:

- (i) With slash and burn cultivation ('Podu' as locally called) completely eliminated, survival is by agricultural labour only, accessed by migration up to the Minumaluru coffee plantations of the Andhra Pradesh Forest Development Corporation, 10 km away which by short cuts over the hills, would be a couple of kilometers shorter. Daily wages there are Rs. 52 per day for both male and female. But such employment attracts so much competition that its availability becomes limited and they look out for work elsewhere at lower wages.
- (ii) The daily wages they get by way of doing agricultural labour is Rs 20 for male and female both. Even in Minumaluru area, where they go in search of employment, work availability is limited to the months of June, July and August, and again January. During these 4 months they may get work for about 40 days in all. About ½ of the 53 households of this habitation go to this area for work and return on the same day back home.
- (iii) All the 53 households go hungry in this village during September – November and part of December. During these 100 days, every one will go hungry for at least 60 days.
- (iv) Debts in each household are a reality. Debts range from Rs 3,000 to Rs 7,000 obtained from the *Sahukars* (money lenders) of Vaddadi Madugula area, 45 Kms from here, at a rate of interest of 36 %. These *sahukars* are businessmen to whom the debt is repaid through agricultural produce raised by the tribals such as Ginger, Turmeric, Redgram, Pippali root (a medicinal herb) and Niger seed. These are high value products but the *sahukars* purchase them against the loans

taken at a price of at least 30 % less than the prevailing market rates. Where the transactions are on this basis, no interest would have been charged for the loan. This is a clear case of classical bonded labour.

- (v) The D.R. Depot in Minamuluru 10 Km away is the nearest Public Distribution System (PDS) source. However, rice would be made available only once in a month, in most months of the year. Since the tribals do not have the cash required to buy their 20 kg entitlement all at one time, as already pointed out by me earlier elsewhere in this report, their quota lapses for the month. At least on 6 occasions out of the 12 months in a year, their entitlement in the Public Distribution System lapses in this manner.
- (vi) In the last few days Anthyodhaya Anna Yojana (AAY) cards have been issued to 45 of 52 households as all the households living here belong to the category of Primitive Tribal Group. The only reason why the other 7 did not get their cards is because even earlier they were without cards, though they were poor and belong to the Primitive Tribal Group category.
- (vii) There are 3 old age pensioners here but who get their pension only once in 3 months. To obtain this they have to go the Gram Panchayat Headquarters at Vantadapalli. However, 5 persons above 60, who are eligible for sanction of old age pension have not been sanctioned these pensions.
- (viii) The Community Health Worker (CHW) Kombli's honorarium is Rs 400 per month. However, she is paid this not every month but once in 6 months! She has been CHW for 5 years now and her honorarium has all these years been paid only in 6-monthly installments and not regularly every month. She works as an agricultural labourer for her livelihood. She told me that she was getting her tablets supply regularly as she is regular in going to the Minamaluru PHC for her monthly visits.
- (ix) The source of drinking water here is a spring, known as 'voota' locally. No chlorination has been undertaken at this source.
- (x) The spraying of homes was done this year for the first time only six days ago! That spraying did not kill any mosquitoes or flies either! No spraying was undertaken of areas outside, in the village. One of the officers accompanying me pointed out that normally Malathion residue smells for about 10 days but no such smell was evident here in this village. Questioned again, the people

confirmed that neither at the beginning of nor during the current rainy season was any spraying undertaken in the village this year.

- (xi) Answering questions from me about officers who had visited the village during the last 5 years, the villagers told me that while no Project Officer, ITDA, Paderu had visited the village in the course of the half decade past, there was one visit by the Sub Collector, Paderu 3 years ago. There was one visit each by the Mandal Development Officer and Mandal Revenue Officer 3 years ago and this was when they had accompanied the visiting Sub Collector. The medical officers from the Primary Health Center, Minamaluru, had visited this village thrice in the last 5 years, all of them during the current year and all of them in the month of June 2005 – after 4 deaths had occurred in May 2005.
- (xii) In the year 2003 three persons had died of fever or *visha jwaram* in this village. In 2004, 2 persons had died of the same cause.

4. Jogulapuram village of G. Madugula Gram Panchayat of G. Madugula Mandal – 5th August 2005, 3.25 P.M. to 6.30 PM

This visit to G. Madugula Gram Panchayat was to study the atmosphere in the PHC, G. Madugula and to understand how it serves the neighbouring areas. Hence, the village of Jogulapuram was first visited, followed by the visit to the Primary Health Center. Smt Machiraju Mani Kumari, former Minister, Sri Lake Raja Rao, MLA Paderu and Sri Chitti Naidu, former MLA, Paderu accompanied me on this visit.

2. Jogulapuram village saw one case of death this year of an 18-year-old girl Koda Padmakumari D/O Vekanna Dora. She had just passed standard X and had obtained a seat in the college to start her intermediate studies. She died on 1st July 2005. She had high fever and shivering as well. She also developed severe stomachache. Her fever started on a Friday but went down the next day. However, by Tuesday next her fever returned and by Thursday she had developed severe stomach ache. On Thursday she was taken to a private hospital in G. Madugula, 2 Kms away from her village run by a Rural Medical Practitioner (RMP). She was given a drip, complained of a great deal of heat in the body and drank plenty of water. On Thursday itself the RMP asked that she be taken back home. She was brought home at 6 P.M. on Thursday evening and she died at 6 AM the next morning. The family spent Rs 300 on her treatment in the private hospital.

I asked her mother Koda Muthyalamma why her daughter was taken to a private hospital when a Government – run PHC was available at the same place and at the same distance. Muthyalamma replied: “She was not taken there as the PHC was over-crowded. There is only one doctor there and therefore attention and treatment was bound to be slow. It was also being said that all those admitted in the PHC were suffering from Malaria”. This perception about the PHC throws a lot of light on the image of a typical PHC in the system in the public eye. She also told me that this kind of a fever accompanied by shivering was not seen in the past couple of years in her village.

3. I gathered further information in the village regarding certain connected socio-economic issues affecting the everyday lives of the people. This is given below:

- (i) Agricultural labour wages are Rs 30 per day for both male and female.
- (ii) There was considerable hunger in the village. Of the 31 households, at least half of them went hungry in the months of September, October and November. Again hunger levels would go up from April onwards. In short, these households experienced hunger during 8 out of the 12 months in a year.
- (iii) While all 31 households have been issued white cards of entitlement for subsidized rice at Rs 5.25 / kg, none of them has been given the Anthyodhaya Anna Yojana (AAY) cards which would give them rice at Rs 3.00 per kg. The policy of the Government is that only Primitive Tribal Groups (PTG) is eligible for AAY cards. The tribe living in this village, not being a PTG, would thus not be eligible for cheap rice though they are all actually very poor. Thus, not actual poverty status but a general categorization of tribals determines eligibility for cheaper rice under the AAY scheme.
- (iv) The Domestic Requirements (DR) Depot at Madugula supplies Public Distribution System rice just only once in a month leading to the non- lifting of subsidized rice because of the absence of the wherewithal with the tribals to do so all at one go.
- (v) Every household is indebted in this village, the debts ranging from Rs 2000 – 6000, taken usually from *sahukars* or moneylenders. These loans have been taken not only for agricultural operations but also, even, for buying food grains. The rate of interest at which these amounts have been borrowed is Rs 5 per hundred per month or 60%. The *sahukars* who lend them are from places

- (vi) Health expenditure, especially by women, is high despite there being a Primary Health Centre in the neighbourhood. Often, this expenditure goes up to Rs 3000 per year per family, the main ailments being fevers; jaundice and debility (paralysis) induced by malnutrition. This is private health expenditure, as people do not go to the PHC because attention in the PHC is poor compared to that at the Private Hospitals and relief provided more effective and faster.
- (vii) There is considerable Child Labour in this village. Children here start working from the age of 10 by going to the neighbouring villages like G. Madugula, G.M. Kotturu and Boosipalli - all about 1 km from here. They not only work in the coffee gardens of the tribals but also, even in Government programmes like Check Dams, Vana Samrakshna Samiti, road works etc. In check dam programmes the children carry on their heads stones, and mix sand and cement. Girl children are particularly used in the latter activity.
- (viii) The Community Healthy Worker (CHW) P. Simhachalam has studied up to the sixth standard and has three girl children. She has with her drugs like chloroquine, iron tablets and paracetamol. However, when she offered to take Padmakumari to the PHC the latter refused. The drugs offered by the CHW were also refused as Padmakumari was afraid and the drugs were bitter. No information was conveyed to the PHC either by the CHW or the family about Padmakumari's condition. The CHW's honorarium is Rs 400 per month but she is paid this once in six months only. The CHW has a debt of Rs 1,000.
- (ix) Two males and two women, eligible for Old Age Pension in this village, have not yet been sanctioned old age pension.
- (x) Spraying in this village was done for the first time this year on 23rd July 2005. No spraying had been done prior to that date in this village during the current year.

4. I visited the Primary Health Centre at G. Madugula between 4.45 P.M. and 5.45 P.M. and spoke to the Medical Officers there.

The following are the vacancies at the PHC, G. Madugula:

Sl. No	Category	Sanctioned Posts	Vacant
1.	Medical officers	2	1 post of Lady medical officer since 4 months
	One lady medical officer has been deputed from the PHC, Araku to this place for 1 month. She came here about a month ago		
2.	Multipurpose Health Extension Officers	2 males	1 post vacant since 4 years
3	Public Health Nurse (PHN)	1	Post vacant since 6 months
4.	Multipurpose Health Supervisor (MPHS) (Male)	5	4 posts vacant since 6 years
5.	MPHS (Female) or Health visitor	3	All three posts vacant – 1 since 6 month and 2 since 2 ½ years
6.	Staff Nurse	1	In place
7.	Pharmacist	1	In place
8.	Lower Division Computer Assistant	1	Vacant, since June 2005, when it was needed most, he having been transferred.
9.	Multipurpose Health Assistant (Male)	19	All in place
10.	Multipurpose Health Assistant (Female)	18	2 vacancies
11.	Lab Technicians	2	In place

5. I held discussions with the lady medical officer Dr. Vanisree, deputed since a month to this PHC, on the situation prevailing in the PHC area and also Dr. Kumar, Senior Entomologist, deputed from the office of the DM and HO, Vishakapatnam to supervise the work in this Mandal. I also got the admission register at the PHC checked for admission of fever cases since April 2005 and found the following information:

Sl.No	Month	Total Admissions	Of them fever cases
1.	April, 05	165	127
2.	May, 05	183	162
3.	June, 05	213	137
4.	July, 05	186	152

During the discussion on the above, the Medical Officer confirmed that all these were cases of high fever and most of them are malarial cases. She also stated that malnutrition was rampant in the PHC area as seen from the patients admitted. At the time of my visit there was

one in-patient by name Smt Kimudu Venkatalakshmi, W/O Rama Rao, she having been admitted the previous night there. She was a case of Malaria Positive Falciparum. I saw her and found her thoroughly disoriented and in a state of delirium. The medical officer said that the previous night she was in a coma and had now come out of it. She was on E-Mal injections and Quinine drip. It was stated that she had been admitted once before earlier and that this was her second admission to this PHC. On the first occasion itself she was detected as Falciparum Positive but treatment with a Chloroquine – Primaquine combination had not been effective and she returned within 15 days.

6. Dr. Kumar, Senior Entomologist told me during discussions that the SPR in G. Madugula is 1.84 for Malaria. He said that this was not an epidemic situation. To constitute an epidemic, the SPR should be 5 % and above, he said. He stated that there had been no fatalities in the PHC, G. Madugula of cases admitted with fever, between April and August 2005. However, the Mandal Praja Parishad President, who was present there, stated that on the 12th July 2005 one cerebral malaria case – Sri Someli Lakshmana Rao S/o Sanyasaiah, aged 18 years – was indeed admitted into the PHC, that after 5 days the patient was shifted to Paderu where he died after another 5 days. He added that there have been about 30 such cases admitted here in this PHC but sent back home or referred to Paderu, all such cases having ended in death.

7. I had a meeting with the Tribal leaders, which is discussed as part IV of this Report.

8. After this meeting with the tribal leaders, I proceeded to the office of the ITDA, Paderu at 7:30 p.m. and held a meeting with Shri. Siddarth Jain IAS, Project Officer, ITDA, Shri. Sudharshan IAS, Sub Collector, Paderu, Dr. P. Rama Rao, District Medical and Health Officer, Visakhapatnam as also other officers of the project with reference to some of the material that had been made available to me by the Project Officer at my request, to assess the level of preparedness and steps being currently taken to deal with the health crisis in the Visakhapatnam Agency area. After completing this work, accompanied by the Project Officer, ITDA and Sub Collector, Paderu, I proceeded to Araku Valley around midnight reaching there in the wee hours of the 6th August 2005.

**5. Champaguda Village of Madagada Gram Panchayat of Araku Valley
Mandal – 6th August 2005 – 9:45 a.m. to 11 a.m.**

I visited this village because of its significance in the context of the very large number of deaths of malaria reported in this village in the Complaint presented to the Honourable Commission by Shri. K. Yerran Naidu and other leaders of the Telugu Desam Party. A total number of 44 names has been given as dead in this village in the Complaint petition, these being, serial numbers 154 and 155; 157 to 161; 168; 170; 178 to 213. During my public and open Inquiry in the village, which was attended by about 20 tribal residents of the habitation including their village elder (*Kula Pedda* in Telugu) Shri. Korra Potti Naidu, a Konda Dora, the assembled tribal villagers told me that none of these 44 persons was dead and that they were all alive. In fact, one of these 44 names, namely, Vantala Malli shown at serial number 193 did not even exist. I read out aloud all the names given in the complaint petition as dead, and found that in each case the village elder and the rest of the gathering affirmed that the person bearing the name read out was by no means dead. After a double verification, I asked the gathering if any of them had passed on these names to any one, as having died. They told me that they had never given these names to any one as having been dead. I specifically asked the village elder Shri. Potti Naidu if any one had approached him in regard to this and he replied that no one had done so. He made the point to me that he was the village elder and neither a birth nor a death took place here without his knowing it. “After all, I am the one who gives names to the newly born in this village, and therefore, none of the newborns or those who die would be unknown to me” he said to me. After this, I questioned the assembled villagers again about these names and they affirmed that they had not given these names to any one. When I probed the matter further, one of the tribals by name, Korra Budra S/o Korra Potti told me that Shri. Ramalingam, the Panchayat Secretary of Madagada Panchayat of which Champaguda forms part had given these names to the former Chief Minister of Andhra Pradesh Shri. Chandrababu Naidu at the time of the latter’s visit to this village sometime ago. When I asked him on what basis the Panchayat Secretary of Madagada gave these names to Shri. Chandrababu Naidu, Shri. Korra Budra said that these individuals were suffering from fever at the time. However, the village elder Korra Potti Naidu clarified that not all of them had been suffering from fever and some of them perhaps had a headache or other minor ailments.

2. While, thus, I found that 43 out of the 44 names given as dead were all alive and a 44th name did not even exist, my query to the assembled villagers whether any death had occurred

in the village in the recent days elicited the reply that Vantala Ganganna S/o Pollu, 20 years old, unmarried, a Konda Dora had died on the 19th July 2005 of fever. Shri.Ganganna had died of an illness that lasted nearly 2 months starting from June 2005. He started with a headache, developed chills subsequently and recovered. He subsequently fell ill again with a swollen stomach and could not pass stools. His fevers and chills came in 3 or 4 bouts. He was taken to the Community Health Center at Araku Valley, 7 km from here where he was kept for 7 days. He returned to the village, developed chills again and died 3 days later.

3. It is indeed a most exceptional and extraordinary circumstance that while one non-existent name and 43 names of living persons have been given in the Complaint petition pertaining to the village of Champaguda as persons who had died of malaria, the only person who had actually died of many symptoms, all of which point to the probability of a typical case of malaria, does not find place at all in the Complaint!

4. I also checked with the assembled villagers what the position was in regard to fevers and ailments that they considered generally as malaria and whether there had been any deaths on account of it in the recent past. The assembled villagers were able to recall the position relating to the years 2004 and 2003. They told me that in the year 2004, there were 4 deaths on account of fevers (“malaria”, in their own words). In the year 2003 also there were 4 deaths. The villagers gave me the names of the deceased as follows:

2004

(i) Vantala Ghasi	S/o	Minni Budda	50 years.
(ii) Korra Lambu	S/o	Buddhu	28 years.
(iii) Korra Appamma	W/o	Arjun	24 years.
(iv) Korra Karremma W/o	Ghasi		30 years.

2003

(i) Korra Somulu	S/o	Ghasi	60 years.
(ii) Vantala Kuji	W/o	Gundu	30 years.
(iii) Korra Gachu	D/o	Jogi	11 years.
(iv) Vantala Sundaramma	W/o	Buthi	35 years.

5. After completing my Inquiry in this village, I proceeded to Visakhapatnam and had a brief meeting with the Collector of Visakhapatnam at the Circuit House. At the circuit house at Visakhapatnam, a representative of the Telugu Desam Party, Visakhapatnam Rural handed over to me a letter signed by its President Shri. B. Satyanarayana Murthy which stated that “the list of the patients of Araku Valley Mandal – Champaguda Village, followed by Serial Numbers from 1 to 44 is wrongly shown as deaths. Actually those patients were suffering from various fevers – as we treated them accordingly. Kindly consider this letter favourably and rectify the death list of above mentioned”. I enclose a copy of this letter as **Annex-I** to my report for the perusal and reference of the Honourable Commission.

Leaving Visakhapatnam by rail on the evening of the 6th August 2005, I reached my headquarters the following morning.

PART - II

Among the types of malaria, those induced by *Falciparum* and *vivax* are the most common. The latter i.e. *vivax* is relatively benign. Its main features are chills; headaches and fevers on alternate days. It needs to be dealt with through *chloroquin* for three successive days. *Vivax* rarely kills a patient, though its neglect can lead to chronic fever. *Falciparum* malaria, on the other hand, is a killer malaria; a malignant, fatal malaria. The parasite in this case blocks the blood vessels in the brain and blocks the placenta in pregnant women. The main symptoms of this fatal malaria are high fever, headaches, chills, vomiting, convulsions, dysentery, diarrhea, jaundice and delirium. A *falciparum* patient can die within hours as the parasite blocks the brain vessels. Since the *falciparum* death involves in most cases the central nervous system, becoming unconscious, disoriented and suffering paralysis and brain fever are its other attributes. Given these parameters in an area endemic to malaria like the Visakhapatnam tribal area, it is incumbent on the part of the health officials to find out by studies of patients and oral reports of the close relatives of the deceased as to what actually happened in each case to establish whether or not a death, or even fever, is a case of malaria, and *falciparum* malaria in particular. Repeated studies of an affected person need to be done to establish that a given case is negative. There is every likelihood of positive cases being missed, otherwise. Even in the case of *vivax*, positive cases could easily be missed as *vivax* keeps fever off and on.

2. Now, the basic truth about Visakhapatnam Paderu agency area, where the scheduled tribes constitute 97 percent of the population, is that it is endemic to malaria. Therefore, at any given time, when conditions are favorable such as monsoons, an outbreak of malaria, including falciparum malaria is certain to occur and, given the conditions of sanitation in which the tribal population has been living in this agency area, such an outbreak can easily develop into an epidemic. I have already discussed the inhuman conditions in which the various tribes here have been living in Part I in this report. Given those conditions of extreme and severe malnutrition, with little or nothing to protect their bodies from the swirling winds and lashing rains of 1124 mm a year in a terrain situated at an altitude of 3, 500 ft. above mean sea level, living in huts that can hardly be called shelter, the tribes here are defenceless against the mosquitoes. These mosquitoes can fly up to 3 kilometers carrying their deadly parasites across the hills and valleys. As for their breeding grounds, they are obviously aplenty for we have rivulets and streams in constant flow in the monsoon and, as for stagnant bodies of water they are innumerable. In the monsoon season in this area mangoes come into fruition as also the jackfruits. The hungry tribes consume not only these two fruits but also the pulp within the mango kernel and the seed within the jackfruit pod heavily. The mango kernels and jackfruit seed are stored away in their homes after the fruit itself has been eaten and they attract hordes of mosquitoes. In addition, the rind of jackfruit is also thrown off after the fruit is taken off and this rind with some remnants of the fruit sticking to it attracts mosquitoes on a large scale.

3. This is the environment. Even if an infectious disease, new to the community, is found to be prevalent with a rise of 20% to 30% above normal and it is a representative sample of the entire area and cases are reported for more than a week, the inference is that an epidemic is setting in. If it lasts longer than 3 weeks, it is an epidemic that has set in and is on. We should also recognize that every one case represents fifty hidden cases in the community. All this has to be judged by the mosquito density and the parasitic index i.e. lakhs of parasite in a single slide. Parasitic index is determined by dissection of mosquitoes. Larval index also needs to be determined by scooping water from the stagnant pools and other similar water bodies and sources. The question is: were all these things done by the authorities concerned in Paderu?

4. This leads me to a note that was informally made available to me on the “field observations in respect of suspected malaria epidemic in the Agency Area of Paderu, Visakhapatnam

district, Andhra Pradesh”. These observations have been made by Dr. S. K. Patnaik, Regional Director, ROH & FW, Hyderabad and his team and by Dr. P L Joshi, Director, National Vector Borne Disease Control Programme (NVBDCB), Ministry of Health and Family Welfare, Government of India and his team. I am enclosing at **Annex II**, this note of these two experts.

5. I first deal with the observations made by Dr. Patnaik and his team. The team reportedly visited 14 villages in Paderu and Hukumpet Mandals of the Paderu Agency area to verify the 45 reported deaths from January to July 2005 mentioned in a list received by the Director of NVBDCB, adopting the questionnaire method to elicit correct information. The major symptoms of the deceased as reported by the informants were Fever: 28; Cough/Cold: 23; Diarrhea: 15; **B.** Dysentery: 12; Jaundice: 6; Coma: 1; others: 18. It has been clarified that the number may not add up to 45 due to multiple reasons. However, the probable causes of deaths as per the Primary Health Center records were Jaundice; haemoplagia; epilepsy; bronchial asthma; sunstroke, suicide, electric shock, cardiovascular accidents; appendicitis, cirrhosis of liver, acute renal failure, breast cancer and senility. Of these deaths, according to this team, only 8% were below 15 years of age. The team cross checked 13 blood smear slides which were collected by field workers from the diseased and the results reported negative were reconfirmed by ROH&FW, Hyderabad team.

6. The ROH&FW team then collected on 29th July 2005, blood smears from fever cases in the mega medical camp organized by the Government of Andhra Pradesh at Paderu Town. Specialists from the King George Medical College, Visakhapatnam, were also present at the camp to provide their services. In all, 2600 OPD cases attended this camp on that day of which 180 cases were referred for blood smear collection and examination. Says the team’s report: “Only 29 out of the total slides examined were found positive”. The details are:

Blood slides collected and examined	Total Positive	P. Vivax	P. Falciparum	P & VG	P & G
186	29	Nil	22	3	2

At this stage, it is important for me to point out that the ROH&FW team’s observations that “only 29 out of the total slides examined were found positive” is an understatement. A positive rate of 29 of 186 represents a percentage of 16. This is not something that is

insignificant. Not only this; the *falciparum* incidence is 22 out of 29 positive cases, which is 76% percent of all positive cases. Incidence of *falciparum* to all positive cases is 22 out of 186, which is 12 percent. Any incidence above 2 percent is abnormal and any thing like 12% must be considered an epidemic, considering that the sample was drawn in a mega camp. This sample, therefore, is proof positive of a raging epidemic in the Paderu Agency.

7. This team also crosschecked 128 negative blood smear slides from the Girls Hostel, Paderu, Guttalapat School Camp of the Primary Health Centre, Minumaluru and the DMO's office Paderu. Of the 128 "negatives", as many as 25 were actually found positive. The team says that the discrepancy was about 25% and that "therefore, there is a need for quality assurance for malaria microscopy including reorientation training of the laboratory technicians". It is important for me to point out here that if the discrepancy level is as high as 25%, there is something totally wrong with the personnel and equipment handling malaria as a subject in this area.

8. The team has observed, referring to the Indoor Residual Spray (IRS) operations in the villages - it is not clear if they visited the two villages mentioned- that "the same has been reported more or less satisfactory." That an "expert" team would make such an observation is surprising. However, the team did find "the coverage of rooms to be only 65 to 70 percent which is below the desired level." The team also referred to complaints about shortage of spray pumps as well as defective parts in many, which were reported to have delayed the IRS operations. These facts speak for themselves about the readiness of the health machinery to handle an oncoming situation.

9. A reading of this team's observations clearly establishes the existence of a malaria epidemic in the Paderu Agency area of Visakhapatnam District of Andhra Pradesh. Its reference to the low acceptance levels of Malathion insecticide for IRS shows absence of promotion of proper awareness generation among the tribes on the part of those in charge of the Malaria Programme. Its finding that, as a result, coverage of homes was less than 70% establishes inadequate preparation and readiness to handle the oncoming malaria season in the context of the rains that would aggravate a situation that is always endemic. All this is compounded by shortage of spray pumps as well as defective parts in many, which effectively stalled the start of operations. I cannot but come to the conclusion that this was a tragedy just waiting to happen, thanks to negligence. At this stage, I should refer to the field observations made by Dr. P. L. Joshi, Director, National Vector Borne Disease Control

Programme (NVBDCP), Ministry of Health and Family Welfare, Government of India, who had visited the Champaguda village as also the Araku Malaria Sub-Unit. He considers 29 positive blood smears on cross checking as also 5 positive from a sample 130 smears shown as negative, on cross checking. Significantly, his observations are silent with regard to the total number of blood smears collected and examined against which these 29 were found positive. The two figures together would have given us the magnitude of the epidemic.

10. However, the need stressed by Dr. Joshi to cause a diversion of bed nets from low endemic areas to nearly saturate the high risk Paderu Agency area shows the unpreparedness of the authorities responsible for prevention and other associated action to face up to the imminent challenge developing in the area. The other measures suggested by him are all obviously in order, such as introduction of larvivorous fish preceded by social mobilization, constitution of malaria resource groups (MRG) and their training by the Primary Health Centres. The question, however, is: why was all this not done earlier? For example, how can experts talk of training the Community Health Worker at the Primary Health Centre as part of Malaria Resource Group as a new idea altogether when the CHW as an institution has been in existence for years together? Against this background, I should record my surprise that the Director, NVBDCB should have appreciated the efforts being made by the Sub-Division Administration to control the malaria transmission effectively. I hope that the detailed report of the Director that would follow will have recognized the serious development in the Paderu Agency area.

11. I must record that Dr. Joshi, Director NVBDCB, has done a remarkable job in visiting Champaguda village of Madagada Panchayat and establishing that there was no truth in the allegation that 44 people died of malaria in that village above. His observations show that his enquires found 27 persons allegedly dead were physically present in the village, some of whose photographs were also taken. Another 15 were also found alive and away at work. Only 2 names could not be verified. Dr. Joshi's effort in photographing the live persons who were alleged to have died is to be commended because, while every effort must be made to fight malaria, blatant falsehoods such as declaring dead, people who are actually alive, only subverts efforts at finding the truth as regards the real numbers and cause of deaths in the agency area. Inaccurate figures also can be used by vested interests as an argument against going deep into the issues of health emergency facing the tribes of the area. Showing falsely

the living tribals as dead is itself the most obnoxious manifestation of vested interests that politics develops in a situation of extreme misery of the poorest of the poor.

12. As mentioned earlier, I asked for and have obtained from the Project Officer, ITDA the monthly statements of the daily reports on fever incidence in the Paderu Agency area. These are at **Annex-III**. The statement for May 2005 refers to Sub centers visited, number of villages visited, smears collected, positives and parameters like Annual Parasitic Index (API) and Slide Positivity Rates (SPR). On a number of days the SPR has exceeded 2 %, once going up to 4.15 % as early as in 7th May 2005. The statement for June 2005 shows that on as many as ten days, the SPR exceeded 2%, with the rate going up to 3.24% on 3-6-2005 and still higher to 3.47% on 16-6 2005. The June 2005 statement is based on the samples drawn from the medical camp conducted which are expected to represent a substantial cross section of the area. The API touched 2.20 on June 12, 2005. In July 2005, we have school complexes set up by the Government to draw samples, from 18th July 2005 onwards. From 25th July 2005 to 30th July 2005, the SPR shows above 2% on all days excepting for the 25th July 2005, which is 1.98%. The samples for this period were taken during the second round in the school complexes. The school complexes were about the best indicator of the positivity situation in the area given the fact and the claim that access for the people was improved with the opening of these complexes. At an average of an SPR of 2.32 % for the last week of July 2005, the situation can only be described as very alarming. Given the number of cases reported and the SPR found, including for *falciparum* in the field observations of the Deputy Director of the Regional Office of the Department of Medical and Family Welfare, Government of India and my own findings in every village that I visited that there have been deaths all of which had been preceded by symptoms which are indicative of not only malaria but *falciparum malaria*, the claim of the Government of Andhra Pradesh that only 7 cases of death occurred on account of Malaria in Paderu Agency area sounds extremely unconvincing.

13. I have obtained from the Integrated Tribal Development Agency (ITDA), the cadre strength of the medical and health institutions of Paderu division of Visakhapatnam District year-wise for the period 2001-2002 to 2004-2005. These are at **Annex-IV**. The top three positions of Civil Surgeon, Civil Surgeon (Specialist) and Deputy Civil Surgeon have remained vacant throughout this period of 4 years. I should add that the cadre strength of Deputy Civil Surgeon in each year was three. Thus the top five posts have remained vacant

for the last 4 years. From this we can infer the importance given to the health and well being of scheduled tribes of this agency area by not only the present government of Andhra Pradesh but also the one that preceded it and governed up to May 2004. This is not at all. In addition, the following important categories of posts remained **vacant** as shown below, year wise:

1. **2001-2002** 18 vacant posts of Multi Purpose Health Supervisors (MPHS) (Male) against a sanctioned strength of 58; 8 vacant posts of laboratory technicians against 32 sanctioned; 2 vacant posts of radiographers against 3 sanctioned; 4 vacant posts of Male Nursing Orderlies (MNOs) against 13 sanctioned; 3 vacant posts of Female Nursing Orderlies (FNOs) against 8 sanctioned. Overall vacancy position for all categories was 99 posts against 818 sanctioned.

2. **2002-2003:** 19 vacant posts of Civil Assistant Surgeons /Women Assistant Surgeons against 49 sanctioned; 14 vacant posts of MPHS (Male) against 58 sanctioned; 6 vacant posts of lab-technicians against 32 sanctioned; 2 vacant posts of radiographers against three sanctioned; 3 vacant posts of Dark Room Assistants (DRA) against 3 sanctioned; 9 vacant posts of drivers against 16 sanctioned; 4 vacant posts of MNOs against 13 sanctioned; 3 vacant posts of FNOs against 8 sanctioned and even 4 vacant posts of sweepers against 13 sanctioned. Overall vacancy position for all categories rose to 106 during this year.

3. **2003-2004:** The position deteriorated further during the year 2003-2004. Against a sanctioned strength of 58 MPHS (males) only 15 were in position. There were 43 vacancies in this category against a sanction of 58 posts. This was only slightly better in the case of MPHS (Female). Here there were 10 vacancies against a sanctioned strength of 31; there were six vacancies in MSI. Gr. II against 7 sanctioned posts; as many as 25 posts of laboratory technicians were vacant against 32 sanctioned posts, which is to say that there were just seven Laboratory Technicians in the area in this year. 9 posts of drivers remained vacant against 16 sanctioned. There were 6 vacancies against the sanctioned 13 in the MNO category while in the FNO category vacancies were 3 against 8 sanctioned; 4 vacancies of sweepers remain against a sanction of 13 while both of the 2 posts of dhobi went vacant.

The overall vacancy position rose to 147 against a sanctioned strength of 818. That constituted a vacancy position of 18%.

4. **2004-2005.** The overall vacancy position worsened still further in 2004-05 rising to 22.5 % of the sanctioned posts. The overall number of vacancies became 186 against a sanctioned strength of 825. The vacancies in the MPHS (Males) were 46 against a sanctioned 58! There were just 12 MPHS (Male) against the 58 sanctioned while in the MPHS (Female) category

there were just 16 persons against the 31 sanctioned. All 7 posts of MSI Gr. II remained vacant; 11 out of the 32 sanctioned posts of the laboratory technician were vacant, while 2 of the 3 sanctioned radiographer posts remained vacant; all three sanctioned posts of DRAs were vacant; so were 9 out of 16 sanctioned posts of drivers; posts of 5 MNOs and 3 FNOs were vacant against the sanctioned 13 and 8 respectively. 3 out of the sanctioned 13 posts of sweepers remained vacant while both of the 2 posts of dhobi remained vacant.

To expect that, with this kind of approach to running of medical and health institutions, standards of tribal health will be maintained or improved is a pipe dream. The point deserving of emphasis is that the sample years I have taken were 2001-2002 to 2004-2005. i.e. 4 years saw three years of governance by the Telugu Desam Party and one year of governance by the Congress-I. Specifically, with reference to the points made in the Complaint to the Commission, the only comment needed is that this is a classical case of the pot calling the kettle black.

PART - III

In addition to visiting the affected area personally and analyzing the data obtained from the authorities, I also held discussions with a group of senior tribal leaders of the area, namely, Smt Machiraju Mani Kumari, former Minister in the Government of Andhra Pradesh, Shri Lake Raja Rao, MLA, Paderu and Shri Chitti Naidu, former MLA, Paderu in regard to the situation in the area and sought their views in the matter. The important points made by this group of senior tribal leaders Mani Kumari, Lake Raja Rao and Chitti Naidu on the 5th August, 2005 are as follows:

- (i) There was delay in initiating spraying operations.
- (ii) The required drugs are not available in the hospitals. In the newly started Primary Health Centers (PHC) no doctors have been posted nor staff. Deployment of staff, which is being done temporarily, is no solution to the problems of the tribes as such staff returns only after another emergency starts.
- (iii) Poverty is the main problem of the area. For eight months in a year, the tribes go hungry, as any agriculture is possible in this area only for 4 months in a year. Malnutrition is the main cause of absence of resistance to the epidemics. Malnutrition and malarial fevers peak at the same time, which are the months of May, June, and

- (iv) Safe drinking water is not available anywhere as there is no protected water supply scheme in the Agency. Even where drinking water projects are possible through gravity, they have not been taken up. This results in diarrhea, jaundice and malaria.
- (v) On the health side, there is no effort at diagnosing ailments. Standard drugs are administered for all ailments regardless of the status of the health of the patient.

2. The leaders Mani Kumari, Lake Raja Rao and Chitti Naidu, therefore, stated that in addition to the employment guarantee scheme referred to above the Government needed to improve communications, especially roads in the Agency area, give priority to agriculture – cum – watershed structures like check dams, tanks, and field canals; setup small industries based on forest produce, agricultural produce, coffee, tamarind, turmeric and tomato that are grown here in plenty; health infrastructure institutions should be upgraded so as to be staffed by specialist doctors who can dispense drugs and treatment required for different ailments. All PHCs needed to be upgraded to 30-bedded hospitals with provision for food for the patients and attendants.

I am inclined to agree with the views of these tribal leaders.

PART - IV

CONCLUSIONS AND RECOMMENDATIONS

The foregoing three parts of this report represent the factual position of the actual conditions obtaining in the Agency areas of the District of Visakhapatnam in Andhra Pradesh. The facts as seen and recorded by me speak for themselves. The emerging situation is one of extreme crisis as far as the scheduled tribes inhabiting the Agency area of Visakhapatnam is concerned. Part I of my report shows that the tribes are living in conditions of desperate

poverty. For months together they are going hungry. Their agricultural lands seem to have been occupied and taken over by non-tribes who have no right in law to possess them in the scheduled areas of the State. This, of course, calls for a special survey to establish the magnitude of the deprivation of the land resources of the tribes. The tribes are heavily indebted and no family seems to exist without the burden of an unbearable debt, incurred including for food grains and agricultural operations. The rates of interest at which these have been borrowed are mind – boggling, reaching 60%. At that level of rates of interest no one would ever be able to repay the debt contracted. This chronic indebtedness has led to 2 things – 1. Bonded Labour, the masters being the non-tribes and 2. The agricultural and other produce raised by the tribes being appropriated by the money lending *sahukars* at prices that are at least 30% less than the market prices. The tribals depend heavily on agricultural labour but the wages are so dismally low, as shown by me elsewhere in this report and the number of days of employment available in a year is so few that hunger and malnutrition are a daily occurrence. The Public Distribution System is as good as non-existent. Living in these conditions of poverty and hopelessness, the tribes are both physically and mentally vulnerable to any kind of socio-economic onslaught. Prevailing levels of extreme malnutrition and wide spread anemia expose them to every conceivable kind of infection and communicable diseases. Faced with this consequential predicament to their health, they have nowhere to turn to. The data provided by me under Part II shows the dismal state of affairs in regard to the way the medical and health infrastructure is functioning in the Paderu Agency area. The result is that people have been dying of fevers as my investigations in the villages given under Part I show. My own conclusion based on the symptoms reported by the families and the fellow inhabitants of the deceased in the villages visited by me is that all these **deaths taking place in the Agency area of fever are in all probability deaths caused by malaria.** I should hasten to add that I am no medical man having the authority to state this. However, the circumstantial evidence is overwhelming. The Director of Health Services, Andhra Pradesh in reply to a direct question from me averred that most of the deaths on account of fever are *viral* in origin. This is not an acceptable argument because it reveals an absence of certainty of any kind of cause for the large-scale deaths that are happening on account of fevers. **If the Department is unable to determine what exactly is causing these large-scale deaths, a question arises: Why are blood smears being taken by the Government to check for malaria positivity? Why are all the steps being taken today in the Agency area oriented towards fighting malaria? What is the epidemiological interpretation of the annual malarial parasitic intensity and the slide**

positivity rates, which in some places are uniformly above 2% and, in quite a few cases, have gone beyond to reach even 5%? Given all these facts, the culprit seems to be malaria. The only convincing way by which the Government of India and of Andhra Pradesh could show that this is not malaria would have been if they had done postmortem dissections of several tribals who have died of fevers, accompanied by chills, rigor and other classical malarial symptoms. This, obviously, has not been done. The conclusion, to my mind, is clear.

2. I am convinced that spraying operations of homes in the tribal area in the Paderu Agency was badly delayed. Very little attention has been given to handling stagnant pools of water or for chlorination of drinking water sources. There are large-scale vacancies in the health and medical establishment in the Paderu agency area. The Government of Andhra Pradesh should categorically state whether the required insecticides for purpose of spray were received by the State authorities from the authorities of Government of India, in adequate quantities and in time. If they acknowledge that all the stocks required were received in time, then the responsibility of failure of effectively utilizing them at the village level will be that of the State Government. If, on the other hand, the State Government acknowledges that there were shortfalls and delays or both in the receipt of stocks of insecticides, then the omission lies with the Government of India. The same goes for other drugs like chloroquine and primaquine tablets used in radical malaria treatment. Apart from these, there is also the question relating to simple drugs like paracetamol needed in dealing initially with fevers and those like iron tablets required by pregnant women and adolescent girls. What has unfolded in the Agency area is a mammoth tragedy that calls for an investigation into all these aspects so that the omissions are all identified and a clear line of action and responsibility is laid down for the future.

3. Even according to the Government's own statistics, out of the 1, 26,013 households in the ITDP area of Paderu, 1, 17,834 households are living below the poverty line. Effectively, the entire agency area lives in dire poverty. Of all the poor households, 57,975 households have been determined to be amongst the poorest of the poor. The desperate nature of poverty in this area requires no further acknowledgement. Obviously, practically every household goes hungry in the agency area, as my own investigations through personal interaction with the households in the villages visited by me have shown. Of the 3,468 habitations in the area, only 114 have piped water supply and 2,078 have hand pumps. The rest are open wells. As

many as 1,083 habitations are not covered by any drinking water schemes at all. The number of habitations not covered / connected by roads is 1,270. Less than 45% of the habitations have Anganwadi centers located in them. As pointed out by me earlier, a number of people above 60 years who are eligible for old age pensions have not been sanctioned the benefit. As far as agricultural land availability is concerned, against a total 1.26 lakh households, cultivable land available is only 2.64 lakh acres of which not even 4,000 acres have irrigation. To add to the woes of the tribals, considerable extents of land are in the hands of non-tribals who are not entitled to hold them under the law. A look at the implementation of land transfer regulations shows that of the 5,305 cases detected involving an area of 21,563 acres, only 4,127 cases involving an extent of 16,931 acres have been decided in favour of the scheduled tribes. The rest went to the non-tribals. Even out of the 4,127 cases which went in their favour, only in 3013 cases have the lands been actually restored to the tribals to the extent of 13,909 acres. As for employment for the youth, there are as many as 22,260 educated unemployed youth here without any kind of employment, 5980 of them being girls. All of them have studied beyond 9th standard and as many as 17,527 have done SSC. While 1692 have done their intermediate, 408 are graduates. There are even 3 postgraduates. I do not wish to give more figures but what ever I have mentioned here illustrates the horrific conditions of acute distress prevailing in the ITDP area of Visakhapatnam District. Land, forest and other employment that the educated can access will alone determine the status of the tribals in Paderu. The information I have given here shows that all these factors are adverse to the scheduled tribes in the Paderu area. An examination of the financial outlays utilized to implement economic support schemes in the last five years shows that the unit cost per family has not gone beyond, on an average, Rs.5, 000/-. Of this, only 50% would be subsidy, the balance being Bank loans at 12% interest or margin money at soft rates of interest. At this level of outlay, in a terrain of this kind, the poverty of individual households is unlikely to be eradicated at all through such meager anti-poverty schemes. Apart from the failure of the developmental paradigm in this area, for which the State is responsible, very little seems to have been done even by such non-governmental agencies as are reportedly functioning here. For example, CARE has been implementing for the past several years what is called a Sustainable Tribal Empowerment Project (STEP) in the Paderu agency area. It would be worthwhile to evaluate what exactly has CARE done here, given the conditions that are obtaining today in this area here, including in the field of health.

4. We have already seen the debilitating kind of vacancies that exists in the medical and health establishment of the agency area of Visakhapatnam district. We have seen the desperate conditions of poverty in which the tribal population is living in this area. A combination of the two makes the area a fertile hunting ground for death and disease. This is clearly borne out even by the Government statistics. Of the total number of 2,227 deaths that occurred in the Paderu agency area from 1st January to 25th July 2005 this year from all causes, the number of infants alone that died is 135. In addition, the number that died in the age group of 1 to 5 was 175. Another 175 died in the age group of 5-14 years. As many as 221 had died in the age group of 14-25. Thus, practically, the flower of childhood and the youth population are being destroyed in the tribal area because of their socio-economic conditions and the health environment in which they are living. Specifically on health I need to make some observations about the kind of governance that the Government of Andhra Pradesh in the past 6 or 7 years has given to the State in general and tribal areas in particular. First of all I must point out that there has been a freeze in the recruitment of all kinds of personnel into the Government including in the area of health. In other words, there have been no health personnel recruited in Andhra Pradesh for nearly a decade now, excepting sporadically. In the year 2001 a departure was made in regard to this but the remedy itself was worse than the disease. Vacancies of civil surgeons and certain paramedical staff was resorted to “temporarily on contract basis for a period of one year” extendable from year to year. Within a year the futility of this was realized when the Government acknowledged that the response to filling up of these vacancies on contract basis at the rates of emoluments prescribed by the Government was “not encouraging”. With cosmetic changes in the matter of emoluments, the policy was continued. The results are there for all of us to see today and over a period in the form of the vacancies that I have described in this report. It is, therefore, hardly surprising that we have the kind of outbreak of diseases, which we have witnessed in the current year in the Paderu agency area. This is not something that has happened this year only. There was a more serious outbreak in the year 1999. This policy has been on for several years now, so have been the vacancies, and so has been the disease load in the Paderu agency area. What we are witnessing today in the Paderu agency area is a result of shortsighted policies followed over a period of 6-7 years. This situation seems to have been compounded by delayed action on the part of the Government of India in regard to supply of materials like insecticides for the medical and health machinery to get ready to fight the onslaught of the on coming malarial fever. My discussions at the village level clearly shows that the spraying operations started too late in the villages this year to have had any effect

whatsoever. Delayed supply of material and unacceptable levels of vacancies in the medical and health establishment area is a combination that constitutes an irresistible invitation to death and diseases. How thoroughly unprepared have all concerned been can be seen from the fact that there was dismal failure even in the matter of distribution of impregnated bed nets in the agency area. I enclose a statement on bed nets distributed at **Annex-V** relating to the period March to July 2005 in some of the villages of some of the Malaria sub units. These figures speak for themselves. Nowhere have enough nets been made available to meet even the needs of a third of the population, excepting rarely. Even though the State Government talked in the past about rationalization of institutions and staff to provide better out reach and health delivery services by establishing and strengthening health institutions, an examination of the location of Primary health centres in the Paderu area shows that as many as 13 primary health centres out of the 32 that have been set up in the area cater to a population well above 20,000 each, the norm advocated by the Government of India for primary health centres in the tribal areas. Also, many of these are without buildings. Many claims have been made in regard to the institution of the Community Health Worker (CHW) set up in the tribal areas under the Andhra Pradesh Economic Restructuring Programme under the World Bank's auspices. A total of 8,500 CHW are reportedly working since January 1999 in the scheduled areas of Andhra Pradesh of whom about 3,200 are working in the Paderu agency area. No body can object to the concept of a Community Health Worker. However, for an illiterate tribal girl to function as an effective purveyor of health and medicine and health education, exceptional levels of training and motivation are called for. A look at the way the CHW programme is functioning in the Paderu area makes one believe that in the area of training of the Community Health Worker, there has been near complete failure. Training to them seems to have been imparted sporadically and without much purpose. This apart, as seen during my field investigation, the so-called honorarium of Rs.400/- per month for these Community Health Workers is not being paid to them every month at all. In fact, they are being paid this small honorarium once in 6 months. That is absolutely unacceptable and must be destructive of all motivation. My investigations revealed hunger in the households of the Community Health Workers themselves and they have to go and do agricultural labour work for their own living. A hungry, labouring CHW who is paid her honorarium once in six months is hardly going to be the person who will spread health education amongst other hungry tribals in a terrain like the agency areas of Andhra Pradesh and fight endemic malaria. Despite all this, senior officers of the Medical and Health Departments claim that she is the only one who is doing any thing at all in the agency area. If it is so, then, we have set up very poor standards

of expectations from our health personnel. Even if it is so, given the vacancy position of senior medical personnel and paramedical staff in the echelons above her, who should train her and guide her, the concept of CHW stands thoroughly compromised in the scheme of things.

5. Statistics of blood samples taken, the Annual Parasitic Index (API) and the Slide Positivity Rates (SPR) all indicate a situation that can only be described as of epidemic proportions as far as Malaria is concerned in the Paderu agency area. **Annex-III** shows an SPR that is well above 2% in a number of complexes and in some cases it has ranged from 3.64 to 12.59. Experts agree that an Annual Parasitic Index that goes above 2% is indicative of an abnormal and alarming situation. I understand authoritatively that the API for this year in the Visakhapatnam agency is around 5.43, which represents an extremely alarming situation. Against this background, the Health and Medical establishment of the Government of India and the State Government have taken the stand that most of the deaths that have occurred of fever in Paderu area are not malarial deaths. According to them death by malaria has not even got into the double figures. Their argument is that malaria is proved only when a person, whose blood smear has shown positive, responds to treatment! If this is the criterion, then, almost all cases of fever deaths can be dismissed as not being on account of malaria, especially given the kind of health establishment we have in the agency area; the delays in taking smears; huge discrepancies in negative – positive findings; vacancies in laboratory technicians and poor out reach. However, even lay people know that a single negative slide does not necessarily mean absence of malaria in the area, either. Obviously, no dissections of organs have been done to find out cases of death by fever by the authorities, to eliminate the possibility of malaria as a cause of widespread deaths. **Taking all the circumstances into consideration, I come to the conclusion that there is gross under reporting of cases of deaths because of fever. Also, there is every likelihood that a large number of these unreported cases of deaths by fever are on account of malaria. All the data we have including Dr Patnaik's report tend to point to this conclusion.**

6. This having been said, it needs also to be stated that the figures given in the Complaint petition are clearly exaggerated. In one single village of Champaguda of Madagada Panchayat in Arakuvalley mandal, I found 43 names of living persons shown as having died of Malaria. This one single case of such a large magnitude damages the very credibility of the Complaint petition. A representation of this kind with out reference to truth not only calls

into question the credibility of those making such claims but also harms the cause of the poorest of the poor living in difficult conditions in the agency areas of Andhra Pradesh. If today we are able to establish that a serious situation does prevail really in the Paderu agency area in regard to fevers despite lists of false names given, it is more because of the pains that the NHRC has taken to find out the truth than because of the kind of exaggerated figures incorporated in the Complaint petition. This is illustrated in the next paragraph.

7. I have sought and obtained from the Project Officer, ITDA a statement, enclosed as Annex-VI, showing the information relating to all deaths Mandal-wise for the year 2005. This information is placed side by side with the information of alleged deaths “in the epidemics” furnished in the Complaint, below:

Sl. No.	Name	Numbers as given by the Project Officer, ITDA, Paderu	As given in the Complaint
1.	Paderu Mandal	269	168
2.	G. Madugula Mandal (270 to 579)	249	72
3.	Pedabayalu Mandal (520 to 670)	150	-
4.	Munchingput Mandal (670 to 855)	185	33
5.	Dumbriguda Mandal (856 to 969)	113	64
6.	Arakuvalley (970 to 1121)	151	158
7.	Chintapalli Mandal (1122 to 1421)	299	104
8.	Anantagiri Mandal (1422 to 1520)	98	153
9.	Hukumpeta Mandal (1521 to 1663)	142	166
10.	Koyyuru Mandal (1664 to 1902)	238	18

The number of deaths furnished by the Project Officer is clearly higher than those furnished in the Complaint in respect of 7 out of the 10 Mandals for which we have information. Obviously, the Government of Andhra Pradesh is not suppressing any information about the number of deaths. I have already pointed out the large piece of inaccurate information furnished in the Complaint in regard to Champaguda village in Arakuvalley mandal. That could explain the numbers shown in the Complaint in regard to this Mandal being larger than those furnished by the Project Officer. Since the Honourable Commission has furnished the lists given in the Complaint to the State Government, the latter should be able to explain the discrepancy in regard to the other two mandals Anantagiri and Hukumpeta. Given the inaccurate information furnished in regard to at least one Mandal verified by me in one village, it would be up to the State Government to cross-check all cases of deaths by

comparing the official data with those given in the Complaint and report the findings to the Honourable Commission.

8. I have examined the list furnished in the Complaint in comparison with the information gathered by me personally in the villages visited by me. I find that I have detected more cases of death by fever in the villages of Kujjali, Pantalachinta and Sappiputtu than mentioned in the Complaint. On the other hand, names like Korra Seeta and Korra Kanchamma given in the Complaint do not exist at all in Sappiputtu village, while the name of Marri Nageswara Rao is included in the list though he had died 5 years ago. Thus, the list of names furnished in the Complaint point to a lot of discrepancies and the State Government should be requested to verify all these names and report to the Commission as to their veracity. Similarly, I detected more cases in Kujjali, Pantalachinta and Sappiputtu villages than found in the list furnished by the Project Officer, Paderu. The Government of Andhra Pradesh should, therefore, be requested to check all the names that I have listed out to see if they are reported under any other neighbouring village or not reported at all. If the latter, it is a very serious matter. In any event, we need an investigation into why these names are missing in the Government's list and conclusions arrived at to fix responsibility. **The State Government should conduct a fresh survey of all deaths this year to determine the extent of under reporting of deaths by fever.**

9. Whatever the figures, if we look at the clinical circumstances under which many fever deaths have taken place, the needle of suspicion points to a large number of deaths by Malaria. In 4 out of the 5 villages I visited there have been 28 deaths because of fever, many of them of children. In 3 villages alone 27 deaths of fever have occurred. All these deaths had occurred within 3 days of the fever starting with rigor, including of a 7-month pregnant woman who died while giving birth to a dead baby. Prima facie, these cases look to me like cases of Falciparum Malaria. The point that requires to be made is not whether the number of people shown in the Complaint petition as having died of Malaria is exactly correct or not. It would be futile to debate whether all the fever deaths that have occurred were on account of Malaria, given the reluctance of the health fraternity to admit that an epidemic-like situation obtains in the area. What, however, remains as the truth is that scores of people have died of fever, the cause of which has not been properly determined and that certainly is a matter of grave concern to the NHRC. A reading of the report of Dr Patnaik, Deputy Director, Regional Office of the Department of Health and Family Welfare, Government of India would suffice to show how grim the situation in the Paderu agency area is.

10. At the beginning of this Report I have summarized the basic points made in the Complaint. The main thrust of the Complaint is that the present Government in Andhra Pradesh is responsible for the dismal health situation that prevails in the Agency areas of the State today. I have discussed the health and other related aspects of the lives of the people living in the Agency areas of Visakhapatnam District in full detail in this Report. The facts furnished by me and the analysis made by me of those facts would clearly establish that the health and related situation of the people in this area is grim. However, these would also show that this is not the result of what has been happening only during the past one-year or so, as has been sought to be made out in the Complaint. The situation obtaining today is the result of gross neglect of the problems of the people living in the Tribal area over a period of several years. In my view, governance in the past has been guilty not only of omission to do what should have been done but also of commission of certain things that have led to the current state of affairs. There is no need to repeat all that has been said earlier in this Report to prove this point. However, a reference to a few policy actions on the part of the past Governments is essential to put the issues in perspective. For example, I have no hesitation in concluding that resort to appointing medical personnel on contract basis to serve in tribal areas is a disastrous error of judgment on the part of the previous Government. Also, placing a freeze on recruitment of medical officers and paramedical personnel including in the Tribal areas amounted to a gross misunderstanding of the duties of an elected Government to the human development needs of the poorest of the poor. That a large number of vacancies existed even in the years prior to 2004-05 shows that there has been continuous neglect of the health issues of the tribals. What comes out loud and clear from the facts gathered by me is the lip service that political leaders pay to the welfare of the poor while in truth doing nothing about it. Otherwise, what is the meaning of the figures that show that of the 1, 26,013 households in the ITDP area of Paderu, 1, 17,834 households are living below the poverty line? That is a poverty percentage of 94! It cannot be any body's case that such poverty came in to existence all of a sudden in one year. This kind of poverty represents gross neglect of the tribals over decades for which all political parties that have governed Andhra Pradesh in recent years should take responsibility. At least in the years prior to the mid-1990s such dysfunctional solutions like resort to recruiting essential health and medical personnel on yearly contract basis had not been resorted to. Since mid-1990s that has been the fashion obviously under external donor pressure. Contract employees who have no security of tenure or accountability and that too while expected to work in areas that are inhospitable, cannot deliver health to the poor. In fact, records show that there were not many who were willing to

accept assignments on such contract terms. Naturally enough there have been vacancies on a large scale with all the attendant consequences for the hapless tribals. All other failures such as those in the areas of credit, Public Distribution System, implementation of Land Transfer Regulations, employment generation and bonded labour cannot have been the result of a single year's negligence. Therefore, on this point, the allegations made in the Complaint will not stand scrutiny. Also, we have already seen an example of figures that are not true having been furnished to the Commission in the Complaint. Still, despite this serious flaw in the Complaint, I have found the existence of large-scale incidence of fever and malaria in the Paderu Agency area by ascertaining all relevant facts. Under the circumstances I do not find any need for a Judicial Enquiry into the situation as asked for in the Complaint.

11. The State Government should, however, be directed to initiate action on the following lines:

- 1. The Government of India and the State Government should consider bifurcation of the existing area of the ITDA, Paderu and set up at least two agencies instead of the one presently in existence. This is necessary because the ITDA, Paderu has a total area of 6,293 Sq. Kms consisting of 3,565 habitations. The density of population is 75 per Sq. Km. as against a rural population density of 205 per Sq. Km. for the State as a whole. No single officer as Project Officer would be able to do justice to an area of this size given the kind of terrain requiring to be traversed. The existing structure for the ITDA cannot be held rationally accountable to a demographic profile of this kind. Obviously, what is suggested here for Paderu needs to be done for other ITDAs as well in the State of Andhra Pradesh. Since the Government of India has substantial responsibility to the governance of the scheduled areas of the country through the State Government, we need policy decisions in this regard to be taken by the Government of India as well as the State Government. What can be said with certainty is that the existing jurisdiction of this ITDA is too unwieldy to hold one Project Officer accountable to the development and welfare of the people of the area and if structural reorganization is not effected, the human rights of the tribals living in the Project areas would continue to get violated in the areas of Food, Work and Employment, Health, Shelter, Education and Information.**
- 2. The Government of India and the State Government should together set up a team of eminent health NGOs of national stature and repute to study and pin point the**

causes for delay this year in the matter of supply of all relevant material required in the ITDA area of Paderu in terms of the preparations required to safeguard the health of the people inhabiting the ITDA area. In doing this, the team should study and determine whether there has been under reporting of fever cases by the authorities. The team should also recommend the kinds of decentralization required in regard to all procedures including financial so that all required material can be kept ready and available in various places in the ITDA area itself and so that no time is lost in the matter of transportation of material, availability of spare parts, attention to repairs of equipment etc.

3. The Government of India and the State Government should re-examine policies relating to recruitment, posting and transfer of personnel in the ITDA area so as to ensure that these two Governments take total responsibility for delivery of all services related to human development such as health, nutrition and all other measures aimed at the eradication of poverty of the people of the area. Specifically, dysfunctional policies like contract employment, failure to backup theoretically sound concepts like community health workers with appropriate intensity of training, remuneration etc., should be reviewed and responsibility fixed. The two Governments should ensure that personnel policies are people-centric and not donor-centric. Also, there should be flexibility in the matter of posting of personnel instead of rigid dogmas like posting only tribal personnel in the tribal areas, etc. For example, the present ADMHO, Paderu is not even physically fit to hold the post – he has suffered a stroke i.e., hemiplegia - and yet he seems to have been posted there only because he is a tribal. This is neither fair to him nor the tribals of the area. It should be ensured that in every primary health centre food is provided to the in-patients and wherever necessary to one attendant as well. The BSNL should introduce satellite phone coverage in this area and take other action to introduce the state of the art telecom infrastructure in the ITDA area, because delivery of services and communication infrastructure are intimately inter-connected.
4. In reviewing the situation in the tribal area as part of the effort of this exercise, all other points made in the body of this report such as those relating to the rights of the tribals to land in the scheduled areas, credit needs and the right to work and food may be taken into account and policy answers found for each of them.

5. **The political leadership, in the State, regardless of party affiliations, should hold itself accountable for non-enforcement of measures like mandatory instructions relating to all postings, residence of staff and transfer-related matters in the tribal areas, including those relating to medical and para-medical staff as a first step towards assuming accountability for the eradication at least of absolute poverty in all its dimensions in the scheduled areas, within a time frame, say, of 5 to 6 years.**

The above Report may kindly be placed before the Honourable Chairperson and the Commission for favour of appropriate orders.

K. R. VENUGOPAL.

21st August 2005.

Dear Dr. Man Mohan Singh,

Sub: Complaint from Mr. K Yerran Naidu regarding death of Girijans in Agency Areas in Andhra Pradesh due to major epidemic breakout of Malaria, Anthrax, Dengue, etc.

Ref: Case No.214/1/2005-2006 NHRC (Law Division-IV) dated the 27th July 2005.

I am writing this to thank you for the trouble you have taken in discussing with me some of the issues involved in regard to the above subject and furnishing me information on the programmes under implementation in the Agency area.

I found the hunger and poverty situation in the Paderu agency area pretty grim during my visit there. The note furnished to me by the P.O., ITDA has mentioned about the distribution of rice being done as a special effort in the area. I would like to suggest that given the distress in the area, for the next 3 months every tribal household in the area should be provided at least 50 kg of rice per month and a few other essential commodities free (or specially, heavily subsidized and on long term credit) and the Anganwadis in the area directed to provide supplementary nutrition to children and pregnant and nursing mothers twice a day, pending more permanent measures required to be taken to make the area hunger-free through employment generation etc.,

My discussions with certain health experts also show that the fever situation in the East Godavari agency could be even more serious than in Paderu. There is thus need for action on a war footing in the entire Agency area in this regard.

I thought I would take the liberty of making these suggestions for your immediate consideration and action.

Yours sincerely,

KRVENUGOPAL.

Dr. Man Mohan Singh IAS
Commissioner of Tribal Welfare
Government of Andhra Pradesh
Fax No.040 – 2 331 5236.

Copy to Ms. Chaya Ratan IAS, Principal Secretary , Tribal Welfare.

30th August 2005.

Dear Barihoke Saheb,

Sub: Complaint from Mr. K Yerran Naidu regarding death of Girijans in Agency Areas in Andhra Pradesh due to major epidemic breakout of Malaria, Anthrax, Dengue, etc.

Ref: 1. Case No. 214/1/2005-2006 NHRC (Law Division-IV) dated the 27th July 2005.
2. My report on the above subject to you dated the 20th August 2005.
3. My fax message to you dated the 21st August 2005.

In continuation of my Report 1st cited, I have sent the fax message 2nd cited to you forwarding along with it a copy of the message addressed to the Commissioner of Tribal Welfare under copy to the Principal Secretary, Tribal Welfare, Government of Andhra Pradesh calling for certain immediate measures to fight the grim hunger situation being experienced in the Paderu Agency area. I had also drawn the Tribal Welfare Commissioner's attention to the serious fever situation obtaining in the neighbouring East Godavari agency area, calling for action on a war footing.

2. I am writing this letter with a submission to the Honourable Commission that my Report 1st cited and 2nd cited might be forwarded to the Secretaries to the Government of India in the Ministries of Health and Family Welfare and Tribal Welfare, and the Chief Secretary to the Government of Andhra Pradesh for their comments and immediate necessary action. Considering the seriousness of the situation, I also recommend that the Chief Secretary to the Government of Andhra Pradesh should be requested to place this Report before the Honourable Chief Minister of Andhra Pradesh for his information.

This is for favour of consideration of the Honourable Commission.

Yours sincerely,

K R VENUGOPAL

Shri. A. Barihoke
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