ಖಂಡ 14 :- ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳನ್ನು ಮತ್ತು ಕೈಗೊಳ್ಳಪ್ಪದು ಅಗತ್ಯವಿರುವ ಯಾವುದೇ ಇತರ ವಿಷಯಗಳನ್ನು ಈಡೇರಿಸುವುದಕ್ಕಾಗಿ ನಿಯಮಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

ಪ್ರಸ್ತಾವಿತ ಶಾಸನ ರಚನಾಧಿಕಾರವು ಸಾಮಾನ್ಯ ಸ್ವರೂಪದ್ದಾಗಿದೆ.

ಕೆ.ಜಿ.ಎ. ಮಹಾದೇವಪ್ಪ
ಆರೋಗ್ಯ ಮತ್ತು
ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸಚಿವರು.

ಕೆ.ಪಿ. ರುದ್ರಪ್ಪ
ಕಾರ್ಯದರ್ಶಿ.

ಮುದ್ರಕರು : ಮುದ್ರಣ,ರೇಖಾ ಸಾಮಗ್ರಿ ಮತ್ತು ಪ್ರಕಟಣೆಗಳ ಇಲಾಖೆ, ಸರ್ಕಾರಿ
ಮುದ್ರಣಾಲಯ,ಬೆಂಗಳೂರು. ಇ. ಸಂ. 708/99

ಕರ್ನಾಟಕ ವಿಧಾನ ಪರಿಷತ್ತು

(ಎಂಬತ್ತೊಂಬತನೆಯ ಅಧಿವೇಶನ)

ಕರ್ನಾಟಕ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ (ವಿನಿಯಮ) ವಿಧೇಯಕ, 1998

(1998ರ ವಿಧಾನ ಪರಿಷತ್ತಿನ ವಿಧೇಯಕ ಸಂಖ್ಯೆ 15)

ಕರ್ನಾಟಕ ರಾಜ್ಯದಲ್ಲಿ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ವಿನಿಯಮ ಮತ್ತು ನಿಯಂತ್ರಣಕ್ಕಾಗಿ ಮತ್ತು ಅದಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಅಥವಾ ಅವಕ್ಕೆ ಆಸುಪಾಂಗಿಕವಾದ ವಿಷಯಗಳಿಗಾಗಿ ಉಪಬಂಧ ಕಲ್ಪಿಸಲು ಒಂದು ವಿಧೇಯಕ.

ವೈದ್ಯಕೀಯ ವೃತ್ತಿಧರ್ಮವನ್ನು ಗಮನದಲ್ಲಿರಿಸಿಕೊಂಡು ಸೇವೆಯ ಕನಿಷ್ಠ ಗುಣಮಟ್ಟವನ್ನು ನಿಗದಿಪಡಿಸುವ ಮೂಲಕ ರಾಜ್ಯದಲ್ಲಿ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳನ್ನು ನಡೆಸುವುದನ್ನು ಕಾನೂನಿನ ಮೂಲಕ ವಿನಿಯಮಗೊಳಿಸುವುದು ಸಾರ್ವಜನಿಕ ಹಿತಾಸಕ್ತಿಯಿಂದ ಯುಕ್ತವಾಗಿರುವುದರಿಂದ ;

ಭಾರತ ಗಣರಾಜ್ಯದ ನಲವತ್ತೊಂಬತ್ತನೇ ವರ್ಷದಲ್ಲಿ ಕರ್ನಾಟಕ ರಾಜ್ಯ ವಿಧಾನಮಂಡಲದಿಂದ ಈ ಮುಂದಿನಂತೆ ಅಧಿನಿಯಮಿತವಾಗಲಿ :-

1. ಸಂಕ್ಷಿಪ್ತ ಹೆಸರು, ಪ್ರಾರಂಭ ಮತ್ತು ಅನ್ವಯ.-(1) ಈ ಅಧಿನಿಯಮವನ್ನು ಕರ್ನಾಟಕ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ (ವಿನಿಯಮ) ಅಧಿನಿಯಮ, 1998 ಎಂದು ಕರೆಯತಕ್ಕದ್ದು.

(2) ಇದು ರಾಜ್ಯ ಸರ್ಕಾರವು ಅಧಿಸೂಚನೆಯ ಮೂಲಕ ಗೊತ್ತುಪಡಿಸಬಹುದಾದಂಥ ದಿನಾಂಕದಂದು ಜಾರಿಗೆ ಬರತಕ್ಕದ್ದು ಮತ್ತು ಈ ಅಧಿನಿಯಮದ ಬೇರೆ ಬೇರೆ ಉಪಬಂಧಗಳಿಗಾಗಿ ಬೇರೆ ಬೇರೆ ದಿನಾಂಕಗಳನ್ನು ಗೊತ್ತುಪಡಿಸಬಹುದು.

All private medical institutions

(3) ಈ ಅಧಿನಿಯಮವು ಎಲ್ಲ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಅನ್ವಯವಾಗಿರತಕ್ಕದ್ದು.

2. ಪರಿಭಾಷೆಗಳು.- ಈ ಅಧಿನಿಯಮದಲ್ಲಿ ಸಂದರ್ಭವು ಅನ್ಯಥಾ ಅಗತ್ಯಪಡಿಸಿದ ಹೊರತು,-

(ಎ) 'ಮಾನ್ಯತೆ' ಎಂದರೆ 5ನೇ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ನೀಡಲಾದ ಮಾನ್ಯತೆ ;

(ಬಿ) 'ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರ' ಎಂದರೆ 4ನೇ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ರಚಿಸಲಾದ ಪ್ರಾಧಿಕಾರ.

(ಸಿ) 'ಅಪೀಲು ವಿಚಾರಣಾ ಪ್ರಾಧಿಕಾರ' ಎಂದರೆ ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳಿಗಾಗಿ ರಾಜ್ಯ ಸರ್ಕಾರವು, ಅಧಿಸೂಚನೆಯ ಮೂಲಕ ಅಪೀಲು ವಿಚಾರಣಾ ಪ್ರಾಧಿಕಾರ ಎಂಬುದಾಗಿ ನೇಮಕ ಮಾಡಿದ ಪ್ರಾಧಿಕಾರ.

(ಡಿ) 'ಗೊತ್ತುಪಡಿಸಿದ ದಿನ' ಎಂದರೆ 1ನೇ ಪ್ರಕರಣದ (2)ನೇ ಉಪ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ಗೊತ್ತುಪಡಿಸಿದ ದಿನಾಂಕ ;

(ಇ) 'ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶ' ಎಂದರೆ ಬೆಂಗಳೂರು ಅಭಿವೃದ್ಧಿ ಪ್ರಾಧಿಕಾರ ಅಧಿನಿಯಮ, 1976 (1976ರ ಕರ್ನಾಟಕ ಅಧಿನಿಯಮ 12)ರಲ್ಲಿ ಪರಿಭಾಷಿಸಲಾದ ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶ,

(ಎಫ್) "ಚಿಕಿತ್ಸಕ ಪ್ರಯೋಗಾಲಯ" ಎಂದರೆ ಸಾಮಾನ್ಯವಾಗಿ,-

(i) ಜೈವಿಕ, ರೋಗ ಶಾಸ್ತ್ರ, ವಿಕಾಣು ಜೀವಿಕ, ವಿಕಿರಣ, ಸೂಕ್ಷ್ಮದರ್ಶಕ, ರಾಸಾಯನಿಕ ಅಥವಾ ಇತರೆ ಪರೀಕ್ಷೆ, ಪರಿಶೀಲನೆ ಅಥವಾ ವಿಶ್ಲೇಷಣೆಯನ್ನು ನಡೆಸುವ ; ಅಥವಾ

(ii) ರೋಗನಿದಾನ ಅಥವಾ ರೋಗ ಚಿಕಿತ್ಸೆಯ ಸಂಬಂಧದಲ್ಲಿ ಸಾಮಾನ್ಯವಾಗಿ ಕಲ್ಚರ್‌ಗಳು, ಲಸಿಕೆ, ರಸಿಕೆ ಅಥವಾ ಇತರ ಜೈವಿಕ ಅಥವಾ ವಿಕಾಣು ಜೀವಿಕ ಉತ್ಪನ್ನಗಳನ್ನು ಸಿದ್ಧಪಡಿಸುವ

-ಒಂದು ಸಂಸ್ಥೆ.

(ಜಿ) 'ಆರೋಪಿ' ಎಂದರೆ ಸಂದರ್ಭನುಸಾರವಾಗಿ ಕರ್ನಾಟಕ ಸರ್ಕಾರದ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ ಮತ್ತು ಭಾರತೀಯ ವೈದ್ಯ ಪದ್ಧತಿಯ ಇಲಾಖೆ.

(ಜೆಜ್) ವೈದ್ಯಕೀಯ ವೃತ್ತಿದಾರ ಎಂದರೆ, ಹೋಮಿಯೋಪತಿ ವೃತ್ತಿದಾರರ ಅಧಿನಿಯಮ, 1961 (1961ರ ಕರ್ನಾಟಕ ಅಧಿನಿಯಮ 35), ಆಯುರ್ವೇದ, ಪ್ರಕೃತಿ ಚಿಕಿತ್ಸೆ, ಸಿದ್ಧ ಯುನಾನಿ ಮತ್ತು ಯೋಗ ವೃತ್ತಿದಾರರ ನೋಂದಣಿ ಮತ್ತು ವೈದ್ಯಕೀಯ ವೃತ್ತಿದಾರರ ಸಂಕೀರ್ಣ ಉಪ-ಬಂಧಗಳ ಅಧಿನಿಯಮ, 1961 (1962ರ ಕರ್ನಾಟಕ ಅಧಿನಿಯಮ 9), ವೈದ್ಯಕೀಯ ನೋಂದಣಿ ಅಧಿನಿಯಮ, 1961 (1961ರ ಕರ್ನಾಟಕ ಅಧಿನಿಯಮ 34), ಭಾರತೀಯ ವೈದ್ಯಕೀಯ ಕೇಂದ್ರೀಯ ಪರಿಷತ್ ಅಧಿನಿಯಮ,

1970 (1970ರ ಕೇಂದ್ರ ಅಧಿನಿಯಮ 48), ಹೋಮಿಯೋಪತಿ ಕೇಂದ್ರೀಯ ಪರಿಷತ್ ಅಧಿನಿಯಮ, 1978 (1978ರ ಕೇಂದ್ರ ಅಧಿನಿಯಮ 59) ಮತ್ತು ವೈದ್ಯಕೀಯ ಪರಿಷತ್ ಅಧಿನಿಯಮ, 1956 (1956ರ ಕೇಂದ್ರ ಅಧಿನಿಯಮ 102) ಅಡಿಯಲ್ಲಿ ಅವರು, ಹಾವು ಅಧ್ಯಯನ ಮಾಡಿದ ವೈದ್ಯಕೀಯ ಪದ್ಧತಿಯಲ್ಲಿ ವೃತ್ತಿ ನಡೆಸಲು ನೋಂದಾಯಿತನಾದ ಒಬ್ಬ ವೈದ್ಯಕೀಯ ವೃತ್ತಿದಾರನು ಮತ್ತು ದಂತ ವೈದ್ಯರ ಅಧಿನಿಯಮ, 1948ರ (1948ರ ಕೇಂದ್ರ ಅಧಿನಿಯಮ 16) ಅಡಿಯಲ್ಲಿ ನೋಂದಾಯಿತನಾದ ಒಬ್ಬ ದಂತ ವೈದ್ಯನನ್ನು ಒಳಗೊಳ್ಳುತ್ತದೆ.

(ಜಿ) "ಸ್ಥಳೀಯ ವಿಶೇಷಲಸಾ ಸಮಿತಿ" ಎಂದರೆ 8ನೇ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ನೇಮಕ ಮಾಡಲಾದ ಸಮಿತಿ ;

(ಜೆ) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ "ವ್ಯವಸ್ಥಾಪಕ" ಎಂದರೆ ಅವನನ್ನು ಇತರೆ ಯಾವುದೇ ಪದನಿರಿಂದ ಅಥವಾ ಪದನಾಮದಿಂದ ಕರೆಯಲಿ, ಆ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ನಿರ್ವಹಣೆ ಅಥವಾ ಅದನ್ನು ನಡೆಸುವ ಕಾರ್ಯದ ಪ್ರಭಾರವಲ್ಲಿರುವ ಅಥವಾ ಅದನ್ನು ವಹಿಸಲಾಗಿರುವ ವ್ಯಕ್ತಿ ;

(ಕೆ) 'ಪ್ರಸೂತಿ ಗೃಹ' ಎಂದರೆ ಸಾಮಾನ್ಯವಾಗಿ ಪ್ರಸವದ ಉದ್ದೇಶಕ್ಕಾಗಿ ಮತ್ತು ಒಬ್ಬ ಮಾನ್ಯತೆ ಪಡೆದ ವೈದ್ಯಕೀಯ ವೃತ್ತಿದಾರ ಅಥವಾ ಪ್ರಸೂತಿ ತಜ್ಞರ ಅಥವಾ ಪ್ರಸೂತಿ ತಜ್ಞರ ಸಂಸ್ಥೆಯ ನೇತೃತ್ವದಲ್ಲಿ ಪ್ರಸವ ಪೂರ್ವ ಅಥವಾ ಪ್ರಸವೋತ್ತರ ಆರೈಕೆಯ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಮಹಿಳೆಯರನ್ನು ಸೇರಿಸಿಕೊಳ್ಳುವುದಕ್ಕಾಗಿ ಅಥವಾ ಇರಿಸಿಕೊಳ್ಳುವುದಕ್ಕಾಗಿ ಅಥವಾ ಅವರೆಡೂ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಇರುವ ಸಂಸ್ಥೆ ಮತ್ತು ಇದು ಸಂತಾನಪರಣ ಚಿಕಿತ್ಸೆ ಅಥವಾ ವೈದ್ಯಕೀಯ ಗರ್ಭ ಸಮಾಪನೆಗಾಗಿ ಮಹಿಳೆಯರನ್ನು ಸೇರಿಸಿಕೊಳ್ಳುವ ಅಥವಾ ಇರಿಸಿಕೊಳ್ಳುವ ಸಂಸ್ಥೆಯನ್ನು ಒಳಗೊಳ್ಳುತ್ತದೆ ;

(ಎಲ್) 'ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆ' ಎಂದರೆ ಒಂದು ಆಸ್ಪತ್ರೆ ಅಥವಾ ಖಾಸಗಿ ಸೌಲಭ್ಯವಳ್ಳ ಔಷಧಾಲಯ, ನರ್ಸಿಂಗ್‌ಹೋಂ, ಚಿಕಿತ್ಸಾ ಪ್ರಯೋಗಾಲಯ, ರೋಗನಿದಾನ ಕೇಂದ್ರ, ಪ್ರಸೂತಿ ಗೃಹ, ರಕ್ತನಿಧಿ, ವಿಕಿರಣ ಕೇಂದ್ರ, ಸ್ಕ್ಯಾನಿಂಗ್ ಸೆಂಟರ್, ಫಿಜಿಯೋಥೆರಪಿ ಕೇಂದ್ರ ಮತ್ತು ಸಾರ್ವಜನಿಕರಿಗೆ ರೋಗ ತಪಾಸಣೆ, ರೋಗ ನಿದಾನ ಮತ್ತು ರೋಗ ನಿವಾರಕ ಅಥವಾ ಪರಿಹಾರಕ ಚಿಕಿತ್ಸಾ ಸೌಲಭ್ಯಗಳನ್ನು ಒದಗಿಸುವಂಥ ಯಾವುದೇ ಪದನಿರಿಂದ ಕರೆಯಲಾಗುವ ಅಥ ಇತರ ಸಂಸ್ಥೆಗಳು ; ಆದರೆ ಇದರಲ್ಲಿ ಒಬ್ಬ ವೈದ್ಯಕೀಯ ವೃತ್ತಿದಾರನು ತನ್ನ ವೃತ್ತಿ ನಡೆಸುವ, ಆದರೆ ಖಾಸಗಿ ಸೌಲಭ್ಯವಿಲ್ಲದ ಒಂದು ಕ್ಲಿನಿಕ್ ಸೇರಿರಕ್ಕದ್ದಲ್ಲ.

(ಎಮ್) 'ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆ' ಎಂದರೆ, ಅಲೋಪತಿ ಅಥವಾ ಆಯುರ್ವೇದ, ಯೆನಾನಿ, ಹೋಮಿಯೋಪತಿ, ಯೋಗ, ಪ್ರಕೃತಿ ಚಿಕಿತ್ಸೆ ಮತ್ತು ಸಿದ್ಧ ಮುಂತಾದ

ಮನ್ನಣೆ ಪಡೆದ ಇತರ ಯಾವುದೇ ವೈದ್ಯಕೀಯ ಪದ್ಧತಿಗಳ ಮೂಲಕ ಯಾವುದೇ ಕಾಯಿಲೆಯನ್ನು ತಡೆಗಟ್ಟಲು ಅಥವಾ ಗುಣಪಡಿಸಲು ಅಥವಾ ಯಾವನೇ ವ್ಯಕ್ತಿಯ ಆರೋಗ್ಯ ಸ್ಥಿತಿಯನ್ನು ಸುಧಾರಿಸಲು ಕೈಗೊಳ್ಳಲಾಗುವ ಕ್ರಮಬದ್ಧವಾದ ರೋಗನಿದಾನ ಮತ್ತು ಚಿಕಿತ್ಸೆ, ಮತ್ತು ಇವರಲ್ಲಿ ಆಕ್ಯುಪಂಕ್ಚರ್ ಮತ್ತು ಆಕ್ಯುಪ್ರೆಷರ್ ಚಿಕಿತ್ಸೆಯೂ ಒಳಗೊಳ್ಳುತ್ತದೆ.

(ಎನ್) 'ನರ್ಸಿಂಗ್ ಹೋಂ' ಎಂದರೆ (ದೇಹ ಅಥವಾ ಮನಸ್ಸಿನ) ಖಾಯಿಲೆ, ಬಾಧೆ ಅಥವಾ ದೌರ್ಬಲ್ಯದಿಂದ ನರಳುತ್ತಿರುವ ವ್ಯಕ್ತಿಗಳನ್ನು ನಿರಂತರವಾಗಿ ಗಮನಿಸುವ, ಶುಶ್ರೂಷೆ ನೀಡುವ ಅಥವಾ ಚಿಕಿತ್ಸೆ ನೀಡುವ ಉದ್ದೇಶದಿಂದ ಸಾಮಾನ್ಯವಾಗಿ ಸೇರಿಸಿಕೊಳ್ಳುವ ಅಥವಾ ಇರಿಸಿಕೊಳ್ಳುವ ಅಥವಾ ಇವರಲ್ಲಿ ಯಾವುದೇ ಉದ್ದೇಶಗಳನ್ನೂ ಹೊಂದಿರುವ ಒಂದು ಸಂಸ್ಥೆ ಮತ್ತು ಇದರಲ್ಲಿ ಒಂದು ಪ್ರಸೂತಿ ಗೃಹವೂ ಸೇರುತ್ತದೆ ;

(ಒ) 'ಫಿಜಿಯೋಥೆರಪಿ ಸಂಸ್ಥೆ' ಇದರಲ್ಲಿ ರೋಗ ಅಥವಾ ದೌರ್ಬಲ್ಯಗಳಿಗೆ ಚಿಕಿತ್ಸೆ ನೀಡುವುದಕ್ಕಾಗಿ ಅಥವಾ ಆರೋಗ್ಯ ಸುಧಾರಣೆಗಾಗಿ ಅಥವಾ ವಿಶ್ರಾಂತಿ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಅಥವಾ ಈ ಎಂಡಬಲ್ಲಿ ಇಲ್ಲಿ ಈ ಮೊದಲು ತೀಸಲಾಗಿರುವ ಉದ್ದೇಶಗಳಿಗೆ ಸಮ್ಮತವಾಗಿರುವ ಅಥವಾ ಸಮ್ಮತವಾಗಿಲ್ಲದ ಯಾವುದೇ ಇತರ ಉದ್ದೇಶಕ್ಕಾಗಿ ಸಾಮಾನ್ಯವಾಗಿ ಅಂಗಮರ್ದನ, ಜಲಚಿಕಿತ್ಸೆ, ಪರಿಷ್ಕಾರಾತ್ಮಕ ಅಂಗೂಷಧಿಗಳು ಅಥವಾ ಅಂತಹವೇ ಚಿಕಿತ್ಸೆಗಳನ್ನು ಕೈಗೊಳ್ಳುವ ಒಂದು ಸಂಸ್ಥೆ ಒಳಗೊಳ್ಳುತ್ತದೆ.

(ಪಿ) 'ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆ' ಎಂದರೆ ಈ ಮುಂದಿನವುಗಳು ನಡೆಸುತ್ತಿರುವ ಅಥವಾ ನಿರ್ವಹಿಸುತ್ತಿರುವ ಅಥವಾ ಪ್ರಾಯೋಜಿಸುತ್ತಿರುವ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯನ್ನು ಹೊರತುಪಡಿಸಿದ ಒಂದು ವೈದ್ಯಕೀಯಸಂಸ್ಥೆ :-

(i) ರಾಜ್ಯ ಸರ್ಕಾರ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರ, ಅಥವಾ

(ii) ರಾಜ್ಯ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರದ ಒಡೆತನ ಹೊಂದಿರುವ ಅಥವಾ ಅವುಗಳ ನಿಯಂತ್ರಣಕ್ಕೊಳಪಟ್ಟಿ ಸಾರ್ವಜನಿಕ ವಲಯ ಉದ್ಯಮಗಳು ಅಥವಾ ಇತರ ಶಾಸನಬದ್ಧ ನಿಕಾಯ ;

(iii) ರಾಜ್ಯ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರವು ಒಡೆತನ ಹೊಂದಿರುವ ಅಥವಾ ಅವುಗಳ ನಿಯಂತ್ರಣಕ್ಕೊಳಪಟ್ಟ ಸ್ವಾಯತ್ತ ಸಂಸ್ಥೆಗಳು :.

(iv) ರಾಜ್ಯ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರ ಅಥವಾ ಅವರೆಡೂ, ಶೇಕಡ ಐವತ್ತಕ್ಕಿಂತಲೂ ಹೆಚ್ಚಿನ ಷೇರುಗಳನ್ನು ಹೊಂದಿರುವ, ಕರ್ನಾಟಕ ಸಹಕಾರ ಸಂಘಗಳ ಅಧಿನಿಯಮ, 1959ರ ಅಡಿಯಲ್ಲಿ ನೋಂದಾಯಿತವಾದ ಒಂದು ಸಹಕಾರ ಸಂಘ :

(v) ರಾಜ್ಯ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರವು ಒಡೆತನ ಹೊಂದಿರುವ ಅಥವಾ ಅವುಗಳ ನಿಯಂತ್ರಣಕ್ಕೊಳಪಟ್ಟಿ ಮತ್ತು ಕರ್ನಾಟಕ ಸಹಕಾರ ಸಂಘಗಳ ನೋಂದಣಿ ಅಧಿನಿಯಮ, 1960ರ ಅಡಿಯಲ್ಲಿ ನೋಂದಾಯಿತವಾದ ಒಂದು ಸಹಕಾರ ಸಂಘ.,

(vi) ರಾಜ್ಯ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರ ಅಥವಾ ಯಾವುದೇ ಸ್ಥಳೀಯ ಪ್ರಾಧಿಕಾರವು ಒಡೆತನ ಹೊಂದಿರುವ ಅಥವಾ ನಿರ್ವಹಿಸುವ ಒಂದು ಸ್ಥಾನ;

3. ಎಲ್ಲ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳು ಮಾನ್ಯತೆಯನ್ನು ಪಡೆಯತಕ್ಕದ್ದು.- ಗೊತ್ತುಪಡಿಸಿದ ದಿನವಂದು ಅಥವಾ ತರುವಾಯ ಈ ಅಧಿನಿಯಮದ ಆಡಿಯಲ್ಲಿ ನೀಡಲಾದ ಮಾನ್ಯತೆಯ ನಿಬಂಧನೆಗಳ ಮತ್ತು ಷರತ್ತುಗಳ ಆಡಿಯಲ್ಲಿ ಮತ್ತು ಅವುಗಳಗನುಸಾರವಾಗಿ ಹೊರತು ರಾಜ್ಯದಲ್ಲಿ ಯಾವುದೇ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯನ್ನು ಸ್ಥಾಪಿಸತಕ್ಕದ್ದಲ್ಲ, ನಡೆಸತಕ್ಕದ್ದಲ್ಲ ಅಥವಾ ನಿರ್ವಹಿಸತಕ್ಕದ್ದಲ್ಲ :

ಪರಂತು, ಗೊತ್ತುಪಡಿಸಿದ ದಿನಕ್ಕೆ ನಿಕಟಪೂರ್ವದಲ್ಲಿ ಆಸ್ತಿತ್ವದಲ್ಲಿದ್ದ ಒಂದು ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು, ಗೊತ್ತುಪಡಿಸಿದ ದಿನದಿಂದ ತೊಂಬತ್ತು ದಿನಗಳೊಳಗೆ ಅಂಥ ಮಾನ್ಯತೆಗಾಗಿ ಅರ್ಜಿ ಸಲ್ಲಿಸತಕ್ಕದ್ದು ಮತ್ತು ಅದಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟ ಆದೇಶಗಳು ಬರುವವರೆಗೆ ಅದನ್ನು ನಡೆಸುವುದನ್ನು ಅಥವಾ ನಿರ್ವಹಿಸುವುದನ್ನು ಅರ್ಜಿಯು ವಿಲೆ ಆಗುವವರೆಗೆ ಮುಂದುವರೆಸಬಹುದು.

4. ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರ.- (1) ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶಕ್ಕಾಗಿ ಒಂದು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರ ಮತ್ತು ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶವಲ್ಲದ ಇತರ ಪ್ರದೇಶಗಳ ಇನ್ನೊಂದು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರ ಇರತಕ್ಕದ್ದು.

(2) (ಎ) ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶಕ್ಕಾಗಿ ಇರುವ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಈ ಮುಂದಿನವನ್ನು ಒಳಗೊಂಡಿರತಕ್ಕದ್ದು.

(i) ನಿರ್ದೇಶಕರು, ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ - ಅಧ್ಯಕ್ಷರು

(ii) ವೈದ್ಯಾಧಿಕಾರಿ, ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪಾಲಿಕೆ - ಸದಸ್ಯರು

(iii) ವಿಭಾಗೀಯ ಜಂಟಿ ನಿರ್ದೇಶಕರು, ಬೆಂಗಳೂರು - ಸದಸ್ಯ-ಕಾರ್ಯದರ್ಶಿಯವರು

(ಬಿ) ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶ ವಲ್ಲದ ಪ್ರದೇಶಗಳಿಗೆ ಇರುವ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಮುಂದಿನವನ್ನು ಒಳಗೊಂಡಿರತಕ್ಕದ್ದು :

(i) ನಿರ್ದೇಶಕರು, ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳು - ಆದ್ಯಕ್ಷರು

(ii) ಜಂಟಿ ನಿರ್ದೇಶಕರು, ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ನಿರ್ದೇಶನಾಲಯದ ಕಛೇರಿ - ಸದಸ್ಯರು

(iii) ಜಂಟಿ ನಿರ್ದೇಶಕರು (ವೈದ್ಯಕೀಯ) ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳ ನಿರ್ದೇಶನಾಲಯ ಕಛೇರಿ - ಕಾರ್ಯದರ್ಶಿಯವರು

ಪರಂತು, ಆಲೋಪಥಿಯ ಹೊರತಾಗಿ ಮಾನ್ಯತೆ ಪಡೆದ ಯಾವುದೇ ಭಾರತೀಯ ವೈದ್ಯ ಪದ್ಧತಿಯ ಮೂಲಕ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಯನ್ನು ಒದಗಿಸುತ್ತಿರುವ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಸಂಬಂಧದಲ್ಲಿ ಭಾರತೀಯ ವೈದ್ಯಪದ್ಧತಿ ಇಲಾಖೆಯ ನಿರ್ದೇಶಕರನ್ನು ಅಥವಾ ಉಪ ನಿರ್ದೇಶಕರ ದರ್ಜೆಗೆ ಕಡಿಮೆಯಿಲ್ಲದ, ಅವರ ಪ್ರತಿನಿಧಿಯನ್ನು ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶಕ್ಕಾಗಿ ಮತ್ತು ರಾಜ್ಯದ ಉಳಿದ ಭಾಗಕ್ಕಾಗಿ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರದ ಸದಸ್ಯಸ್ಥಾನಕ್ಕಾಗಿ ಸಹ ಆಯ್ಕೆ ಮಾಡಿಕೊಳ್ಳತಕ್ಕದ್ದು.

5. ಮಾನ್ಯತೆಗಾಗಿ ಅರ್ಜಿ.- (1) ಒಂದು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯನ್ನು ಸ್ಥಾಪಿಸಲು, ನಡೆಸಲು ಅಥವಾ ನಿರ್ವಹಿಸಲು ನಡೆಸಲು ಅಥವಾ ನಡೆಸುವುದನ್ನು ಮತ್ತು ನಿರ್ವಹಿಸುವುದನ್ನು ಮುಂದುವರಿಸಲು ಅಪೇಕ್ಷಿಸುವ ಪ್ರತಿಯೊಬ್ಬ ವ್ಯಕ್ತಿಯು ನಿಯಮಿಸಬಹುದಾದಂಥ ನಮೂನೆಯಲ್ಲಿ ಮತ್ತು ವಿಧಾನದಲ್ಲಿ ಅಂಥ ಶುಲ್ಕವೊಂದಿಗೆ ಅರ್ಜಿಯನ್ನು ಸಂಬಂಧಪಟ್ಟ ಪ್ರಾಧಿಕಾರಕ್ಕೆ ಸಲ್ಲಿಸತಕ್ಕದ್ದು ಮತ್ತು ವೇರೆ ವೇರೆ ವರ್ಗದ ಅಥವಾ ವರ್ಗಗಳ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳಿಗಾಗಿ ವೇರೆ ವೇರೆ ಶುಲ್ಕವನ್ನು ನಿಯಮಿಸಬಹುದು.

6. ಅರ್ಜಿಗಳ ವಿಲೆ.- (1) 5ನೇ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ಅರ್ಜಿಯನ್ನು ಸ್ವೀಕರಿಸಿದ ನಂತರ, ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು 7ನೇ ಪ್ರಕರಣದ ಉಪಬಂಧಗಳನ್ನು ಗಮನದಲ್ಲಿಟ್ಟುಕೊಂಡು ಮತ್ತು ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯು ನಡೆಸಿದ ಅವಶ್ಯಕವಾಗಬಹುದಾದಂಥ ವಿಚಾರಣೆಯ ತರುವಾಯ ನಿಯಮಿಸಬಹುದಾದಂಥ ಷರತ್ತುಗಳಿಗೆ ಒಳಪಟ್ಟು ಮಾನ್ಯತೆಯನ್ನು ನೀಡಬಹುದು ಅಥವಾ ಅರ್ಜಿಯನ್ನು ತಿರಸ್ಕರಿಸಬಹುದು.

ಪರಂತು, ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಅರ್ಜಿದಾರನಿಗೆ ಆ ವಿಷಯದ ಬಗ್ಗೆ ಅಹವಾಲನ್ನು ಹೇಳಿಕೊಳ್ಳಲು ಸೂಕ್ತ ಅವಕಾಶವನ್ನು ನೀಡಿದ ಹೊರತು ಮತ್ತು ಅಂಥ ನಿರಾಕರಣೆಗೆ ಕಾರಣಗಳನ್ನು ದಾಖಲಿಸಿದ ಹೊರತು ಅರ್ಜಿಯನ್ನು ತಿರಸ್ಕರಿಸತಕ್ಕದ್ದಲ್ಲ.

(2) (1)ನೇ ಉಪ-ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ಹೊರಡಿಸಿದ ಪ್ರತಿಯೊಂದು ಆದೇಶವನ್ನು ಅರ್ಜಿದಾರನಿಗೆ ಕೂಡಲೇ ತಿಳಿಸತಕ್ಕದ್ದು.

(3) (1)ನೇ ಉಪ-ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ನೀಡಲಾದ ಪ್ರತಿಯೊಂದು ಮಾನ್ಯತೆಯು ಐದು ವರ್ಷಗಳ ಅವಧಿಯವರೆಗೆ ಸಿಂಧುವಾಗಿರತಕ್ಕದ್ದು ಮತ್ತು ಅದನ್ನು ನಿಯಮಿಸಬಹುದಾದ ಅಂಥ ಸಮೂನೆಯಲ್ಲಿ, ಅಂಥ ವಿಧಾನದ ಮೂಲಕ ಅರ್ಜಿಯನ್ನು ಸಲ್ಲಿಸಿ ಮತ್ತು ಅಂಥ ಶುಲ್ಕವನ್ನು ಸಂದಾಯ ಮಾಡಿ ಐದು ವರ್ಷಗಳಿಗೆ ಒಂದು ಬಾರಿ ನವೀಕರಿಸಿಕೊಳ್ಳಬಹುದು.

7. 6ನೇ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ಅರ್ಜಿಗಳನ್ನು ವಿಲೆ ಮಾಡುವಲ್ಲಿ ಪರಿಗಣಿಸಬೇಕಾದ ಅಂಶಗಳು.- 6ನೇ ಪ್ರಕರಣದ ಅಡಿಯಲ್ಲಿ ಅರ್ಜಿಗಳನ್ನು ವಿಲೆ ಮಾಡುವಾಗ, ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು, ಈ ಮುಂದಿನ ಅಂಶಗಳಿಗೆ ಗಮನ ನೀಡತಕ್ಕದ್ದು ಎಂದರೆ:-

(i) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು ಇರುವ ಅವರಣವು ಆರೋಗ್ಯಕರ ಪರಿಸರದಲ್ಲಿರಬೇಕು ಮತ್ತು ಅದನ್ನು ಸ್ಥಾಪನೆಗೊಳಿಸಿದ ಅಥವಾ ಸ್ಥಾಪಿಸಲಾಗಿರುವ ಉದ್ದೇಶಗಳಿಗೆ ಅದು ಇತರ ರೀತಿಯಲ್ಲಿ ಸೂಕ್ತವಾಗಿರಬೇಕು;

(ii) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು ಸಾಕಷ್ಟು ಸಂಖ್ಯೆಯ ಅರ್ಹ ವೈದ್ಯರು, ನರ್ಸ್‌ಗಳು, ತಾಂತ್ರಿಕ ಮತ್ತು ಇತರೆ ಅರೆ ವೈದ್ಯಕೀಯ ಸಿಬ್ಬಂದಿಯನ್ನು ಹೊಂದಿರಬೇಕು;

(iii) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು, ಅದರ ವಿವಿಧ ಪ್ರಕಾರ್ಯಗಳ ನಿರ್ವಹಣೆಗಾಗಿ ಸಾಕಷ್ಟು ಜಾಗದಸ್ಥಳ ಕಟ್ಟಡಗಳನ್ನು, ಸಾಧನ ಸಲಕರಣೆಗಳು ಮತ್ತು ಇತರೆ ಮೂಲಭೂತ ಸೌಲಭ್ಯಗಳನ್ನು ಹೊಂದಿರಬೇಕು ;

(iv) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು, ನಿಯಮಿಸಬಹುದಾದಂಥ ಸೌಲಭ್ಯಗಳನ್ನು ಒದಗಿಸುವ ಅಂಥ ಕುಶಲ ಮಾನವಶಕ್ತಿ ಮತ್ತು ಸಾಧನ ಸಲಕರಣೆಗಳನ್ನು ಹೊಂದಿರುವ ಮತ್ತು ಅಂಥ ಗುಣಮಟ್ಟವನ್ನು ನಿರ್ವಹಿಸುವ ಸ್ಥಿತಿಯಲ್ಲಿರಬೇಕು ;

(v) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು 9ನೇ ಪ್ರಕರಣದಲ್ಲಿ ಉಲ್ಲೇಖಿಸಲಾದ ಗುಣಮಟ್ಟಗಳಿಗೆ ಅನುಗುಣವಾಗಿರಬೇಕು ; ಮತ್ತು

(vi) ನಿಯಮಿಸಬಹುದಾದ ಅಂಥ ಇತರೆ ವಿಷಯಗಳು.

8. ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿ.- (1) ಪ್ರತಿಯೊಂದು ಜಿಲ್ಲಾಗಿ ಈ ಮುಂದಿನ ವ್ಯಕ್ತಿಗಳನ್ನು ಒಳಗೊಂಡ ಒಂದು ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿ ಇರತಕ್ಕದ್ದು :-

(ಎ)	ಜಿಲ್ಲಾ ಸರ್ಜನ್	- ಅಧ್ಯಕ್ಷರು
(ಬಿ)	ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿ	- ಸಹ ಅಧ್ಯಕ್ಷರು
(ಸಿ)	ಅಧ್ಯಕ್ಷರು ಅಥವಾ ಕಾರ್ಯದರ್ಶಿ, ಭಾರತ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆ, ಜಿಲ್ಲಾ ಕೇಂದ್ರ ಕಛೇರಿ ಶಾಖೆ	- ಸದಸ್ಯರು
(ಡಿ)	ಹಿರಿಯ ತಜ್ಞರು (ಸರ್ಜರಿ)	- ಸದಸ್ಯರು
(ಇ)	ಹಿರಿಯ ತಜ್ಞರು (ಪ್ರಸೂತಿ ಶಾಸ್ತ್ರ) ಮತ್ತು ಸ್ತ್ರೀರೋಗ)	- ಸದಸ್ಯರು
(ಎಫ್)	ಜಿಲ್ಲಾ ಸಾರ್ವಜನಿಕ ಆಸ್ಪತ್ರೆಗಳ ಶುಶ್ರೂಷಾ ಮೇಲ್ವಿಚಾರಕರು)	- ಸದಸ್ಯರು
(ಜಿ)	ಜಿಲ್ಲಾ ಸಾರ್ವಜನಿಕ ಆಸ್ಪತ್ರೆಯ ಒಬ್ಬ ರೆಸಿಡೆಂಟ್ ವೈದ್ಯಾಧಿಕಾರಿ	-ಸದಸ್ಯ ಕಾರ್ಯದರ್ಶಿ

ಪರಂತು, ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪ್ರದೇಶಕ್ಕಾಗಿ ರಾಜ್ಯ ಸರ್ಕಾರವು ಅಧಿಸೂಚನೆಯ ಮೂಲಕ ಆದರಲ್ಲಿ ನಿರ್ದಿಷ್ಟಪಡಿಸಬಹುದಾದಂಥ ವ್ಯಕ್ತಿಗಳನ್ನು ಒಳಗೊಂಡಿರುವ ಒಂದು ಪ್ರತ್ಯೇಕ ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯನ್ನು ನೇಮಕ ಮಾಡಬಹುದು.

ಮತ್ತು ಪರಂತು, ಆರೋಪಿತ್ ಪದ್ಧತಿಯ ಹೊರತಾದ ಯಾವುದೇ ಭಾರತೀಯ ವೈದ್ಯ ಪದ್ಧತಿಯ ಮೂಲಕ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಯನ್ನು ಒದಗಿಸುವ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಪರಿಶೀಲನೆ ನಡೆಸುವ ಉದ್ದೇಶಗಳಾಗಿ ಸಂಬಂಧಪಟ್ಟ ಜಿಲ್ಲೆಯ ಭಾರತೀಯ ವೈದ್ಯಪದ್ಧತಿ ಇಲಾಖೆಯ ಉಪ ನಿರ್ದೇಶಕರನ್ನು ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯ ಒಬ್ಬ ಸದಸ್ಯನನ್ನಾಗಿ ಸಹ ಆಯ್ಕೆ ಮಾಡತಕ್ಕದ್ದು.

(2) ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯು ತಾನಾಗಿಯೇ ಆಗಲಿ ಅಥವಾ ದೂರುಗಳನ್ನು ಸ್ವೀಕರಿಸಿದ ಮೇರಾಗಲಿ, ಯಾವುದೇ ಸಮಾಯದಲ್ಲಿ, ಈ ಅಧಿನಿಯಮದ ಉಪಬಂಧಗಳನ್ನು ಅಥವಾ ಅದರ ಅಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ನಿಯಮುಗಳನ್ನು ಮತ್ತು ಮಾನ್ಯತೆಯ ಷರತ್ತುಗಳನ್ನು ಯಾವುದೇ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು ಸೂಕ್ತವಾಗಿ ಪಾಲಿಸುತ್ತಿದೆಯೇ ಎಂಬುದನ್ನು ಮುನಪರಿಕೆ ಮಾಡಿಕೊಳ್ಳುವುದಕ್ಕಾಗಿ ಅದನ್ನು ಪರಿಶೀಲಿಸಬಹುದು. ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ವ್ಯವಸ್ಥಾಪಕನು ಅಂಥ ಪರಿಶೀಲನೆಗೆ ಯುಕ್ತವಾದ ಎಲ್ಲ ಸೌಲಭ್ಯಗಳನ್ನು ಒದಗಿಸಲು ಜವಾಬ್ದಾರನಾಗಿರತಕ್ಕದ್ದು.

(3) ಪರಿಶೀಲನೆಯ ಸಂದರ್ಭದಲ್ಲಿ ಯಾವುದೇ ದೋಷಗಳು ಅಥವಾ ನ್ಯೂನತೆಗಳು ಕಂಡುಬಂದಲ್ಲಿ, ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯು ಇದನ್ನು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರಕ್ಕೆ ವರದಿ ಮಾಡತಕ್ಕದ್ದು ಮತ್ತು ಅದು ಆದೇಶದ ಮೂಲಕ ಆದರಲ್ಲಿ ನಿರ್ದಿಷ್ಟಪಡಿಸಬಹುದಾದಂಥ ಯುಕ್ತ ಸಮಯದೊಳಗೆ ಅವುಗಳನ್ನು ಪರಿಹರಿಸಿಕೊಳ್ಳುವಂತೆ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ವ್ಯವಸ್ಥಾಪಕರಿಗೆ ನಿರ್ದೇಶಿಸಬಹುದು. ಆ ತರುವಾಯ, ವ್ಯವಸ್ಥಾಪಕನು ಅಂಥ ಪ್ರತಿಯೊಂದು ನಿರ್ದೇಶನವನ್ನು ಪಾಲಿಸತಕ್ಕದ್ದು ಮತ್ತು ಹಾಗೆ ನಿರ್ದಿಷ್ಟಪಡಿಸಿದ ಸಮಯದೊಳಗೆ ನಿರ್ದೇಶನಗಳ ಪಾಲನೆಯ ಬಗ್ಗೆ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರಕ್ಕೆ ವರದಿ ಮಾಡತಕ್ಕದ್ದು.

9. ಗುಣಮಟ್ಟಗಳು.- (1) ಪ್ರತಿಯೊಂದು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು, ಸಿಬ್ಬಂದಿ ಮತ್ತು ಆವರ ವಿದ್ಯಾರ್ಹತೆಗಳು, ಶಸ್ತ್ರ ಚಿಕಿತ್ಸಾ ಕೊಠಡಿ, ಕಟ್ಟಡಗಳು, ಆಗತ್ಯವಿರುವ ಸ್ಥಳಾವಕಾಶಗಳು, ಸಾಧನ ಸಲಕರಣೆಗಳು, ರೋಗಿಗಳಿಗೆ ಮತ್ತು ಆವರನ್ನು ನೋಡಿಕೊಳ್ಳುವವರಿಗೆ ಒದಗಿಸಬೇಕಾದ ಸೌಲಭ್ಯಗಳು, ನಿರ್ವಹಣೆ ಮತ್ತು ಅಂಥವೇ ಇತರ ವಿಷಯಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ಈ ಅಧಿನಿಯಮದ ಅಥವಾ ಇತರ ಯಾವುದೇ ಕಾನೂನುಗಳಿಂದ ಅಥವಾ ಆಡಿಯಲ್ಲಿ ನಿರೂಪಿಸಲಾದ ಗುಣಮಟ್ಟಗಳಿಗೆ ಅನುಗುಣವಾಗಿರತಕ್ಕದ್ದು.

(2) ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳಾಗಿ ರಾಜ್ಯ ಸರ್ಕಾರವು (1)ನೇ ಉಪ ಪ್ರಕರಣದಡಿ ನಿರ್ದಿಷ್ಟಪಡಿಸಲಾದ ಗುಣಮಟ್ಟಗಳಿಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳನ್ನು ವರ್ಗೀಕರಿಸಬಹುದು ಮತ್ತು ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ವಿವಿಧ ಪ್ರವರ್ಗಗಳಾಗಿ ವಿವಿಧ ಗುಣಮಟ್ಟಗಳನ್ನು ನಿಯಮಿಸಬಹುದು.

10. ವಿಧಿಸಬಹುದಾದ ಶುಲ್ಕವನ್ನು ಸೂಚಿಸತಕ್ಕದ್ದು.-(1) ಪ್ರತಿಯೊಂದು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು ರೋಗಿಗಳು ಹಾಗೂ ಸಾರ್ವಜನಿಕರ ಮಾಹಿತಿಗಾಗಿ ವಿವಿಧ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಗಳಿಗಾಗಿ ಮತ್ತು ಇತರ ಸೇವೆಗಳಿಗಾಗಿ ಆಯ ವಿಧಿಸಬಹುದಾದ ಶುಲ್ಕಗಳ ವಿವರ ಪಟ್ಟಿಯನ್ನು ಸೂಚನಾ ಫಲಕಗಳಲ್ಲಿ, ವಿಷಯ ವಿವರ ಪಟ್ಟಿಗಳು ಅಥವಾ ಶುಲ್ಕ ಸೂಚಿಕಾರ್ಯಗಳ (ಟ್ಯಾರಿಫ್ ಕಾರ್ಡ್) ಮೂಲಕ ಎದ್ದು ಕಾಣುವಂತೆ ಸೂಚಿಸತಕ್ಕದ್ದು.

(2) ಯಾವುದೇ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು, ವಿವರ ಪಟ್ಟಿಯಲ್ಲಿ ಸೂಚಿಸಲಾದ ಶುಲ್ಕಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಮೊಬಲಗನ್ನು ರೋಗಿಗೆ ಅಥವಾ ಆವನ ಸಂಬಂಧಿಕರಿಗೆ ವಿಧಿಸತಕ್ಕದ್ದಲ್ಲ ಅಥವಾ ಆವರಿಂದ ವಸೂಲು ಮಾಡತಕ್ಕದ್ದಲ್ಲ ಮತ್ತು ಹಾಗೆ ವಿಧಿಸಲಾದ ಅಥವಾ ವಸೂಲು ಮಾಡಲಾದ ಪ್ರತಿ ಮೊಬಲಗಿಗೆ ಸೂಕ್ತ ರೀತಿಯನ್ನು ನೀಡತಕ್ಕದ್ದು.

708-F2

11. ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಬಾಧ್ಯತೆಗಳು.-(1) ಪ್ರತಿಯೊಂದು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು,-

(i) ರಸ್ತೆ ಅಪಘಾತಗಳು, ಆಕಸ್ಮಿಕ ಅಥವಾ ಪ್ರಚೋದಿತ ಸುಟ್ಟ ಗಾಯಗಳು ಅಥವಾ ವಿಷ ಸೇವನೆ ಅಥವಾ ಕ್ರಿಮಿನಲ್ ಆಕ್ರಮಣ ಮತ್ತು ಇದೇ ರೀತಿಯವುಗಳಿಗೆ ಗುರಿಯಾಗಿರುವಂಥ, ಸಂಸ್ಥೆಗೆ ಬರುವ ಎಲ್ಲ ವೈದ್ಯಕೀಯ ಕಾನೂನು ಅಥವಾ ಸಂಭವನೀಯ ವೈದ್ಯಕೀಯ ಕಾನೂನು ಪ್ರಕರಣಗಳಲ್ಲಿ ಆವಶ್ಯಕವಿರುವ ಪ್ರಥಮ ಚಿಕಿತ್ಸೆ ನೀಡುವ ನಿಯಮವನ್ನು ಮತ್ತು ಇತರ ಜೀವ ರಕ್ಷಕ ಅಥವಾ ಸಮಸ್ಥಿತಿಗೊಳಿಸುವ ಶುರ್ತು ಚಿಕಿತ್ಸಾ ಕ್ರಮಗಳನ್ನು ನೀಡುವುದು;

(ii) ರಾಜ್ಯ ಸರ್ಕಾರವು ಕಾಲ ಕಾಲಕ್ಕೆ ನಿರ್ದಿಷ್ಟಪಡಿಸಬಹುದಾದಂಥ ರೀತಿಯಲ್ಲಿ ಎಲ್ಲ ರಾಷ್ಟ್ರೀಯ ಮತ್ತು ರಾಜ್ಯ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಆನುಷ್ಠಾನಕ್ಕೆ ತರುವಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸುವುದು ಮತ್ತು ಸಂಬಂಧಪಟ್ಟ ಪ್ರಾಧಿಕಾರಗಳಿಗೆ ಆ ಬಗ್ಗೆ ನಿಯತಕಾಲಿಕ ವರದಿಗಳನ್ನು ಸಲ್ಲಿಸುವುದು

(iii) ನಿಯಮಿಸಬಹುದಾದ ಅಥವಾ ಸಮೂಹಿಯಲ್ಲಿ ಮತ್ತು ಅಂಥ ವಿಧಾನದಲ್ಲಿ ಸೂಕ್ತ ವೈದ್ಯಕೀಯ ದಾಖಲೆಗಳನ್ನು ನಿರ್ವಹಿಸುವುದು ;

(iv) ಸೋಂಕು ರೋಗ ತಗಲಿರುವವರಿಂದ ಅದು ಇತರರಿಗೆ ಹರಡದಂತೆ ತಡೆಗಟ್ಟಲು ಸೋಂಕು ರೋಗಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ಶಾಸನಬದ್ಧ ಕರ್ತವ್ಯಗಳನ್ನು ನಿರ್ವಹಿಸುವುದು ಮತ್ತು ಅದನ್ನು ಸಂಬಂಧಪಟ್ಟ ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಪ್ರಾಧಿಕಾರಿಗಳಿಗೆ ಕೂಡಲೇ ವರದಿ ಮಾಡುವುದು.

-ಗಳನ್ನು ಕೈಗೊಳ್ಳತಕ್ಕದ್ದು.

(2) ಯಾವುದೇ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ಸರ್ಕಾರಿ ವೈದ್ಯರ ಮತ್ತು ಅರೆ ವೈದ್ಯಕೀಯ ಸಿಬ್ಬಂದಿಯ ಸೇವೆಗಳನ್ನು ಪಡೆದುಕೊಳ್ಳತಕ್ಕದ್ದಲ್ಲ.

12. ಮಾನ್ಯತೆಯ ಅಮಾನತು ಅಥವಾ ರದ್ದಿಯಾತಿ.-(1) ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ತಾನಾಗಿಯೇ ಅಗಿರಿ ಅಥವಾ ಈ ಅಧಿನಿಯಮದ ಯಾವುದೇ ಉಪಬಂಧಗಳ ಅಥವಾ ಅದರ ಅಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ನಿಯಮಗಳ ಅಥವಾ ಮಾನ್ಯತೆಯ ಷರತ್ತುಗಳ ಉಲ್ಲಂಘನೆಯ ದೂರಿನ ಆಧಾರದ ಮೇಲಾಗಲಿ, ಯಾವುದೇ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗೆ ನೋಟೀಸು ನೀಡಿ, ಅದರಲ್ಲಿ ನಮೂದಿಸಲಾದ ಕಾರಣಗಳಿಗಾಗಿ ಅದರ ಮಾನ್ಯತೆಯನ್ನು ಏಕೆ ಅಮಾನತ್ತುಗೊಳಿಸಬಾರದು ಅಥವಾ ರದ್ದುಗೊಳಿಸಬಾರದು ಎಂಬುದಕ್ಕೆ ಕಾರಣ ತೋರಿಸುವಂತೆ ಕೇಳಬಹುದು.

(2) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗೆ ತನ್ನ ಅಪವಾದಲನ್ನು ಹೇಳಿಕೊಳ್ಳಲು ಸೂಕ್ತ ಅವಕಾಶವನ್ನು ನೀಡಿದ ನಂತರ ಮತ್ತು ಅವಶ್ಯವೆಂದು ಭಾವಿಸಬಹುದಾದ ಅಂಥ

ವಿಚಾರಣೆಯನ್ನು ನಡೆಸಿದ ತರುವಾಯ, ಅಂಥ ಉಲ್ಲಂಘನೆ ನಡೆದಿದೆ ಎಂದು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರಕ್ಕೆ ಮನವರಿಕೆಯಾದರೆ, ಅದು ತಾನು ಸೂಕ್ತವೆಂದು ಭಾವಿಸುವ ಅಂಥ ಅವಧಿಯವರೆಗೆ ಮಾನ್ಯತೆಯನ್ನು ಅಮಾನತುಗೊಳಿಸಬಹುದು ಅಥವಾ ಮಾನ್ಯತೆಯನ್ನು ರದ್ದುಗೊಳಿಸಬಹುದು ಮತ್ತು ಆ ಕೂಡಲೇ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗೆ ಆ ಆದೇಶವನ್ನು ಕಳಿಸಬಹುದು.

ಪರಂತು, 11ನೇ ಪ್ರಕರಣದ (2)ನೇ ಉಪ ಪ್ರಕರಣದ ಉಲ್ಲಂಘನೆಗಾಗಿ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ಮಾನ್ಯತೆಯನ್ನು ಅಮಾನತುಗೊಳಿಸುವ ಅಥವಾ ರದ್ದುಗೊಳಿಸುವ ಸಂದರ್ಭದಲ್ಲಿ, ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಸಂಬಂಧಪಟ್ಟ ಸರ್ಕಾರಿ ವೈದ್ಯರ ಮತ್ತು ಅರೆ ವೈದ್ಯಕೀಯ ಸಿಬ್ಬಂದಿಯ ವಿರುದ್ಧ ಕ್ರಮ ಕೈಗೊಳ್ಳುವುದಕ್ಕಾಗಿ ಹಾಗೆ ಅಮಾನತ್ತಿನಲ್ಲಿರಿಸಿದ ಅಥವಾ ರದ್ದುಗೊಳಿಸಿದ ಸಂಗತಿಯನ್ನು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಕೂಡಲೇ ವರದಿ ಮಾಡತಕ್ಕದ್ದು.

13. ಆಪೀಲುಗಳು.- (1) ಮಾನ್ಯತೆಗಾಗಿ ಸಲ್ಲಿಸಲಾಗಿರುವ ಅರ್ಜಿಯನ್ನು ನಿರಾಕರಿಸಲಾಗಿರುವ ಅಥವಾ ಮಾನ್ಯತೆಯನ್ನು ಅಮಾನತುಗೊಳಿಸಲಾಗಿರುವ ಅಥವಾ ರದ್ದುಗೊಳಿಸಲಾಗಿರುವ ಅಥವಾ ಈ ಅಧಿನಿಯಮದಡಿ ಮಾಡಿರುವ ಯಾವುದೇ ಮೂಲ ಆದೇಶದಿಂದ ಬೇರೆ ರೀತಿಯಲ್ಲಿ ತೊಂದರೆಗೊಳಗಾಗಿರುವಂಥ ಯಾವುದೇ ಖಾಸಗೀ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು, ನಿಯಮಿಸಬಹುದಾದಂಥ ವಿಧಾನದಲ್ಲಿ ಮತ್ತು ಅಂಥ ಶುಲ್ಕವನ್ನು ಸಂದಾಯ ಮಾಡಿದ ಮೇಲೆ ಆಪೀಲು ವಿಚಾರಣಾ ಪ್ರಾಧಿಕಾರಕ್ಕೆ ಆಪೀಲನ್ನು ಸಲ್ಲಿಸಬಹುದು.

(2) ಅಂಥ ಪ್ರತಿಯೊಂದು ಆಪೀಲನ್ನು, ಯಾವ ಆದೇಶವ ವಿರುದ್ಧವಾಗಿ ಆಪೀಲನ್ನು ಸಲ್ಲಿಸಲಾಗಿದೆಯೋ ಆ ಆದೇಶವನ್ನು ಸ್ವೀಕರಿಸಿದ ದಿನಾಂಕದಿಂದ ಮೂವತ್ತು ದಿನಗಳೊಳಗಾಗಿ ಸಲ್ಲಿಸತಕ್ಕದ್ದು.

(3) ಆಪೀಲು ವಿಚಾರಣಾ ಪ್ರಾಧಿಕಾರವು, ಆಪೀಲು ಸಲ್ಲಿಸಿದ ಅರವತ್ತು ದಿನಗಳ ಅವಧಿಯೊಳಗೆ ವಿಚಾರಣೆಯನ್ನು ನಡೆಸಿದ ತರುವಾಯ, ತಾನು ಸೂಕ್ತವೆಂದು ಭಾವಿಸುವಂಥ ಆದೇಶವನ್ನು ಹೊರಡಿಸಬಹುದು.

14. ದಂಡನೆಗಳು.-ಈ ಅಧಿನಿಯಮದ ಯಾವುದೇ ಉಪಬಂಧಗಳನ್ನು ಅಥವಾ ಅದರ ಅಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ಯಾವುದೇ ನಿಯಮಗಳನ್ನು ಯಾರೇ ವ್ಯಕ್ತಿಯು ಉಲ್ಲಂಘಿಸಿದಲ್ಲಿ, ಅವರಾದ ನಿರ್ಣಯದ ನಂತರ ಆರು ತಿಂಗಳ ಅವಧಿಯವರೆಗೆ ವಿಸ್ತರಿಸಬಹುದಾದ ಕಾರಾವಾಸದಿಂದ ಅಥವಾ ಹತ್ತು ಸಾವಿರ ರೂಪಾಯಿಗಳವರೆಗೆ ವಿಸ್ತರಿಸಬಹುದಾದ ಜುಲ್ಮಾನೆಯಿಂದ ಅಥವಾ ಅವರೆಡರಿಂದಲೂ ದಂಡಿತನಾಗತಕ್ಕದ್ದು.

15. ಪ್ರವೇಶ, ಪರಿಶೀಲನೆ, ಇತ್ಯಾದಿಗಳಿಗೆ ಅಧಿಕಾರ.- (1) ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳನ್ನು ನೆರವೇರಿಸುವುದಕ್ಕಾಗಿ ನಿಯಮಿಸಬಹುದಾದಂಥ ನಿಯಮಗಳಿಗೆ ಒಳಪಟ್ಟು ರಾಜ್ಯ ಸರ್ಕಾರವು ಯಾವುದೇ ನಿರ್ದಿಷ್ಟ ಉದ್ದೇಶಕ್ಕಾಗಿ ರಾಜ್ಯ ಸರ್ಕಾರದ ಯಾವುದಾದರೂ ಅಧಿಕಾರಿಗೆ (ಇಲ್ಲಿ ಇನ್ನು ಮುಂದೆ ಅಧಿಕೃತ ಅಧಿಕಾರಿಯೆಂದು ಉಲ್ಲೇಖಿಸಲಾಗುವುದು), ಈ ಮುಂದಿನವುಗಳ ಬಗ್ಗೆ ಅಧಿಕಾರ ನೀಡಬಹುದು-

(ಎ) ಎಲ್ಲ ಯುಕ್ತ ಸಮಯಗಳಲ್ಲಿ ಮತ್ತು ಹಾಗು ಯೋಗ್ಯವೆಂದು ಭಾವಿಸುವಂಥ ಯಾರಾದರೂ ವ್ಯಕ್ತಿಗಳು ರಾಜ್ಯ ಸರ್ಕಾರದ ಸೇವೆಯಲ್ಲಿ ಇದ್ದರೆ ಅಂಥ ಸಹಾಯಕರುಗಳೊಂದಿಗೆ ಸಾಸಿಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯಾಗಿ ಬಳಸಲಾಗುತ್ತಿರುವ ಅಥವಾ ಬಳಸಲಾಗುತ್ತಿರಬಹುದೆಂದು ಆತನಿಗೆ ನಂಬಲು ಕಾರಣವಿರುವ ಯಾವುದೇ ಸ್ಥಳವನ್ನು ಪ್ರವೇಶಿಸುವುದು.

(ಬಿ) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಆವರಣಗಳನ್ನು ಮತ್ತು ಅಲ್ಲಿ ಕಂಡುಬರುವ ಯಾವುದೇ ರಿಜಿಸ್ಟರು, ದಾಖಲೆ, ಸಲಕರಣೆ, ವಸ್ತು ಅಥವಾ ದಸ್ತಾವೇಜನ್ನು ಪರಿಶೀಲಿಸಲು ಮತ್ತು ಪರೀಕ್ಷೆ, ವಿಶ್ಲೇಷಣೆ ಅಥವಾ ತನಿಖೆಯ ಉದ್ದೇಶಕ್ಕಾಗಿ ಹಾಗು ಅವಶ್ಯಕವೆಂದು ಭಾವಿಸಬಹುದಾದಂಥ ಯಾವುದೇ ದಸ್ತಾವೇಜು ಅಥವಾ ದಾಖಲೆಯನ್ನು ವಶಪಡಿಸಿಕೊಳ್ಳಲು ಹಾಗೂ ಅಂಥ ಉದ್ದೇಶಕ್ಕಾಗಿ ವಿಲ್ಲಿಯವರೆಗೆ ಆವಗಳನ್ನು ಇಟ್ಟುಕೊಳ್ಳುವುದು ಅವಶ್ಯಕವೆಂದು ಅವನು ಅಭಿಪ್ರಾಯಪಟ್ಟರೆ ಅಲ್ಲಿಯವರೆಗೆ ಇಟ್ಟುಕೊಳ್ಳುವುದು, ಅದರೆ ದಸ್ತಾವೇಜುಗಳನ್ನು ಮತ್ತು ದಾಖಲೆಗಳನ್ನು ವಶಪಡಿಸಿಕೊಂಡ ತರುವಾಯ, ಹಾಗೆ ವಶಪಡಿಸಿಕೊಂಡಿರುವುದಕ್ಕೆ ಕಾರಣವನ್ನು ಕಾರ್ಯ ಸಾಧ್ಯವಾದಷ್ಟು ಬೇಗನೆ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ವ್ಯವಸ್ಥಾಪನಿಗೆ ತಿಳಿಸತಕ್ಕದ್ದು.

(ಸಿ) ಹಾಸಿ ಅವಶ್ಯಕವೆಂದು ಭಾವಿಸುವಂಥ ವಿಚಾರಣೆ ಮಾತಲು ಮತ್ತು ಆ ಸ್ಥಳದಲ್ಲಿ ಅಥವಾ ಬೇರೆಡೆಯಲ್ಲಿ ಯಾವನೇ ವ್ಯಕ್ತಿಯ ಹೇಳಿಕೆಯನ್ನು ತೆಗೆದುಕೊಳ್ಳವುದು,

(ಡಿ) ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳನ್ನು, ನೆರವೇರಿಸುವುದಕ್ಕಾಗಿ ಅವಶ್ಯಕವಾಗಬಹುದಾಂಥ, ಇತರೆ ಅಧಿಕಾರಿಗಳನ್ನು ಚಲಾಯಿಸುವುದು ,

ಪರಂತು, ತನ್ನನ್ನು ಅಪರಾಧವಲ್ಲಿ ಸಿಲುಕಿಸಿವಂಥ ಮಾಹುವ ಯಾವುದೇ ಪ್ರಶ್ನೆಗೆ ಉತ್ತರಿಸಲು ಅಥವಾ ಯಾವುದೇ ಸಾಕ್ಷ್ಯವನ್ನು ನೀಡಲು ಯಾರೇ ವ್ಯಕ್ತಿಯನ್ನು ಈ ಉಪ ಪ್ರಕರಣದಡಿ ಅಗತ್ಯಪಡಿಸತಕ್ಕದ್ದಲ್ಲ.

ಮತ್ತೂ ಪರಂತು, ಯಾವುದೇ ಖಾಸ ಸ್ಥಳದನ್ನು (ಒಂದು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆ ಹಾಗೂ ಪಸತಿ ಆಗಿರದ) ಈ ಪ್ರದೇಶದ ಅಧಿಕಾರ ವ್ಯಾಪ್ತಿಯನ್ನು ಹೊಂದಿರುವ ಮ್ಯಾಜಿಸ್ಟ್ರೇಟನ್ನು ಸರ್ಚ್ ವಾರಂಟಿನ ಮೂಲಕ ಅಧಿಕಾರ ನೀಡಿದ ಹೊರತು ಪ್ರವೇಶಿಸತಕ್ಕದ್ದಲ್ಲ ಮತ್ತು ಶೋಧಿಸತಕ್ಕದ್ದಲ್ಲ ಮತ್ತು ಈ ಪ್ರಕರಣದ ಮೇರೆಗಿನ ಎಲ್ಲಾ

ಶೋಧನೆಗಳನ್ನು ಮತ್ತು ಜಪ್ತಿಗಳನ್ನು ಸಾದ್ಯವಾದಷ್ಟು ಮಟ್ಟಿಗೆ ದಂಡ ಪ್ರಕ್ರಿಯಾ ಸಂಹಿತೆ 1973ರ (1974ರ ಕೇಂದ್ರ ಅಧಿನಿಯಮ 2) ಉಪಬಂಧಗಳಿಗೆ ಅನುಸಾರವಾಗಿ ಮಾಡತಕ್ಕದ್ದು.

(2) ಅಧಿಕೃತ ಅಧಿಕಾರಿಯು (1)ನೇ ಉಪ ಪ್ರಕರಣದ ಆಡಿಯಲ್ಲಿ ಮಾಡಿದ ಪರಿಶೀಲನೆ, ಶೋಧನೆಗಳು ಮತ್ತು ಜಪ್ತಿಯ ಫಲಿತಾಂಶದ ಬಗ್ಗೆ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರಕ್ಕೆ ವರದಿಯೊಂದನ್ನು ಸಲ್ಲಿಸತಕ್ಕದ್ದು ಮತ್ತು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಈ ಅಧಿನಿಯಮದ ಆಡಿಯ ಸದರಿ ಅದೇಶದ ಬಗ್ಗೆ ಅಗತ್ಯ ಕ್ರಮ ಕೈಗೊಳ್ಳತಕ್ಕದ್ದು.

16. ಕಂಪನಿಯಿಂದ ಅಪರಾಧಗಳು.- (1) ಈ ಅಧಿನಿಯಮದ ಯಾವುದೇ ಉಪ ಬಂಧಗಳು ಅಥವಾ ಆವುಗಳ ಆಡಿಯಲ್ಲಿ ಮಾಡಿದ ಯಾವುದೇ ನಿಯಮದ ವಿರುದ್ಧವಾಗಿ ಅಪರಾಧವನ್ನು ಒಂದು ಕಂಪನಿಯು ಮಾಡಿರುವಲ್ಲಿ, ಅಪರಾಧವನ್ನು ಮಾಡಿದ ಕಾಲದಲ್ಲಿ ಆ ಕಂಪನಿಯ ಪ್ರಭಾರದಲ್ಲಿದ್ದ ಮತ್ತು ಕಂಪನಿಯ ವ್ಯವಹಾರವನ್ನು ನಡೆಸುವುದಕ್ಕೆ ಕಂಪನಿಗೆ ಪವಾಬ್ದಾರನಾಗಿದ್ದ ಪ್ರತಿಯೊಬ್ಬ ವ್ಯಕ್ತಿಯನ್ನು ಹಾಗೂ ಕಂಪನಿಯನ್ನು ಅಪರಾಧದ ತಪ್ಪಿತಸ್ಥನೆಂದು ಭಾವಿಸತಕ್ಕದ್ದು ಮತ್ತು ಅದಕ್ಕನುಸಾರವಾಗಿ ಅವರು ವ್ಯವಹರಣೆಗೆ ಒಳಗಾಗಲು ಮತ್ತು ದಂಡನೀಯಗಾಗಲು ಬದ್ದನಾಗತಕ್ಕದ್ದು.

(2) (1)ನೇ ಉಪ ಪ್ರಕರಣದಲ್ಲಿ ಏನೇ ಒಳಗೊಂಡಿದ್ದರೂ, ಅಂಥ ಅಪರಾಧವನ್ನು ಒಂದು ಕಂಪನಿಯು ಮಾಡಿರುವಲ್ಲಿ ಮತ್ತು ಅಪರಾಧವನ್ನು ಕಂಪನಿಯ ಯಾವೆಬ್ಬ ನಿರ್ದೇಶಕ, ವ್ಯವಸ್ಥಾಪಕ, ಕಾರ್ಯದರ್ಶಿ ಅಥವಾ ಇತರೆ ಅಧಿಕಾರಿಯ ಸಮ್ಮತಿಯಿಂದ ಮಾಡಲಾಗಿದೆಯೆಂದು ರುಜುವಾತಾದಲ್ಲಿ ಅಥವಾ ಯಾವುದೇ ನಿರ್ಯಹಣೆಯ ಕಾರಣದಿಂದ ನಡೆಯಿತೆಂದು ಅರೋಪಿಸಲು ಬಹುದಾದಲ್ಲಿ, ಅಂಥ ನಿರ್ದೇಶಕ, ವ್ಯವಸ್ಥಾಪಕ, ಕಾರ್ಯದರ್ಶಿ ಅಥವಾ ಇತರೆ ಅಧಿಕಾರಿಯನ್ನು ಅಂಥ ಅಪರಾಧದ ತಪ್ಪಿತಸ್ಥನೆಂದು ಭಾವಿಸತಕ್ಕದ್ದು ಮತ್ತು ಅವರು ಅದಕ್ಕನುಸಾರವಾಗಿ ವ್ಯವಹರಣೆಗೆ ಗುರಿಯಾಗತಕ್ಕದ್ದು ಮತ್ತು ದಂಡಿತರಾಗತಕ್ಕದ್ದು.

ವಿವರಣೆ.-ಈ ಪ್ರಕರಣದ ಉದ್ದೇಶಕ್ಕಾಗಿ,

(ಎ) "ಕಂಪನಿ" ಎಂದರೆ, ಒಂದು ನಿಗಮಿತ ನಿಕಾಯ ಮತ್ತು ಅದು ಒಂದು ಸ್ಥಾಸ, ಒಂದು ಫರ್ಮ್, ಒಂದು ಸಂಘ ಅಥವಾ ವ್ಯಕ್ತಿಗಳ ಇತರೆ ಸಂಸ್ಥೆಯನ್ನು ಒಳಗೊಳ್ಳುತ್ತದೆ.

(ಬಿ) "ನಿರ್ದೇಶಕ" ಎಂದರೆ.-

(i) ಒಂದು ಫರ್ಮ್‌ಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ಫರ್ಮಿನ ಒಬ್ಬ ಪಾಲುದಾರ ;

(ii) ಒಂದು ಸಂಘ, ಒಂದು ಸ್ಥಾಸ ಅಥವಾ ವ್ಯಕ್ತಿಗಳ ಇತರೆ ಸಂಸ್ಥೆಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ, ಸಂಘ, ಸ್ಥಾಸ ಅಥವಾ ಇತರೆ ಸಂಸ್ಥೆ ಎಂದರೆ, ಅವುಗಳ ನಿಯಮಗಳ

ಆಡಿಯಲ್ಲಿ ಸಂದರ್ಭಾನುಸಾರ ಸಂಘ, ನ್ಯಾಸ ಅಥವಾ ಇತರೆ ಸಂಸ್ಥೆಯ ವ್ಯವಹಾರಗಳ ವ್ಯವಸ್ಥಾಪನೆಯನ್ನು ನಿರ್ವಹಿಸಿಕೊಂಡಿರುವ ವ್ಯಕ್ತಿ.

17. ಅಪರಾಧಗಳ ಸಂಜ್ಞೆಯೆಕೆ.- ಯಾವುದೇ ನ್ಯಾಯಾಲಯವು, ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯು ಅಧ್ಯಕ್ಷರು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರದ ಪೂರ್ವಾನುಮೋದನೆಯೊಂದಿಗೆ ಲಿಖಿತವಲ್ಲಿ ದೂರನ್ನು ಸಲ್ಲಿಸಿದ ಹೊರತು ಈ ಅಧಿನಿಯಮದ ಆಡಿಯಲ್ಲಿ ಶಿಕ್ಷಿಸಬಹುದಾದ ಯಾವುದೇ ಅಪರಾಧದ ಸಂಜ್ಞೇಯತೆಯನ್ನು ತೆಗೆದುಕೊಳ್ಳತಕ್ಕದ್ದಲ್ಲ.

18. ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರಿಗಳಿಗೆ ನಿರ್ದೇಶನ ನೀಡಲು ರಾಜ್ಯ ಸರ್ಕಾರದ ಅಧಿಕಾರ.- ರಾಜ್ಯ ಸರ್ಕಾರವು, ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳನ್ನು ಪಾಲಿಸುವುದಕ್ಕಾಗಿ ಅವಶ್ಯಕವೆಂದು ಅಥವಾ ಯುಕ್ತವೆಂದು ಅಭಿಪ್ರಾಯಪಡುವಂಥ ನಿರ್ದೇಶನಗಳನ್ನು ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರಿಗಳಿಗೆ ಅಥವಾ ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಗಳಿಗೆ ನೀಡಬಹುದು. ಸರ್ಕಾರವು ಸದರಿ ನಿರ್ದೇಶಗಳನ್ನು ಹೊರಡಿಸುವುದನ್ನು ಆಗತ್ಯಪಡಿಸುವ ಕಾರಣಗಳನ್ನು ಆಭಿಲೇಖಿಸತಕ್ಕದ್ದು ಮತ್ತು ಅಂಥ ನಿರ್ದೇಶನಗಳನ್ನು ಪಾಲಿಸುವುದು ಸಂದರ್ಭಾನುಸಾರ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರದ ಅಥವಾ ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಗಳ ಕರ್ತವ್ಯವಾಗಿರತಕ್ಕದ್ದು.

19. ಸದ್ಭಾವನೆಯಿಂದ ಕೈಕೊಂಡ ಕ್ರಮಕ್ಕೆ ರಕ್ಷಣೆ.-ಈ ಅಧಿನಿಯಮದ ಉಪಬಂಧಗಳ ಅಥವಾ ಅವುಗಳ ಆಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ಯಾವುದೇ ನಿಯಮ ಅಥವಾ ಆದೇಶದ ಅನುಸರಣೆಯಲ್ಲಿ ಸದ್ಭಾವನೆಯಿಂದ ಮಾಡಿದ ಅಥವಾ ಮಾಡಲು ಉದ್ದೇಶಿಸಿದಂಥ ಯಾವುದೇ ಕಾರ್ಯಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟಂತೆ, ರಾಜ್ಯ ಸರ್ಕಾರದ ಅಥವಾ ಯಾವುದಾದರೂ ಅಧಿಕಾರಿಯ, ಪ್ರಾಧಿಕಾರದ ಅಥವಾ ಯಾವುದಾದರೂ ವ್ಯಕ್ತಿಯ ವಿರುದ್ಧದಾವೆ, ಪ್ರಾಸಿಕ್ಯೂಷನ್ ಅಥವಾ ಇತರೆ ನ್ಯಾಯಿಕ ವ್ಯವಹಾರಗಳನ್ನು ಹೂಡತಕ್ಕದ್ದಲ್ಲ.

20. ತೊಂದರೆಗಳ ನಿವಾರಣೆ.-ಈ ಅಧಿನಿಯಮದ ಉಪಬಂಧಗಳನ್ನು ಜಾರಿಗೊಳಿಸುವಲ್ಲಿ ಯಾವುದೇ ತೊಂದರೆ ಉದ್ಭವಿಸಿದರೆ ರಾಜ್ಯ ಸರ್ಕಾರವು ರಾಜ್ಯಪತ್ರದಲ್ಲಿ ಆದೇಶದನ್ನು ಪ್ರಕಟಿಸುವ ಮೂಲಕ ತೊಂದರೆಯನ್ನು ನಿವಾರಿಸಲು ತನಗೆ ಆಗತ್ಯವೆಂದು ಅಥವಾ ಯುಕ್ತವೆಂದು ಕಂಡುಬರುವಂಥ ಈ ಅಧಿನಿಯಮದ ಉಪಬಂಧಗಳಿಗೆ ಅಸಂಗತವಾಗದಂಥ ಉಪಬಂಧಗಳನ್ನು ಮಾಡಬಹುದು.

ಪರಂತು ಅಂಥ ಯಾವುದೇ ಆದೇಶವನ್ನು ಈ ಅಧಿನಿಯಮವು ಪ್ರಾರಂಭವಾದ ದಿನಾಂಕದಿಂದ ಎರಡು ವರ್ಷಗಳ ಅವಧಿ ಮುಕ್ತಾಯವಾದ ತರುವಾಯ ಮಾಡತಕ್ಕದ್ದಲ್ಲ.

21. ನಿಯಮಗಳ ರಚಿಸುವ ಅಧಿಕಾರ.-(1) ರಾಜ್ಯ ಸರ್ಕಾರವು, ರಾಜ್ಯಪತ್ರದಲ್ಲಿ ಅಧಿಸೂಚನೆ ಹೊರಡಿಸುವ ಮೂಲಕ ಮತ್ತು ಪೂರ್ವ ಪ್ರಕಟಣೆಯ ತರುವಾಯ ಈ ಅಧಿನಿಯಮದ ಉದ್ದೇಶಗಳನ್ನು ಈಡೇರಿಸುವುದಕ್ಕಾಗಿ ನಿಯಮಗಳನ್ನು ರಚಿಸಬಹುದು.

(2) ವಿಶೇಷವಾಗಿ ಮತ್ತು ಹಿಂದೆ ಹೇಳಿದ ಅಧಿಕಾರದ ಸಾಮಾನ್ಯತೆಗೆ ಬಾಧಕವಾಗದಂತೆ, ಅಂಥ ನಿಯಮಗಳು ಈ ಕೆಳಕಂಡ ಅಥವಾ ಯಾವುದೇ ವಿಷಯಗಳಿಗೆ ಉಪಬಂಧ ಕಲ್ಪಿಸಬಹುದು, ಎಂದರೆ.-

(ಎ) 5ನೇ ಪ್ರಕರಣದಡಿ ಮಾನ್ಯತೆಗಾಗಿ ಅರ್ಜಿಯನ್ನು ಸಲ್ಲಿಸತಕ್ಕ ರೀತಿ ಮತ್ತು ಅರ್ಜಿಯೊಂದಿಗೆ ಇರತಕ್ಕ ಶುಲ್ಕ ;

(ಬಿ) 6ನೇ ಪ್ರಕರಣದ ಆಡಿ ಯಾವ ಪರಿಶ್ರಿಗೆ ಒಳಪಟ್ಟು, ಯಾವ ಸಮೂಸೆಯಲ್ಲಿ ಮತ್ತು ಯಾವ ಅವಧಿಗಾಗಿ ಮಾನ್ಯತೆಯನ್ನು ನೀಡಬಹುದೋ ಆ ಯಾವುದೇ ಪರಿಶ್ರುಗಳು, ಸಮೂಸೆ ಮತ್ತು ಅವಧಿ ;

(ಸಿ) 6ನೇ ಪ್ರಕರಣದ ಆಡಿ ಯಾವ ವಿಧಾನ ಮತ್ತು ಯಾವ ಸಮೂಸೆಯಲ್ಲಿ ಯಾವ ಅವಧಿಗಾಗಿ ಮತ್ತು ಯಾವ ಶುಲ್ಕವ ಸಂದಾಯದ ಮೇಲೆ ಮಾನ್ಯತೆಯನ್ನು ನವೀಕರಿಸಬಹುದೋ ಆ ವಿಧಾನ ಮತ್ತು ಸಮೂಸೆ, ಅವಧಿ ಮತ್ತು ಶುಲ್ಕ ;

(ಡಿ) 7ನೇ ಪ್ರಕರಣದ ಆಡಿ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಪರಿಗಣಿಸಬೇಕಾದ ಅಂಶಗಳು ;

(ಇ) 9ನೇ ಪ್ರಕರಣದ ಆಡಿಯಲ್ಲಿ ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರವು ಜಾರಿಗೊಳಿಸಬೇಕಾದ ಗುಣಮಟ್ಟಗಳು.

(ಎಫ್) 13ನೇ ಪ್ರಕರಣದ ಆಡಿಯಲ್ಲಿ ಆಪೀಲನ್ನು ಸಲ್ಲಿಸಬಹುದಾದ ವಿಧಾನ ಮತ್ತು ಆ ಬಗ್ಗೆ ಸಂದಾಯ ಮಾಡಬೇಕಾದ ಶುಲ್ಕ ;

(ಜಿ) ನಿಯಮಿಸಲು ಆಗತ್ಯವಿರುವ ಅಥವಾ ನಿಯಮಿಸಲಹುದಾದ ಯಾವುದೇ ಇತರೆ ವಿಷಯ.

2. ರಾಜ್ಯ ವಿಧಾನಮಂಡಲದ ಸದನಗಳ ಮುಂದೆ ಮಂಡಿಸಬೇಕಾದ ನಿಯಮಗಳು ಮತ್ತು ಆದೇಶಗಳು.- 18ನೇ ಪ್ರಕರಣದ ಆಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ಪ್ರತಿಯೊಂದು ಆದೇಶ ಮತ್ತು 19ನೇ ಪ್ರಕರಣದ ಆಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ಪ್ರತಿಯೊಂದು ನಿಯಮವನ್ನು ಆದಷ್ಟು ರಚಿಸಿದ ತರುವಾಯ ಆದಷ್ಟು ಬೇಗನೆ ರಾಜ್ಯ ವಿಧಾನಮಂಡಲದ ಪ್ರತಿಯೊಂದು ಸದನದ ಮುಂದೆ ಅದು ಅಧಿವೇಶನದಲ್ಲಿರುವಾಗ ಒಂದು ಅಥವಾ ಎರಡು ಅಥವಾ ಜೆಟ್ಟಿನ ಆನುಕ್ರಮ ಅಧಿವೇಶನಗಳಲ್ಲಿ ಅವಕಾಶವಾಗಬಹುದಾದಂಥ ಒಟ್ಟು ಮೂವತ್ತು ದಿನಗಳ ಅವಧಿಯಬರಿಗೆ ಮಂಡಿಸತಕ್ಕದ್ದು ಮತ್ತು ಮೇಲೆ ಹೇಳಿದ ಅಧಿವೇಶನದ ನಿಕಟೋತ್ತರ ಅಧಿವೇಶನ ಅಥವಾ ಆನುಕ್ರಮ ಅಧಿವೇಶನಗಳು ಮುಕ್ತಾಯವಾಗುವುದಕ್ಕೆ ಮುಂಚೆ, ಯಾವುದೇ ನಿಯಮ ಅಥವಾ ಆದೇಶದಲ್ಲಿ ಯಾವುದೇ ಮಾರ್ಪಾಟು ಮಾಡಬೇಕೆಂದು ಉಭಯ ಸದನಗಳು ಒಪ್ಪಿದರೆ ಅಥವಾ ಯಾವುದೇ

ನಿಯಮ ಅಥವಾ ಆದೇಶವನ್ನು ಮಾಡಬಾರದೆಂದು ತೀರ್ಮಾನಿಸಿದರೆ, ತದನಂತರ ಆ ನಿಯಮ ಅಥವಾ ಆದೇಶವು ಸಂದರ್ಭಾನುಸಾರ ಅಂಥ ಮಾರ್ಪಾಟಾದ ರೀತಿಯಲ್ಲಿ ಮಾತ್ರ ಪರಿಣಾಮಕಾರಿಯಾಗತಕ್ಕದ್ದು ಅಥವಾ ಪರಿಣಾಮಕಾರಿಯಾಗತಕ್ಕದ್ದಲ್ಲ, ಆದಾಗ್ಯೂ ಅಂಥ ಯಾವುದೇ ಮಾರ್ಪಾಟು ಅಥವಾ ರದ್ದಿಯಾತಿಯು ಆ ನಿಯಮದ ಅಥವಾ ಆದೇಶದ ಆಡಿಯಲ್ಲಿ ಹಿಂದೆ ಮಾಡಿದ ಯಾವುದೇ ಕಾರ್ಯದ ಸಿಂಧುತ್ವಕ್ಕೆ ಬಾಧಕವಾಗತಕ್ಕದ್ದಲ್ಲ.

23. ನಿರಸನ ಮತ್ತು ಉಳಿಸುವಿಕೆ.- (1) ಕರ್ನಾಟಕ ಖಾಸಗಿ ನರ್ಸಿಂಗ್ ಹೋಂಗಳ (ವಿನಿಯಮ) ಅಧಿನಿಯಮ, 1976 ನ್ನು (1976 ರ ಕರ್ನಾಟಕ ಅಧಿನಿಯಮ 75) ಈ ಮೂಲಕ ನಿರಸನಗೊಳಿಸಲಾಗಿದೆ.

(2) ಹಾಗೆ ನಿರಸನಗೊಳಿಸಿದ್ದಾಗ್ಯೂ,-

(ಎ) ನಿರಸನಗೊಂಡ ಅಧಿನಿಯಮದ ಆಡಿ ಮಾಡಲಾದ ಯಾವುದೇ ಕೃತ್ಯ ಅಥವಾ ಕೈಗೊಳ್ಳಲಾದ ಯಾವುದೇ ಕ್ರಮವನ್ನು ಈ ಅಧಿನಿಯಮದ ಸಂವಾದಿ ಉಪಬಂಧಗಳ ಆಡಿಯಲ್ಲಿ ಮಾಡಲಾಗಿದೆ ಅಥವಾ ಕೈಗೊಳ್ಳಲಾಗಿದೆ ಎಂದು ಭಾವಿಸತಕ್ಕದ್ದು ;

(ಬಿ) ನಿರಸನಗೊಂಡ ಅಧಿನಿಯಮದ ಮೇರೆಗೆ ನೋಂದಣಿಗಾಗಿ ಅಥವಾ ನವೀಕರಣಕ್ಕಾಗಿ ಈ ಅಧಿನಿಯಮವು ಪ್ರಾರಂಭವಾಗುವುದಕ್ಕೆ ಮುಂಚೆ ಸಲ್ಲಿಸಲಾದ ಮತ್ತು ಈ ಅಧಿನಿಯಮವು ಪ್ರಾರಂಭವಾದ ದಿನಾಂಕದಂದು ಪರಿಗಣನೆಗಾಗಿ ಬಾಕಿ ಇರುವ ಎಲ್ಲ ಅರ್ಜಿಗಳನ್ನು ರದ್ದುಗೊಳಿಸತಕ್ಕದ್ದು ಮತ್ತು ಅಂಥ ಅರ್ಜಿಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ಸಂದಾಯ ಮಾಡಿದ ಶುಲ್ಕವು ಯಾವುದಾದರೂ ಇದ್ದರೆ, ಅದನ್ನು ಅರ್ಜದಾರನಿಗೆ ಮರುಪಾವತಿ ಮಾಡತಕ್ಕದ್ದು ಮತ್ತು ಅಂಥ ಅರ್ಜದಾರನು ಈ ಅಧಿನಿಯಮದ ಉಪಬಂಧಗಳ ಆಡಿಯಲ್ಲಿ ನ್ಯೂನತೆಗಾಗಿ ಹೊಸದಾಗಿ ಅರ್ಜ ಸಲ್ಲಿಸಬಹುದು.

ಉದ್ದೇಶಗಳು ಮತ್ತು ಕಾರಣಗಳ ಜೇಳಿಕೆ

ರಾಜ್ಯದಲ್ಲಿ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ನೀತಿ ಪರಿಣಾಮಕಾರಿಯಾದ ನಿಯಂತ್ರಣ ಹೊಂದುವ ಉದ್ದೇಶಕ್ಕಾಗಿ, ಕರ್ನಾಟಕ ಖಾಸಗಿ ನರ್ಸಿಂಗ್ ಹೋಂಗಳ (ವಿನಿಯಮ) ಅಧಿನಿಯಮ, 1976 ಕ್ಕೆ ಬದಲಾಗಿ ಒಂದು ಸಮಗ್ರ ಖಾಸನವನ್ನು ತರುವುದು ಅವಶ್ಯಕವೆಂದು ಭಾವಿಸಲಾಗಿದೆ. ಈ ವಿಧೇಯಕವು, ಇತರ ವಿಷಯಗಳೊಂದಿಗೆ ಈ ಮುಂದಿನವುಗಳ ಬಗ್ಗೆ ಉಪಬಂಧ ಕಲ್ಪಿಸುತ್ತದೆ.

(i) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಮಾನ್ಯತೆ ಹಾಗೂ ಮಾನ್ಯತೆಯ ಅಮಾನತ್ತು ಮತ್ತು ರದ್ದಿಯಾತಿ ;

(ii) ಮಾನ್ಯತಾ ಪ್ರಾಧಿಕಾರ ಮತ್ತು ಸ್ಥಳೀಯ ಪರಿಶೀಲನಾ ಸಮಿತಿಯ ರಚನೆ ;

(iii) ವಿವಿಧ ಗುಣಮಟ್ಟಗಳಿಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳನ್ನು ವರ್ಗೀಕರಿಸುವುದು ಮತ್ತು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳು ಸಿಬ್ಬಂದಿ, ಶಸ್ತ್ರಚಿಕಿತ್ಸಾ ಕೊಠಡಿ, ಕಟ್ಟಡಗಳು, ಸಾಧನ ಸಲಕರಣೆಗಳು, ಮುಂತಾದವುಗಳಿಗೆ ಸಂಬಂಧಿಸಿದ ಗುಣಮಟ್ಟಗಳನ್ನು ಪಾಲಿಸುವಂತೆ ಅಗತ್ಯಪಡಿಸುವುದು ;

(iv) ಪ್ರತಿಯೊಂದು ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯನ್ನು ವಿವಿಧ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಗಾಗಿ ಮತ್ತು ಇತರ ಸೇವೆಗಳಿಗಾಗಿ ಅದು ವಿಧಿಸುವ ಶುಲ್ಕ ಪದ್ಧತಿಯನ್ನು ಪ್ರಕಟಿಸುವಂತೆ ಅಗತ್ಯಪಡಿಸುವುದು ;

(v) ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಜೊಣೆಗಾರಿಕೆ ;

(ಗ) ಅಧಿನಿಯಮ ಮತ್ತು ನಿಯಮಗಳ ಉಲ್ಲಂಘನೆಗಾಗಿ ದಂಡಗಳು.

ಇತರ ಕೆಲವು ಪರಿಣಾಮಾತ್ಮಕ ಮತ್ತು ಆನುಷಂಗಿಕ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಸಹ ಮಾಡಲಾಗಿದೆ.

ಆದ್ದರಿಂದ ಈ ವಿಧೇಯಕ.

ಆರ್ಥಿಕ ಜ್ಞಾಪನ

ಪ್ರಸ್ತಾವಿತ ಕ್ರಮದಿಂದಾಗಿ ಯಾವುದೇ ಹೆಚ್ಚಿನ ವೆಚ್ಚ ಉಂಟಾಗುವುದಿಲ್ಲ.

ಪ್ರತ್ಯಾಯೋಜಿತ ಶಾಸನ ರಚನಾಧಿಕಾರ ಕುರಿತು ಜ್ಞಾಪನ ಪತ್ರ

ಖಂಡ 5 :- ಈ ಖಂಡವು, ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳ ಮಾನ್ಯತೆ ಪಡೆಯುವ ಸಂಬಂಧದಲ್ಲಿ ಆರ್ಜ ಸಲ್ಲಿಸಬೇಕಾದ ನಮೂನೆ ಮತ್ತು ವಿಧಾನವನ್ನು ನಿಗದಿ ಸಂದಾಯ ಮಾಡಬೇಕಾದ ಶುಲ್ಕಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ನಿಯಮುಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

ಖಂಡ 6 :- ಈ ಖಂಡವು ಈ ಮುಂದಿನ ವಿಷಯಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ನಿಯಮುಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ,-

(i) ಮಾನ್ಯತೆಯ ಮುಂದೂರಾಕಿ ಪರಕ್ತುಗಳು,

(ii) ಆರ್ಜಯ ನಮೂನೆ ಮತ್ತು ವಿಧಾನ ಮತ್ತು ಶುಲ್ಕಗಳ ಸಂದಾಯ.

ಖಂಡ 7 :- ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳು ಒದಗಿಸಬೇಕಾದ ಸೌಲಭ್ಯಗಳು, ಹೊಂದಿರಬೇಕಾದ ಕುಶಲ ಮಾನವಶಕ್ತಿ ಮತ್ತು ಸಲಕರಣೆಗಳು ಮತ್ತು ನಿರ್ವಹಿಸಬೇಕಾದ ಗುಣಮಟ್ಟಗಳು ಮತ್ತು ಅಂಥ ಇತರ ವಿಷಯಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ನಿಯಮುಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

ಖಂಡ 9 :- ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯ ವಿವಿಧ ವರ್ಗಗಳಿಗಾಗಿ ವಿವಿಧ ಗುಣಮಟ್ಟಗಳನ್ನು ಗೊತ್ತುಪಡಿಸುವುದಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ನಿಯಮುಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

ಖಂಡ 11 :- ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳು ನಿರ್ವಹಿಸಬೇಕಾದ ವೈದ್ಯಕೀಯ ದಾಖಲೆಗಳನ್ನು ಯಾವ ನಮೂನೆಯಲ್ಲಿ ಮತ್ತು ಯಾವ ವಿಧದಲ್ಲಿ ನಿರ್ವಹಿಸಬೇಕೆಂಬುದಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ನಿಯಮುಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

ಖಂಡ 13 :- ಈ ಅಧಿನಿಯಮದ ಅಡಿಯಲ್ಲಿ ಮಾಡಲಾದ ಯಾವುದೇ ಮೂಲ ಆದೇಶದಿಂದ ಕೊಂದರೆಗೊಳಗಾದ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಯು ಅಪೀಲು ಪ್ರಾಧಿಕಾರಕ್ಕೆ ಅಪೀಲನ್ನು ಸಲ್ಲಿಸುವಾಗ ಯಾವ ವಿಧಾನದಲ್ಲಿ ಮತ್ತು ಯಾವ ಶುಲ್ಕವೊಂದಿಗೆ ಸಲ್ಲಿಸಬೇಕೆಂಬುದಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ನಿಯಮುಗಳನ್ನು ರಚಿಸಲು ರಾಜ್ಯ ಸರ್ಕಾರಕ್ಕೆ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

Translated by Dr Manjunath for VHAK.

L3-2

KARNATAKA LEGISLATIVE ASSEMBLY

(EIGHTY EIGHTH SESSION)

Karnataka Private Medical Institutions (Regulation) legislation - 1998

(1998 Legislative Act No. 15)

To regulate and control Private Medical Institutions and to create (conceive) (order) a legislation to its related or its associated (incidental) matters.

Keeping Medical profession in mind to prescribe minimum quality of service to regularise Private Medical Institution through legislation having Public interest (in mind)

During fortynineth year of Indian Republic Karnataka State legislative assembly enacted as follows:

I. Brief name commencement and application

This Act shall be called as Karnataka Private Medical Institutions (Regulation) Act 1998.

This will come into effect from the date notified (appointed) by State Government through Act. And notify different dates for different (sub section) of Act.

This Act will be applicable to all Private Medical Institutions.

II. DEFINITIONS In this convenient (opportune) Act otherwise required

(a) 'Recognition' means Recognition given under 5th section
(b) 'recognitory Authority' means Authority Constituted under 4th chapter.

(c) 'Appeal Enquiry Authority' means authority nominated by the State Government for the purposes of this Act.

(d) Appointed Date means appointed date under (2) Sub section (chapter) of Section (chapter) (1)

Needs some (few) changes in sentence construction to be more in line with English idiom! Otherwise OK

To Dr CMF, RN, Dr VB

VHAK is taking it up.
A meeting was held at SJMC - attended by Dr CMF

16/3/99

- This is an important development we should all read through this carefully and make suggestions for modifications/additions to VHAK. RN

(e) 'Bangalore Metropolitan Area' means defined in Bangalore Development Authority Act 1976 (1976 Karnataka Act 12)

(f) 'Clinical Laboratory' means generally

(i) Biological, Pathological.....Radiation, Microseopic, Chemical or other test, study (examination) or analysis conducted or

(ii) An Institution which prepares culture, serum, vaccine or other pathological or Histo pathological products preparation during diagnosis or treatment.

(g) 'Department' means Health & Family Welfare department and Indian Systems of Medicine department accordingly.

(h) Medical Professional means Homeopathy practitioners under Act 1961 (1961 Karnataka Act 35) Ayurveda, Naturopathy, Sidda, Unani and Yoga practitioners Registration and Medical Practitioners .....1961 (1962 Karnagtaka Act------9) Medical Registration Act, 1961 (1961 Karnataka Act------34) Central Council of Indian Medicine Act, 1970 (1970 Central Act 48) Homeopathy Central Council Act 1978 (1978 Central Act 59) Medical Council act 1956 (1956 Central Act 102)

Practitioners registered under Medical System in which the practitioner studied one Medical Practitioner and (1948 Central Act 10) One Dentist registered under Dental Doctors Act 1948.

(i) Local Study: Committee means nominated Committee under Section 8.

(j) Related to Private Medical Institution A 'Manager' means, whether he is called by any other name or designation, a persons who is Manager of a Private Medical Institution or who is in charge or handling person.

(k) 'Maternity Home' means generally for the purpose of delivery and care at the time of Child birth or before delivery or after care purposes an Institution to admit women or keep them or for both purposes and also for sterlisation treatment or medical termination of pregnancy includes institution which admits and keep them.

(l) 'Medical Institution' means a hospital or a clinic with bed facility, nursing home, clinical laboratory, pathology centre, Maternity home, Blood Bank, Radiation centre, Scanning Centre, Physiotherapy centre and Disease check up for public, diagnosis and prevention or rehabilitation treatment facility Institutions that provides any such facility called by any name, But in this a Medical Practitioner who does his practice, but a clinic without bed facility not included.

(m) 'Medical treatment' means Allopathy or Ayurveda, Unani, Homeopathy, Yoga, Nature cure and Sidda through other recognised Medical system any disease prevention, treatment or any other systematic diagnosis and treatment done to improve health condition of all individual this includes accupuncture and Accupressure also.

(n) 'Nursing Home' means Physical & Mental (body & mind's) disease any institution, including maternity home which observes having disease, (Physical & Mental) (body & mind's) suffering or ailing from weakness, cares and treatment generally admits and with the purpose of keeps or having both purposes such institutions.

(o) 'Physiotherapy Institution' this includes disease or treating illnesses or improvement in health or for the purpose of rest or any other purpose mentioned earlier in this section directly or indirectly or any other purpose generally, massage, hydrotherapy relief exercises any Institution does such treatment.

(p) 'Private Medical Institution' means any Institution run, managed or sponsored medical institution one other than the following

(i) State Government or Central Government or
(ii) Owned by State or Central Government or Public Sector Industries regulated by Government or other legal corporation!
(iii) Owned by State or Central Government or their regulated autonomous Institutions.
(iv) State or Central Government or both or a co-operative society having more than fifty percentage shares, registered under Karnataka co-operative Societies Act 1959.

(v) Owned by State or Central Government or regulated by them and registered Co-operative Society registered under Karnataka Co-operative Societies registration Act. 1960.

(vi) Any Local authority owned by State or Central Government or Trust managed by.

III. All Private Medical Institutions should get recognition

Any Private Medical Institution should not be established, run or managed in State after a prescribed date or after given recognition, rules and under conditions and according to under this Act.

But, an Institution existing before the prescribed date, should submit application for such recognition within ninety days from the prescribed date and could run and manage till related orders are despatched or arrived.

IV. Recognitory Authority

1. There should be one Recognitory authority for Bangalore Metropolitan Area and another Recognitory Authority for other than Non Bangalore Metropolitan areas.

2. (a) Bangalore Metropolitan Are Recognitory authority should have the following

(i) Director, Medical Education - president
(ii) Medical Officer Bangalore Metropolitan Corporation - Member
(iii) Regional Joint Director, Bangalore - Member, Secretary

(b) Other than Bangalore Metropolitan Area Recognitory Authority should have following

(i) Director, Health & Family Welfare Services - President
(ii) Joint Director, Medical Education - Member
Medical Education Directorate Office
(iii) Joint Director (Medical) Health & Family Welfare Services Directorate Office. - Member Secretary

But apart from Allopathy any other recognised Medical Institution related to Indian Medicine giving treatment for Bangalore Metropolitan area and for states other area recognitory Authority should alos select Director, Indian

System of Medicine or a representative not less than the grade of Asst. Director.

V. Application for Recognition Every individual, wish to establish run or manage continue to manage Medical Institution in a specified form and method with such fee remit with application to the concerned authority and could specify (order) different fee for different grade or grades private Medical Institution.

VI. (1) Grading (Ranking) (Assorting) of applications

After receiving application under Section 5, the Recognitory Authority should keep clauses of section 7 in mind and after necessary enquiry by the local study committee and under specified (ordered) conditions could give recognition or reject the application.

But Recognitory authority should not reject the application unless the applicant is given appropriate oppurtunity for (hearings) and such reasons for rejection is documented (noted)(Made note of);

(2) Applicant should be informed immediately about each order released under No.1 sub section.

(3) Every recogniton given under No.1 sub section will be valid for five years and could be renewed once in five years through an application and payment of such fee should be remitted in such specified form.

VII. Factors to be considered in disposing applications under 6th section

Recognitory authority while disposing applications under 6th section should keep in mind the following factors that means i.e.

(i) The place surrounding Private Medical Institution should be in a healthy environment and it should be (fit) otherwise appropriate for the purposes of establishment or want to establish one in future.

(ii) Private Medical Institution should have sufficient number of qualified Doctors, Nurses, Technical & other Para Medical staff.

(iii) Private Medical Institution for their maintenance of various Departments should have buildings with adequate space, means machinaries and other infrastructural facilities.

(iv) Private Medical Institution should have (specified facilities and) such Human Resource means, machinaries and should be in a position to maintain such standards.

(v) Private Medical Institution should be according to the standards mentioned in section 9.

(vi) Specified such other matters.

VIII. Local Study Committee

1. There should be a Local Study Committee comprising of the following individuals for every district.

(a) District Surgeon - chairman
(b) District Health & Family Welfare Officer - Co-Chairman
(c) President of Secretary
Indian Medical Association, Dist. Central Office Branch - - Member

(d) Senior Expert (Surgery) - Member
(e) Senior Expert (Obstetrics & Gynecology) - Member
(f) Dist. Public Hospitals Nursing/Superintendent - Member
(g) Resident Medical Officer of Dist. Public Hospital - Member, Secretary

But for Bangalore Metropolitan Area State Government could constitute a seperate study committee with specific individuals through a notification (instruction).

And but, for the purposes of study of other than allopathy Medical Institutions providing treatment through Indian system of Medicine respective District Indian Medicine Department's Asst. Director also should be selected as a Member of Local Study Committee.

2. Local Study Committee could on its own or after receiving complaint, at any time, conduct study (supervision) to understand whether any medical institution is observing clauses or rules and recognition conditions made under this act. The Manager of Private Medical Institution is responsible to provide all facilities for such supervision (study).

3. At the time of supervision (study) if Local Study Committee sees any defects or deficienses should report to the Recognition Authority and could instruct the Private Medical Institution Manager to rectify specified within a reasonable time. After that the Manager should follow every instruction and report to the Recognition Authority about the following (observing) of instructions within a specified time.

IX. Standards

1. Every Private Medical Institution staff and their necessary qualification, operation theatre, buildings, necessary space, means, machinaries, facilities to be provided for patients and their attendants, maintenance or any other matter related should be according standards mentioned under this act or any other law.

2. For the purpose of this act the State Government under sub-section No.1 related to specific standards could grade and set Private Medical Institutions under different categories of Medical Institutions according to standards.

X. Fee charges to be informed

For patients and for Public information every Private Medical Institution should inform fee charged for various Medical treatment and other services, details of fee structure (tariff card) should be displayed on the Notice Board in a prominent place.

2. No Private Medical Institution should charge or collect more than what is mentioned in Tariff Card from the patients or ~~their~~ relatives and even amount if charged or collected give suitable receipt.

XI. Responsibilities of Private Medical Institutions

1. Every Private Medical Instituttion ...
(i) To provide necessary first aid and life saving or maintaining emergency Medical care for all medicolegal or possible medicolegal incidents, street accidents, Accidential or provoked burns or poisoningsation or criminal assault or of similar pattern.

(ii) To participate actively in all National and State Health programmes specified from time to time by the State Government and to submit reports (regarding) regularly to concerned authorities.

(iii) To maintain appropriate Medical records in specified such form and in such method.

(iv) To prevent infectious diseases spreading from the person affected to others and to take all legal actions, carry out and report immediately to public health authorities.

2. Carry out these no Private Medical Institution should take the services of Government Doctor and Para Medical Staff. clear

XII. Suspension or Cancellation of recognition

(i) Recognitory authority either by itself of by a complaint of Violation of rules or recognition conditions made under clauses or sub sections of this act, can give show cause notice to anyPrivate Medical Institution and ask why not their recognition be suspended or cancelled for the reasons mentioned.

(ii) After having given suitable time (chance) and conducted possible necessary enquiry if recognition authority understands that, such violation has taken place, it can suspend or cancel recognition till such date it feels right and intimate to the Private Medical Institution immediately.

But while suspending or cancelling recognition of Private Medical Institution for violation of section 11 sub section 2 recognition authority should immediately report to the State Government about suspension or cancellation also action to be taken against concerned Government Doctor and Para Medical staff.

XIII. Appeals

(i) Any Private Medical Institution submitted application for recognition has been rejected or suspended ~~noted~~ recognition or faced any other difficulty due to basic order under this Act can appeal to the appellate enquiry authority in a fixed method and after paying such fee.

(d) To fulfil the objectives of this act may be necessary in future execute other officers.

But, not to necessiate any individual to answer any question or to provide any witness which entagles himself or herself in crime under this sub section.

But also, not to enter and search any residential area (not a Private Medical Institution also residence) without the authority through a search warrant of a magistrate having jurisdiction of that area and all search and confiscation according to this section as far as possible should be done according to sub section of Criminal procedure code of 1973 ~~(Central Act of 1979)~~ (1974 Central Act 2)

(ii) Appointed Officer should report to the recognition authority about the result of study, search and confiscation under (1) sub section and recognition authority should take necessary action regarding the current order under this act.

offences
XIV. ~~Crimes~~ from Company

1. If a company has committed any crime against any rules of sub section of this act or under. Every individual (person) who is incharge of the company and was responsible to run the business of the company also at the time of the crime should be thought of guilty of crime ~~company~~ and according to that submit oneself for litigation and (to carry on legal proceedings) should be bound to penalisation.

2. Any thing that is inclusive in (1) sub section, proved if a company has committed such crime and crime committed by any one of Director, Manager, Secretary or from the consent of other Officer, or if accused as (charged) happend due to any managerial reasons, such Director, Manager, Secretary or other Officer should be thought of guilty of crime and according to that submit oneself to carry on legal procedures and get penalized.

Description - for the purpose of this section (a) 'Company' means, this includes a limited corporation, and that trust, firm a union of individuals of other institutions.

(b) 'Director' means (i) A partner of a firm related to a firm. (ii) Union, Trust or other institution in relation to a union,

a trust or individuals in relation to other institution means an individual or person who has taken the responsibility of management subject to the affairs of union, trust or other institutions under their rules.

XVII. Cognisance of ~~Crimes~~ offences

Any court, Local Study Committee Chairman, should not take cognisance of Crime which could be punished under this act unless submitted along with pre acceptance of recognition authority with a written complaint.

XVIII. Power of the State Government to give the direction to Recognitory Authorities.

To guard (observe) (protect) the objectives of this act the State Government can give necessary or opines appropriate direction to recognitory authority or local study committee. The Government shall current directions and reasons, that necessiate to release and to observe such directions shall be the duty of Recognitory Authority or Local Study committee accordingly.

IX. Protection for action taken with good intention.

No prosecution or legal proceedings will be filed (booked) against any individual of State Government any officer or authority with relation to any action intended or taken with good intention in following [enforcing] any rule or order made under sub sections of this act.

XX. Prevention of problems

If any problem arises in implementation of sub sections of this act the State Government can publish orders in gazette to prevent problems which are necessary or seen appropriateby it can make sub sections which are not in consistent to the sub sections of this act.

But any such order shall not be made after the expiry of two years duration of this act since act since its beginning.

XXI. Power to formation of rules

(i) Formation of rules can be done by the State Government to fulfil the objectives of this act through gazette notification and after pre publication.

(ii) Specially and which does not generally obstruct the powers mentioned previously (before) such rules can create sub sections on any matter, mentioned below, that means-

(a) Method of submitting application for recognition and fees prescribed with application under section (5)

(b) Under which condition, what (which) form and for what duration recognition could be given any such conditions, form and duration under section (6)

(c) Which method and which form what duration and on what payment of fee for renewal of recognition such method and form, duration and fee under section (6)

(d) Factors to be considered by recognitory authority under section (7)

(e) Standards to be (enacted) executed by recognitory authority under section (9)

(f) Method to submit appeal and payment of fee to be made under section (13)

(g) Any necessary rules or any other matter to be laid down (be ordered) (to nominate)

XXII. Rules and orders to be placed in front of state legislature houses.

Every order made under section 18 and every rule made under section 19 shall be placed after its formulation in front of each house of State Legislature at the earliest during one or two or more consecutive sessions contained in a duration of total thirty days when the session is on and before closing of above mentioned session. Immediate after session or consequtive sessions, if both the houses agree to make any

changes in any rule or order or if decides not to make any rule or order, after that that rule or order shall come into effect or shall not come into effect only in such changed manner (method). Even then any such change or cancellation will not come in the way of any existing action made under this rule or order.

XIII. Repeal and Retain

(i) Karnataka Private Nursing Home (regulation) act, of 1976 (1976 Karnataka Act 75) has been repealed through this.

(ii) Even though repealed

(a) Any act or any action under the repealed act should be thought made or done under agreed upon sub section of the act.

(b) according to repealed act all the pending applications submitted before and on the date of commencement of this act submitted for consideration registration or renewal shall be cancelled and all the fee paid anything related to such application to be repaid to applicant and such applicant may submit a fresh application for the lapses under sub sections of this act.

OBJECTIVES AND STATEMENT OF REASONS:

To obtain effective regulation of Private Medical Institution's policy.
(For the purpose of obtaining), it is felt necessary to bring a comprehensive policy, instead of Karnataka Private Nursing Home (Regulation) act, 1976. This act, along with other matter create sub section regarding the following.

(i) Private Medical Institutions recognition and suspension of regulation and cancellation.

(ii) Formulation of regulatory authority and local study committee.

(iii) To classify Private Medical Institutions in relation to various standards and to necessiate to observe standards with relation to Private Medical Institutions, staff, operation theatre, buildings, means and machinaries etc.,

(iv) To necessiate each Private Medical Institution to publish its fee (charge) order method for various Medical treatment and other services.

(v) Responsibility of Private Medical Institution

(vi) Penalty for violation of act and rules. Few other effective and incidental transaction of purpose has also been made.

Hence this act.

FINANCIAL MEMORANDUM

There will not be extra (additional) expenditure from the present action.

Memorandum regarding power to formulate .....legislation

Section 5 this section gives power to the State Government in relating to obtain ~~and~~ recognition for Private Medical Institution related to form of submission of application and method and fee to be paid.

section 6 This section gives power to the State Government to formulate rules with relation to following matters.

(i) Recognition approval conditions (for approval of recognition)
(ii) Application form (specimen) & method & payment of fees.

Section 7 Facilities to be provided by Private Medical Institution necessary skilled Human Power (resource) and machineries and standards to be maintained (observed) and gives power to the State Government with relation to formation of rules of such other matter.

Section 9 Gives power to the State Government to formulate rules to specify various standards for seperate classes of Private Medical Institutions.

Section 11 Gives power to the State Government to formulate rules regarding what form and which method to maintain Medical records of Private Medical Institutions.

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Section 9 Gives power to the State Government to formulate rules to specify various standards for seperate classes of Private Medical Institutions.

Section 11 Gives power to the State Government to formulate rules regarding what form and which method to maintain Medical records of Private Medical Institutions.

Section 13 Gives power to the State Government to formulate in relation to which method and what fee while submitting appeal to appelate authority regarding any problem faced by Private Medical Institution due to any basic order.

Section 14 Gives power to the State Government to formulate rules to fulfill the objectives of this act and carry on any other action of other matter.

Dr. H.C.MAHADEVAPPA
Minister, Health & Family Welfare

Mr.H.C.RUDRAPPA
Secretary

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IT98

INCOME TAX EXEMPTION TO EDUCATIONAL AND MEDICAL INSTITUTIONS - AMENDMENTS MADE BY FINANCE ACT 1998

The educational and medical institutions in India have been enjoying the benefit of exemption from Income Tax for some decades.

Section 10 (22) of the Income Tax Act 1961 provided for exemption of "any income of a University or other educational institutions, existing solely for educational purposes and not for the purposes of profit".

Section 10 (22A) of the Act provided for exemption of "any income of a hospital or medical institution existing solely for philanthropic purposes and not for the purposes of profit".

Through an amendment made by the Finance Act 1998 the above two clauses have been omitted with effect from 1999-2000. According to the Union Finance Minister, the Government had to resort to such an action since "the blanket exemption" from Income Tax in respect of educational and medical institutions had been "misused" and, therefore such institutions need "to come under a discipline".

There were wide protests from different quarters against the move of the Central Government in taking away the privileges of educational and medical institutions. In response to the representations made by various organizations, associations and our member institutions, the Union Finance Minister has agreed to continue the exemption with certain modifications in the Act for education and medical institutions.

Accordingly, Section 10 (23C) of the Income Tax 1961 has been ammended and certain clauses have been inserted to provide exemption to any income of such University or other Educational institution or hospital or medical institution which is established not for the purpose of profit and

- which is wholly or substantially financed by the Government; or
- whose aggregate annual receipts do not exceed a prescribed amount; or
- which may be approved by the prescribed authority under Section 10 (23C).

Other Educational and Medical Institutions which are of charitable nature will henceforth have to claim income tax exemption under Sections 11 and 12 of the Act subject to the fullfilment of necessary conditions. They will have to make application for registration under Section 12A of the Act and shall be required to obtain order for registration.

The Prescribed Amount

The Finance Minister has announced that the "prescribed amount" will be Rs 1 crore for the time being. It may be reduced later.

Approval Under Section 10 (23C)

Under Section 10 (23C) any income received by any person on behalf of the following funds, is exempt from tax :

a. the Prime Minister's National Relief Fund [sec 10(23C)(i)]; or

b. the Prime Minister's Fund (Promotion of Folk Art) [sec. 10 (23C)(ii)]; or

c. the Prime Minister's Aid to Students Fund [sec. 10 (23C) (iii); or

d. the National Foundation for Communal Harmonay [sec. 10 (23C) (iiia)]; or

e. any other charitable fund or institution which is notified by the Central Gorvernment [sec. 10 (23C) (iv)]; or

f. any trust (including any other legal obligation) or institution wholly for public religious purposes or wholly for religious and charitable purposes which is notified by the Central Government [sec. 10 (23C)(v)].

Application for approval under sub-clause (iv) and (v) (Refer e & f above)

Public charitable and religious trusts/associations/societies registered under the Societies Registration Act, 1860, etc, which seek notification by the Central Government under section 10(23C)(iv)/(v) are advised to file an application directly to the Commissioner of Income-tax under whose jurisdiction the case of the trust / association / society falls. In the case of a trust/association/society which enjoys recognition certificate under section 80G it will be the Commissioner who has issued the certificate. In cases where no 80G certificate has been obtained it will be the Commissioner in charge of Trust Circle.

Along with the application, the following details should be submitted to the Commissioner:

* A copy of the deed of trust/memorandum and articles of association.

* A list of trustees including settlor/members of the Governing Council, etc

* A photostat copy of the registration granted by the Charity Commissioner / Registrar of Societies.

* A photostat copy of the communication from the Commissioner with reference to the application of the trust / society for registration under section 12A(a).

* A photostat copy of the latest 80G certificate issued by the Commissioner.

* True copies of the assessment orders passed for the last three years.

* Copies of audited accounts and balance sheet for the years subsequent to the assessment.

* Copies of annual reports wherever available.

An extra copy of this application with the enclosures may be endorsed to the Secretary (IT) (A-I), Central Board of Direct Taxes, Department of Revenue, Ministry of Finance, North Block, New Delhi.

Exemptions under Section 10 (23C) (iv) and (v) is subject to the following conditions:

1. Government has been empowered (for the prupose for the grant of exemption) to notify any fund or institution established for charitable purposes, having regard to its objects and importance throughout India or throughout any one or more States; and any trust and institutions, which is either wholly for public religious purposes or wholly for public religious and charitable purposes having regard to the fact that it is administered and supervised in a manner to insure that its income is properly applied for its objects.

2. For availing the exemption the trust or institution (educational or medical) has to comply with the following provisions of the section 10 (23C):

   a. make an application to the prescribed authority [i.e. the Director General (Income Tax - Exemption)] for the purpose for the grant of exemption or continuance thereof;

b. furnish documents including audited annual accounts or information to the Central Government inorder to satisfy itself about the genuineness of the activity of the fund or trust or institution ;

c. apply or accumulate its income wholly and exclusively to the objects for which it is established;

d. invest solely in investments specified under Section 11 (5) of the Act;

e. do only the business incidental to the attainment of its objectives and maintain separate books of account in respect of such business.

The Educational and Medical Institutions which may be approved under Section 10 (23C) will have to convert their investments made before 1 June 1998 to those approved under Section 11 (5) on or before 30 March 2001.

Forms or Modes of Investment under Section 11 (5)

A uniform pattern of investment is laid down, with effect from April 1 1983 for all categories of funds belonging to charitable and religious trusts or institutions. The same pattern of investment will apply in relation to accumulation of income in excess of 25 per cent. The uniform forms or modes for investing funds of charitable and religious trusts and institutions are given below:

a. investment in Government savings certificates;

b. deposit in any Post Office Savings BAnk Account;

c. deposit in any account with any scheduled bank or a co-operative society engaged in carrying on the business of banking (including a co-operative land mortgage bank or a co-operative land development bank);

d. investment in any Central Government or State Government securities;

e. investment in units of the Unit Trust of India;

f. investment in debentures of any corporate body, the principal whereof and the interest whereon are guaranteed by the Central or a State Government;

g. investment or deposits in any public sector company;

h. immovable property;

i. deposits with or investment in any bonds issued by any financial corporation engaged in providing long-term funds for industrial development in India, if the corporation is approved by the Central Government for the purpose of Section 36(1)(viii);

b. furnish documents including audited annual accounts or information to the Central Government inorder to satisfy itself about the genuineness of the activity of the fund or trust or institution ;

c. apply or accumulate its income wholly and exclusively to the objects for which it is established;

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h. immovable property;

i. deposits with or investment in any bonds issued by any financial corporation engaged in providing long-term funds for industrial development in India, if the corporation is approved by the Central Government for the purpose of Section 36(1)(viii);

j. deposits with or investment in any bonds issued by any public company carrying on the business of providing long-term finance for construction or purchase of house in India for residential purposes, if the company is approved by the Central Government for the purpose of section 36(1) (iii);

k. deposits with Industrial Development Bank of India (with effect from April 1, 1985); and

l. Investment in Units issued under any scheme of **mutual fund referred to in section 10 (23D).**

* SBI Mutual Fund and Canbank Mutual Fund set up by the State Bank of India and Canara Bank respectively.

* LIC Mutual Fund.

* The India Magnum Fund N.V. Mutual Fund set up by State Bank of India.

* Indian Bank Mutual Fund set up by Indian Bank.

* PNB Mutual Fund set up by Punajb National Bank.

* BOI Mutual Fund set up by Bank of India.

* Asian Convertibles and Income Fund Mutual Fund set up by State Bank of India.

* GIC Mutual Fund set up by the General Insurance Corporation of India.

* Canbank (offshore) Mutual Fund set up by the Canara Bank.

* BOB Mutual Fund set up by the Bank of Baroda.

* ICICI Mutual Fund * Indbank Offshore Mutual Fund.

* Commonwealth Equity Fund Mutual Fund.

* Kothari Pioneer Mutual Fund * Taurus Mutual Fund.

* Morgan Stanley Mutual Fund * Apple Mutual Fund.

* CRB Mutual Fund * Shriram Mutual Fund.

* 20th Century Mutual Fund * Birla Mutual Fund.

* JM Mutual Fund * IDBI Mutual Fund.

* Ind Bank Communicatins (Offshore) Fund.

* HB Mutual Fund * Alliance Capital Mutual Fund.

TAX EXEMPTION FOR CHARITABLE AND OTHER TRUSTS

Income of a charitable trust is exempt from tax according to the provisions of Sections 11 and 12. The trust should be one established in accordance with the law and its objects should fall within the definition of the term "Charitable Purposes".

Charitable Purposes

Definition

In India the expression 'Charitable Purposes' was defined for the first time in the Charitable Endowments Act, 1890 (Act No. VI of 1890). Section 2 of that Act defined Charitable Purposes as including "Relief of the Poor, Education, Medical Relief and the advancement of any other object of general public utility but not including a purpose which relates exclusively to religious teaching or worship".

Section 2 (15) of the Income Tax 1961 uses the above definition for charitable purposes as follows: "to include relief of the poor, education, medical relief, and the advancement of any other general public utility".

The test to determine the 'charitable purpose' within the meaning of Income Tax Act for the purpose of grant of exemption is "what is the predominant object of the activity--whether it is to carry out a charitable purpose or to earn profit ?" If the predominant object is to carry out a charitable purpose and not to earn profit, the purpose would not lose its charitable character merely because some profit arises from the activity. [C.I.T. vs A.P.R.T. Corporation (1986); AIR 1986 SC 1054]. The essential factor to determine whether it is a charity or not would be whether there is any private gain by setting up the institution or society.

Essential Condition for Exemption under Section 11

1. The property from which income is derived should be held under a trust or other legal obligation.

2. The property should be held for charitable or religious purposes. In the case of a charitable trust created on or after 1 April 1962, the following conditions are also to be complied with:

   a. the trust should not be created for the benefit of any particular religious community or caste;

   b. no part of the income should enure directly or indirectly for the benefit of the settlor or other specified persons, and

   c. the property should be held wholly for charitable purposes;

3. The exemption is confined to only such portion of the trust's income which is applied to charitable or religious purposes or is accumulated for applying to such purposes within the limit if accumulation permitted under Section 11 (1) and (2).

4. The trust should get itself registered with the Commissioner of Income Tax within one year from the date on which the trust is created. The accounts of the trust should be audited for such accounting year in which its income exceeds Rs 50,000/-. The funds of the trust should be invested in any one or more of modes or forms mentioned in Section 11 (5).

5. According to Section 11 (1), in order to claim full tax exemption, a charitable trust or institution has to apply atleast 75% of the income to charitable or religious purposes.

CHARITABLE / RELIGIOUS TRUST -- APPLICATION FOR REGISTRATION

Application for registration of charitable / religious trust etc shall be made in duplicate in Form No. 10A and shall be accompanied by the following documents:

1. Original copy of instrument creating the trust / institution, i.e. trust deed, with one copy thereof, where trust /institution is created under an instrument. Certified copy in lieu of original copy of trust deed can also be accepted by the Commissioner.

2. Documents evidencing the creation of trust / institution, with one copy thereof, where trust / institution is created otherwise than under an instrument.

3. Where the trust / institution has been in existence during any year(s) prior to financial year in which application for registration is made, the applciation should be accompanied by two copies of accounts of trust / institution relating to prior year or years, not being more than 3 years immediately preceding the year in which application is made.

Conclusion

For the persent those institutions with annual receipts below Rs 1 crore will continue to enjoy income tax exemption as in the past. But the Law has become more complex for educational and medical institutions which are not financed wholly or substantially by the Government and those whose receipts exceed Rs 1 crore they will have adhere to all the regulations under Section 10 (23C) besides obtaining specific approval of the Government and conversion of all the existing investments under Section 11(5) on or before 30 March 2001.

Educational and medical institutions in the voluntary sector especially those which are run by the Christian Minority in our Country contribute substantially to education and health care, thereby supplementing the Governments' efforts in eradicating illiteracy and improving the health of the people. Withdrawal of the exemption will adversely affect the health care institutions. The end-result, overburdening of people, especially the poor and the marginalized, with escalating cost in health care. Besides, the **quality of health care services** now being provided by the institutions will suffer. Exemption from income tax has been of great help. The savings, along with the contributions from philanthropists and general public, are being utilised for upgrading the skills of the personnel involved in the delivery of health care and in equipping the institutions with latest technology. Such being the case, one expects the government to render additional support, rather than taking away the already extended benefit.

Compiled by Mr Thomas Kunnil, CHAI, Secunderabad

LB-4

PRIVATE HOSPITAL LEGISLATION

Thomas Kunnil

1. INTRODUCTION

Recent years have witnessed a mushrooming of private hospitals, nursing homes, clinics, dispensaries, etc all over the country. These are run to provide medical care facilities to people but many of them function in an unorganized and haphazard manner. Some of the institutions charge exorbitantly for their services. In the process, the poor and the needy are denied the services. They either flout or do not follow health norms or ethical principles. Many of them are located in unhygenic and environmentally polluted areas.

It is the duty and responsibility of every government to set standards for health care and to see that quality care is offered. Health being a State subject (Entry 6 of List II of 7th schedule to the Constitution of India), it is the State legislature that makes Laws on the subject. So, legislations on health may not be uniform throughout India.

Usually, the State legislature passes the broad outlines or skeleton of the Act. It is the bureaucrats who give 'flesh and blood to the Act so that it may live'.

Legislation on private nursing homes is not a new phenomenon. It was there even before Independence. In the early 50's, a few States had made attempts to bring out legislations for controlling private nursing homes and clinics.

2. BILLS ON PRIVATE HOSPITALS/NURSING HOMES

a) Maharashtra

There was an Act known as "Bombay Nursing Homes Registration Act 1949" (Bombay Act No. XV of 1949). In 1973 rules were made known as "Maharashtra Nursing Homes Registration Rules 1973".

b) Delhi

The Union Territory of Delhi enacted "The Delhi Nursing Homes Registration Act, 1953" (Act 6 of 1953). The rules made under this Act in September 1953 were amended by the Delhi Nursing Homes Registration

(Amendment) Rules 1965. Further amendments were made by the Delhi Nursing Homes Registration (Amendment) Rules 1992

c) **Madhya Pradesh**

The Madhya Pradesh State government brought an Act in 1954 known as "The Madhya Pradesh Nursing Home Registration Act 1954" (28 of 1954). It was repealed in 1973 by the Act of The Madhya Pradesh Upcharyagriha Tatha Rujopchar Sambandhi Sthapanaye Registrikaran Tatha Anugyapan Adhiniyam 1973 (No. 47 of 1973). Under this Act Rules have been made known as Madhya Pradesh Upcharyagriha Tatha Rujopchar Sambandhi Sthapanaye (Registrikaran Tatha Anugyapan) Rules 1997.

d) **Bihar**

An attempt was made by the Government in 1975 by issuing an ordinance to control the Nursing Homes and clinical establishments but it could not become a law due to various reasons. Finally in 1996 the Bihar government brought another proposal to control the private nursing homes under an Act known as "Bihar Nursing Homes and Clinical Establishment" (Registration and License) Act 1996.

e) **Kerala**

In 1997 Mr P P Sulaiman Rawther, MLA presented a Bill in the State Assembly known as Kerala Private Hospitals (Control Board) Bill (Bill No. 58 of 1997). But no discussion or follow-up was made by the Government.

f) **Tamil Nadu**

The Tamil Nadu Government has enacted the Tamil Nadu Private Clinical Establishments (Regulations) Act 1997. Subsequently, Tamil Nadu Private Clinical Establishments (Regulations) Rules 1998 have been made and published.

g) **Andhra Pradesh**

On 16 May 1995 the Speaker of the Andhra Pradesh State Legislative Assembly constituted a House Committee to go into the question of concessions, tax/import duty exemptions and other benefits given to the corporate hospitals like Deccan Medical Centre (Appolo Hospital), CDR, Medwin, Medinova, Medicity and other private nursing homes by the State and Central Governments and the conditions upon which such concessions etc were given and to find out :

a) Whether or not the said Corporate Hospitals/Nursing Homes honoured the conditions imposed for granting such conditions, exemptions, benefits etc.,

b) to examine the efforts made by the authorities concerned in seeking compliance of the terms and conditions imposed upon them by

Government for granting such concessions, etc., and the action if any taken against them for failure to honour the conditions;

c) to make suitable recommendations for strict compliance of the conditions imposed on the Hospitals by the Government in future.

The Committee had made a thorough study of the matter and given a number of recommendations including the need to bring "a comprehensive legislation to regulate Private Hospitals, Nursing Homes, Diagnostic Centres etc by the Government and to issue licences to the Private Hosptials / Nursing Homes. The Committee also recommended that a provision be made in the Legislation to the effect that unnecessary investigations and prescriptions of drugs are avoided.

The Committee also drafted a model Bill to be enacted by the State Legislature and the Act is to be called "The Andhra Pradesh Private Hosptials, Nursing Homes, Clinical Establishments (Licensing & Registration) Act 1996.

h. **Gujarat, Karnataka, Rajasthan & West Bengal**

Similar legislations are being contemplated by the States of Gujarat, Karnataka, Rajasthan & West Bengal. Details are not available.

3. POSSIBLE REASONS FOR THE SUDDEN EMERGENCE OF LEGISLATION ON PRIVATE HOSPITALS.

- There is a drastic cut in the governmental expenditure on health.
- International funding agencies insist on a cut on the subsidy given to health care.
- Taking advantage of the situation and the encouragement on the part of the Government, a large number of Private Hospitals have come up. Most of these hospitals, nursing homes, clinics are without proper and adequate personnel and facilities leading to sub-standard health care.

- Enlightened consumers through various forums started pressurising the government to bring adequate control over the functioning of private health care institutions.

4. Objectives

Through the proposed legislation various State Governments aim to:

- regulate and streamline the private and other health care institution
- ensure maintenance of proper medical ethics and guidelines
- set standard for health care at different levels
- introduce uniform fee structure
- control private practice of government doctors, and
- to help to earn some revenue which would be used for rural health services

5) VARIOUS PROVISIONS OF THE BILL/ACT :

a) Applicability

It applies to all health care institutions under private sector i.e. hospitals, dispensaries, maternity homes, clinical establishments, pathological laboratories, x-ray, ultra-sound, body scan, endoscopy and all other types of diagnostic centres. It also applies to all systems of medicine--allopathy, ayurveda, homoeopathy, unani and various other alternative systems.

It does not apply to hospitals, clinics, dispensaries and other clinical establishments of central or state government or local authority.

It also does not apply to any asylum for lunatics, or hospital for patients suffering from mental diseases within the meaning of the Indian Lunacy Act any asylum for leprosy patients within the meaning of Leprosy Act (Act 3 of 1898).

In Madhya Pradesh, the Act applies only to areas with population of 50,000 and above.

b) Registration

Registration and licence is a legal requirement for running a health care establishment. No preson shall be permitted to carry on any nursing home or clinical establishment unless the same is duly registered in accordance with the provisions of the Act.

The existing health care institutions are expected to register under the Act within three months from the date of the enactment of the Act.

c) Application for registration and licence

Any person intending to start or carry on nursing home or a clinical establishment shall make an application to the authority in such form and manner as may be prescribed by the Government.

d) **Registration fee / Renewal fee**

The registration fee varies from State to State. Usually the prescribed fee is shown in the rules made under the Act. The governments of Delhi, Madhya Pradesh, Maharashtra and Tamil Nadu have already brought out the Rules. Registration/ Renewal fee in these States are shown as follows:

Delhi

Up to 10 beds Rs 500/-; 11 - 30 beds Rs 1000/- ; above 30 beds Rs 2000/-

Madhya Pradesh

Up to 10 beds Rs 200/-; 11 - 20 beds Rs 350/-; 21 - 30 beds Rs 450/-; For each additional bed above 30 beds Rs 15/-; Physiotherapy centre Rs 200/-; Clinical laboratory Rs 200/- For outdoor clinics Rs 200/-

Maharashtra : Up to 10 beds Rs 50/-; above 10 beds Rs 100/-

Tamil Nadu

	Rural Area Rs	Urban Area Rs
Clinics	250.00	250.00
Health Centres, Hosptials		
Upto 10 beds	500.00	1000.00
11 to 40 beds	1000.00	2000.00
more than 40 beds	1500.00	3000.00
Hospitals, Health Centres with lab or Xray or scan	2000.00	4000.00
Clinical Laboratories and or Xray centres or ultra sonogram centre	1000.00	2000.00
CT Scan and or MRI Scan Centre	1500.00	3000.00
Physiotherapy Centre	1000.00	2000.00

[Note : 1. The maximum for any combination of two or more establishments shall not exceed Rs. 5000/-
2. Renewal fee shall be one half of the fees shown above.]

e) **Certificate of Registration:**
It will be granted to the applicant within 30 days if he/she has complied with all requirements of the Act and the rules made thereunder. Such certificate should be displayed in a conspicuous place in the nursing home.

If, after the inquiry and after giving an opportunity to the applicant of being heard, the competent authority is satisfied that the applicant has not complied

with the requirements of this act and the rules made thereunder, it shall, for reasons to be recorded in writing, reject the application for registration.

f) **Validity of the Certificate of Registration**:

Andhra Pradesh	: 1 year;	Bihar	: 1 year
Kerala	: 3 years;	Tamil Nadu	: 5 years
Madhya Pradesh	: 1 year;	Delhi	: 1 year

g) **Suspension or cancellation of registration**

At anytime after the grant of registration and licence, if the competent authority receives any complaints or comes to know that the clinical establishment is not adhering to the terms and conditions of the licence, an enquiry will be ordered. If the competent authority is satisfied that there has been a breach of any provision of the Act or the rules made thereunder or the conditions of the registration, action will be taken against such clinical establishment and suspend its registration for such period as it may think fit or cancel its registration.

h) **Inspection or enquiry**

The competent authority shall have the right to order an inspection of, or inquiry in respect of any clinical establishment, its buildings, laboratories and equipment and also the work conducted or done by the clinical establishment. This can be done at any time of the day and with or without serving any notice to the institution concerned.

i) **Appeal**

Any private clinical establishment aggrieved by an order of the competent authority rejecting an application for registration or an order of suspension or cancellation of the registration or the inquiry ordered, may within thirty days of the receipt of the order, prefer an appeal to such authority and in such manner as may be prescribed. The appeal to be submitted to :

i. Bihar	:	To the state level committee whose decision shall be final which would not be challenged in a court lower than High Court.
ii. Delhi	:	To the Chief Commissioner

iii. Andhra Pradesh	:	To the Appellate Board consisting of the Director of the Medical Education and Secretary, Health and Medical and Family Welfare and two other experts in the field of medical science to be nominated by the State Government.
iv.Tamil Nadu	:	To the Appellate Authority (the Director of Medical and the Rural Health Services).

j) Penalty

Whoever contravenes any of the provisions of the Act or any condition of the registration will be punished. The penality clause varies from State to State.

a. Bihar

Imprisonment for 6 months or a fine of Rs 50,000/-. A second or subsequent proved offence will be punished by an imprisonment of one year and or a fine of Rs 50,000/-. For every day of continuing offence from the date on which the offence has been proved, an additional fine of Rs 5,000/- in respect on each day on which the offence continuing after such conviction. Such offenders and illegally operating institutions can be closed by use of force by the licensing authority.

b. Kerala : A fine of Rs 50,000/- or 5 years imprisonment or both.

c. Tamil Nadu: A fine of not less than Rs 5000/- which may extend upto Rs. 15,000/-

d. Madhya Pradesh : A fine of Rs 500/-

e. Andhra Pradesh :

Major offence with a fine of not less than Rs 20,000/- which may extend upto Rs 1 lakh. In case of continuing contravention, a fine of Rs 1000/- per day. Minor offence with a fine of not less than Rs 500/- which may extend upto Rs. 2000/- in case of continuing contraventions a fine of Rs 50/- per day.

k) Furnishing returns:

Every Private Hospital / Clinical Establishment shall within the time fixed furnish such returns from time to time to the competent authority.

l) **Display of service charges**

i) **Kerala**

The Private Hospital Control Board has been authorised to fix the charges for various services rendered by the clinical establishment. If anyone collects more than what is fixed by the government, he/she will be punished as per the rules made under the Act. The clinical establishment is expected to issue separate receipts for consultation fee, treatment charges, room rent etc.

ii) **Delhi**

The owner or keeper of the nursing home shall display the charges levied for various services available in the nursing home.

6. VARIOUS VIEW POINTS

Any legislation introduced with a view to regulating the health care system is welcome. But the proposed Bill in its present form cannot be accepted due to the following reasons:

1. **Equality before Law**

A law made to regulate or streamline must apply equally to all health care institutions--whether governmental or non-governmental. Making it applicable only to non-governmental institutions is discriminatory.

2. **Private and Voluntary**

Clubbing together all non-governmental institutions as "private" is not correct. The "voluntary, not-for-profit" institutions must be separated from the "private-for-profit-institutions". It is unconstitutional to treat "dissimilar institutions as similar".

The Voluntary, not-for-profit health care institutions are helping the government in the discharge of the duties and responsibilities of the government to provide health care to the people. As such, governments should support such institutions as are providing free or concessional care to the poor.

3. **Rural vs Urban**

It is not proper to bring all kinds of institutions -- large and small, urban and rural -- under the same umbrella.

4. Registration, Renewal and Fee

It is an impossible task to get a clinical establishment registered within the prescribed time limit of 3 months. The rigid requirements of registration will definitely entail a long delay due to administrative constraints.

At least 6 months' time should be given for registration etc. The period of renewal must be 5 years. There should be different rates of fees for issuing licence and its renewal, depending upon the type of institutions and its location.

5. Licencing Authority

The appropriate authority / competent authority to issue the license should be autonomous and not consisting of government servants alone.

There has to be an appellate body, independent of the government.

6. Uniform Fees

The government should not decide on a uniform maximum fees to be charged by the institutions. Fees would vary, based on the type of institution, facilities available, quality of services, types of investigations etc. Primary health care has to be made affordable and accessible, ensuring equity.

7. Inspection & Enquiry

The inspection by the competent authority should be carried out only at reasonable time and only after giving notice to the institution concerned.

No licence may be withdrawn without proper inspection, inquiry and without issuing a notice. A representative of the institution should be included in the committee for inspection and inquiry.

7. HOW SHOULD WE RESPOND?

a) Create Awareness

CHAI members and other NGOs involved in the health care activites should be made aware of the implications of the proposed Bills / Acts. Besides, the people whom we serve should be taken into confidence and they be made part of our campaign against any Laws that affect the poor and the needy. Seminars/workshops at different levels may be conducted for the benefit of the members and others.

b) Committees / Forums

In order to address various issues including Hospital Legislation that affect the health care institutions under voluntary sector, State committees / forums could be created . Through them we could voice our concern and take appropriate action to prevent such laws which hamper the smooth functioning of health care institutions in the voluntary sector.

d) Presentation of Memorandum

The voluntary sector can voice their views and recommendations to the State Government concerned by presenting a memorandum. The memorandum should be highlighting the contribution of the sector to the well-being of the people. These may be supported with facts and figures showing the number of persons treated under different categories and also the free services rendered.

e) Alternative Legislation

Drafting and presenting alternative legislation to the government may be another method of making the governments pass laws that are pro-people. It is easier for the politicians to say yes when they are given options.

f) Lobbying

Through lobbying the various policies of the government can be influenced. Establishing close contacts with local politicians, especially the MLAs and MPs will go a long way in voicing our concern in the State legislatures and Parliament. The government should be requested to include representatives of the voluntary sector in the consultative / expert committees working on various health legislations.

g) Legal Action

Needless to mention, we have every right to get justice from a court of law--either High Court or Supreme Court--against unconstitutional laws as Justice(Retd) V R Krishna Iyer puts it "equals cannot be equated with unequals".

8. PRO-ACTIVE ROLE OF CHAI MEMBERS

We have to respect and accept any law that is made to streamline and regulate the private health care delivery systems which is not efficient or adequate to meet the needs of the people, especially the poor. How do we contribute to such a process ?

a) Setting Standards

We need to develop standards for our hospitals and other health care institutions consistent with the needs of the community and in tune with the developments in the health care and social fields. Our health care services are to be streamlined in such a way as to maintain and develop, according to the needs of the Community, essential services for health promotion and prevention of ill-health.

Standards have to be maintained for quality performance. Implicit in performance is the need to achieve the desired outcome. It would include professional competence and all aspects of care.

Such standards must be worked out to ensure quality in health care. Among them are :

* effectiveness : doing the right things, the services provided should meet the needs of the people;
* efficiency : doing things right; using the resources carefully, with clear standards;
* acceptability : choice of service, confidentiality, culturally suited;
* accessibility : people must be able to use the services;
* appropriateness : relevance to the siutation
* equity : all persons needing care get the services.

(Courtesy : Dr C M Francis' article in Health Action (September 1997))

Standards have to be evolved for

i) Personnel

The institution should have adequate personnel with sufficient training. A qualified, efficient and committed band of personnel is an asset to the institution. Their continued medical education should be ensured.

ii) Space and facilities

Adequate space and facility for in-patient and out-patient care should be made available. For example : The floor space for nursing home shall be 100 square feet for one bed. A labour room / operation theatre shall have minimum 180 sq feet floor space etc.

iii) Equipment and instruments

The hospital or health care institutions should have all necessary equipment and instruments for the patients' care.

iv) Functional programmes

The doctor--patient and nurse--patient ratio should be maintained. The diagnosis and other support services should be according to the bed strength of the institution.

In short ,each institution, based on its size, location and needs of the people in the area will have to decide on the standards to be maintained so that quality of care is ensured.

The **Bureau of Indian Standards (BIS)** has laid down some standards for hospitals which are 30 bedded and above. **The National Institute for Health and Family Welfare** has also formulated standards of Hospitals with 50 beds and above.

Nearly 70% of CHAI members fall within the category of 1-20 beds. No standards have been worked out so far for institutions below 30 beds by the government or any other agencies. Therefore, CHAI has initiated the process of evolving its own standard for institutions upto 20 beds by conducting a study with special emphasis to Bihar. We hope by the beginning of 2000 we will have our own standard for institutions below 20 beds.

b) Self Regulation

Self-Regulation is another method to ensure quality from within. Here the members define and set the minimum standard, internal administration which includes personnel management and patient care. The members create their own inspection team for quality control.

While making assessment of various services rendered by the hospital or other health care institutions, according to Dr C M Francis, the following questions can be asked.

* Does the hospital show genuine interest in solving the problems of the patient
* When the hospital promises to do something by a certain time, does it do so ?
* Are the records maintained error-free ?
* Do the personnel give personal attention, are they willing to help and consistently courteous ?

* Are the staff accessible / approachable ?

* Do the staff have adequate knowledge and are they willing to answer the questions of the patients and their families to their satisfaction ?

* Are the hospital facilities good ? Do they have the appropriate equipment ? Are they maintained in good working order ?

* Is the hospital clean ?

* Are the staff neat and clean ?

* Are the staff honest in their dealings ? Do they maintain confidentiality ? Do they respect the dignity and rights of the patients ?

* Is the waiting time reasonable ?

* Does the hospital attend to all the needs of the patient -- physical, mental, social and spiritual ?

* Is the hospital involved in community health in the neighbourhood ?

* Is the cost of care reasonable and affordable ?

(Courtesy : Dr C M Francis' article in Health Action (September 1997))

It is also necessary to ensure that our health care institutions take into consideration the various laws applicable to hospitals while evolving personnel policies. For example; such as The Industrial Employment (standing orders) Act 1946, Payment of Wages Act 1936, Minimum Wages Act 1948. The Employees Provident Fund Act 1952, Payment of Gratuity Act 1972, The Trade Union Act 1926. The workers compensation Act 1923, Industrial Dispute Act 1947, etc.

CONCLUSION

We need to appreciate the Government's efforts to streamline and regulate the health care delivery system through legislation and thereby bringing accountability and quality of care in health care institutions under the Private Sector. But before embarking on making legislation, the Government should be taken into confidence all the stakeholders in the process and more importantly, the person at the receiving end, the common people. At the same time, we need to get our house in order by introducing our own standards of care which are adequate and appropriate to the needs of the community.

L-3- 5

OUR COMMON HUMANITY

The Final Draft of The Asian Charter on Human Rights

Preamble

For long the peoples of Asia suffered from gross violations of their rights and freedoms during colonial rule. Today large sections of our people continue to be exploited and oppressed and many of our societies are torn apart by hatred and intolerance. Increasingly the people realise that peace and dignity are possible only when the equal and inalienable rights of all persons and groups are recognised and protected. They are determined to secure peace and justice for them and the coming generations through the struggle for human rights and freedoms. Towards that end they adopt this Charter as an affirmation of the desire and aspirations of the peoples of Asia to live in peace and dignity.

Background to the Charter

1.1. The Asian struggle for rights and freedoms has deep historical roots, in the fight against oppression in civil society and the political oppression of colonialism, and subsequently for the establishment or restoration of democracy. The reaffirmation of rights is necessary now more than ever before. Asia is passing through a period of rapid change, which affects social structures, political institutions and the economy. Traditional values are under threat from new forms of development and technologies as well as political authorities and economic organisations that manage these changes.

1.2. In particular the marketization and globalization of economies are changing the balance between the private and the public, the state and the international community, and worsening the situation of the poor and the disadvantaged. These changes threaten many valued aspects of life, the result of the dehumanising effect of technology, the material orientation of the market, and the destruction of the community. People have decreasing control over their lives and environment, and some communities do not have protection even against eviction from their traditional homes and grounds. There is a massive exploitation of workers, with wages that are frequently inadequate for even bare subsistence and low safety standards that put the lives of workers in constant danger.

1.3. Asian development is full of contradictions. There is massive and deepening poverty in the midst of growing affluence of some sections of the people. Levels of health, nutrition and education of large numbers of our people are appalling, denying the dignity of human life. At the same time valuable resources are wasted on armaments, Asia being the largest purchaser of arms. Our governments claim to be pursuing development directed at increasing levels of production and welfare but our natural resources are being depleted most irresponsibly and the environment is so degraded that the quality of life has worsened immeasurably, even for the better off among us. Building of golf courses has a higher priority than the care of the poor and the disadvantaged.

1.4. Asians have in recent decades suffered from various forms of conflict and violence arising from ultra-nationalism, perverted ideologies, ethnic differences, and fundamentalism of all religions. Violence emanates from both the state and sections of civil society. For large masses, there is little security of person, property or community. There is massive displacement of communities and there are an increasing number of refugees.

1.5. Governments have arrogated enormous powers to themselves. They have enacted legislation to suppress people's rights and freedoms and colluded with foreign firms and groups in the plunder of national resources. Corruption and nepotism are rampant and there is little accountability of those holding public or private power. Authoritarianism has in many states been raised to the level of national ideology, with the deprivation of the rights and freedoms of their citizens, which are denounced as foreign ideas inappropriate to the religious and cultural traditions of Asia. Instead there is the exhortation of spurious theories of 'Asian Values' which are a thin disguise for their authoritarianism. Not surprisingly, Asia, of all the major regions of the world, is without a regional official charter or other regional arrangements for the protection of rights and freedoms.

1.6. In contrast to the official disregard or contempt of human rights in many Asian states, there is increasing awareness among their peoples of the importance of rights and freedoms. They realise the connections between their poverty and political powerlessness and the denial to them of these rights

and freedoms. They believe that political and economic systems have to operate within a framework of human rights and freedoms to ensure economic justice, political participation and accountability, and social peace. There are many social movements that have taken up the fight to secure to the people their rights and freedoms.

1.7. Our commitments to rights are not due to because of any abstract ideological reasons. We believe that respect for human rights provides the basis for a just, humane and caring society. A regime of rights is based on the belief that we are all inherently equal and have an equal right to live in dignity. It is based on our right to determine our destiny through participation in policy making and administration. It enables us to develop and enjoy our culture and to give expression to our artistic impulses. It is respectful of diversity. It recognises our obligations to future generations and the environment they would inherit. It establishes standards for assessing the worth and legitimacy of our institutions and policies.

General Principles

2.1. It is possible from specific rights and the institutions and procedures for their protection to draw some general principles which underline these rights and whose acceptance and implementation facilitates their full enjoyment. The principles provide the broad framework for public policies within which we believe rights should be promoted.

Universality and Indivisibility of Rights

2.2. We endorse the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and other international instruments for the protection of rights and freedoms. We believe that rights are universal, every person being entitled to them by virtue of being a human being. Cultural traditions affect the way in which a society organises relationships within itself, but they do not detract from the universalism of rights which are primarily concerned with the relationship of citizens with the state and the inherent dignity of persons and groups. We also believe that rights and freedoms are indivisible and it is a fallacy to suppose that some kinds of rights can be suppressed in the name of other rights. Human beings have social, cultural and economic needs and aspirations that cannot be fragmented or compartmentalised, but are mutually dependent. Civil, political and cultural rights have little meaning unless there are the economic resources to exercise and enjoy them. Equally, the pursuit and acquisition of material wealth is sterile and self-centred without political freedoms, the opportunity to develop and express one's personality and to engage in cultural and other discourses.

2.3. Notwithstanding their universality and indivisibility, the enjoyment and the salience of rights depend on social, economic and cultural contexts. Rights are not abstractions, but foundations for action and policy. Consequently we must move from abstract formulations of rights to their concretisation in the Asian context by examining the circumstances of specific groups whose situation is defined by massive violations of their rights. It is only by relating rights and their implementation to the specificity of the Asian situation that the enjoyment of rights will be facilitated. Only in this way will Asia be able to contribute to the worldwide movement for the protection of rights.

2.4. Widespread poverty, even in states which have achieved a high rate of economic development, is a principal cause of the violation of rights. Poverty forces individuals, families, and communities into the alienation of their rights: prostitution, child labour, slavery, sale of human organs, and the mutilation of the body to enhance the capacity to beg. A life of dignity is impossible in the midst of poverty. The Asian states must direct their development policies towards the elimination of poverty through more equitable forms of development.

The Responsibility for the Protection of Human Rights

2.5. The responsibility for the protection of rights is both international and domestic. The international community has agreed upon norms and institutions that should govern the practice of human rights. The peoples of Asia support international measures for the protection of rights. State sovereignty cannot be used as an excuse to evade international norms or institutions. The claim of state sovereignty is justified only when a state fully protects the rights of its citizens.

2.6. On the other hand, international responsibility cannot be used for the selective chastisement or punishment of particular states; or for the privileging of one set of rights over others. Some fundamental causes of the violation of human rights lie in the inequities of the international world economic and political order. The radical transformation and

democratization of the world order is a necessary condition for the global enjoyment of human rights. The logic of the universalism and equality of rights is the responsibility of the international community for the social and economic welfare of all people throughout the world, and consequently the obligation to ensure a more equitable distribution of resources and opportunities across the world.

2.7. The primary responsibility for the promotion of human rights is that of states. The rights of states and peoples to just economic, social, political and cultural development must not be negated by global processes. States must establish open political processes in which rights and obligations of different groups are acknowledged and the balance between the interests of individuals and the community is struck. Democratic and accountable governments are the key to the promotion and protection of rights.

2.8. The capacity of the international community and states to promote and protect rights has been weakened by processes of globalization as more and more power over economic and social policy and activities has moved from states to business corporations. Business corporations are responsible for numerous violations of rights, particularly those of workers, women and indigenous peoples. It is necessary to strengthen the regime of rights to make corporations liable for the violation of rights.

Sustainable Development and the Protection of the Environment

2.9. Economic development must be sustainable. We must protect the environment against the depredations of commercial enterprises to ensure that the quality of life does not decline just as the gross national product increases. Technology must liberate, not enslave human beings. Natural resources must be used in a manner consistent with our obligation to future generations. We must never forget that we are merely temporary custodians of resources of nature. Nor should we forget that these resources are given to all humankind, and consequently we have a joint responsibility for their responsible, fair and equitable use.

Rights

3.1. We endorse all the rights that are contained in international instruments. It is unnecessary to restate them here. We believe that these rights need to be seen in a holistic manner and that individual rights are best pursued through a broader conceptualisation which forms the basis of the following section.

The Right to Life

3.2. Foremost among rights is the right to life, from which flow other rights and freedoms. The right to life is not confined to mere physical or animal existence but includes the right to every limb or faculty through which life is enjoyed. It signifies the right to live with basic human dignity, the right to livelihood, the right to a habitat or home, the right to education and the right to a clean and healthy environment without which there can be no real and effective exercise or enjoyment of the right to life. A state must also take all possible measures to prevent infant mortality, to eliminate malnutrition and epidemics, to increase life expectancy through a clean and healthy environment and adequate preventive as well as curative medical facilities and to make primary education free and compulsory.

3.3. Yet in many parts of Asia, wars. ethnic conflicts, cultural and religious oppression, corruption of politics, environmental pollution, disappearances, torture, state or private terrorism and other acts of mass violence continue to be a scourge of humanity and take the lives of thousands of innocent human beings.

3.4. To ensure the right to life, propaganda for war or ethnic conflict or incitement to hatred and violence in all spheres of individual or societal or national or international life should be prohibited.

3.5. A state has the responsibility to thoroughly investigate cases of torture, disappearances and custodial deaths, rapes and sexual abuses and to bring the culprits to justice.

3.6. There must be no arbitrary deprivation of life. States should take measures not only to prevent and punish deprivation of life by criminal acts and acts of terrorism by individuals and groups but also prevent arbitrary killings and mayhem by their own security forces. The law must strictly control and limit the circumstances in which a person may be deprived of his or her life by state authorities or officials.

3.7. Every state must abolish the death penalty. Where it exists, it may be imposed rarely and only for the most serious crimes. Before a person can be deprived of life by the imposition of the death penalty, he or she must be ensured a far trial before an independent and impartial tribunal with full and adequate opportunity of legal representation of his or her choice, adequate time for preparation of

defence, presumption of innocence and the right to review by a higher tribunal. Execution should never be carried out in public or otherwise exhibited in public.

The Right to Peace

4.1. All persons have the right to live in peace so that they can fully develop all their capacities, physical, intellectual, moral and spiritual, without being the target of any kind of violence. The peoples of Asia have suffered great hardships and tragedies due to wars and civil conflicts which have caused many deaths, mutilation of bodies, external or internal displacement of persons, breakup of families, and in general the denial of any prospects of a civilised or peaceful existence. Both the state and civil society have in many countries become heavily militarized in which all scores are settled by force and citizens have no protection against the intimidation and terror of state or private armies.

4.2. The duty of the state to maintain law and order should be conducted under strict restraints in accordance with standards established by the international community, including humanitarian law. Every individual and group is entitled to protection against all forms of state violence, including violence perpetrated by its police and military forces.

4.3. The right to live in peace requires that political, economic or social activities of the state, of the corporate sector or of the civil society, should respect the security of all peoples, especially of vulnerable groups, in relation to the natural environment they live in, the political economic and social condition which permit them to satisfy their needs and aspirations without recourse to oppression, exploitation, violence, and without detracting from all that is of value in their society.

4.4. In fighting fascist invasion, colonialism, and neo-colonialism, Asian states played a crucial role in creating condition for their peoples to live in peace. In this fight, they had justifiably to stress the importance of national integrity and non-intervention by hegemonic powers. However, the demands of national integrity or protection against foreign domination cannot now be used as a pretext for refusing to the people their right to personal security and to peaceful existence any more than the suppression of people's rights can be justified as an excuse to entice foreign investments. Neither can they justify a refusal to inform the international community about the individual security of its people. The right of persons to live in peace can be guaranteed only if the states are accountable to the international community.

4.5 The international community of states has been deeply implicated in wars and civil conflicts in Asia. They have used Asian groups as surrogates to wage wars and have armed groups and governments engaged in internal conflicts. They have made huge profits out of the sale of armaments. The enormous expenditures on arms have diverted public revenues from programmes for the development of the country or the welfare of the people. Military bases and other establishments (often of foreign powers) have threatened the social and physical security of the people who live in their vicinity.

The Right to Democracy

5.1. Colonialism and other modern developments completely changed the nature of Asian political societies. The traditional systems of accountability and public participation in affairs of state as well as the relationship of citizens to the government were altered fundamentally. Citizens became subjects, while the government became more pervasive and powerful. Colonial laws and authoritarian habits and style of administration persisted after independence. The state has become the source of corruption and the oppression of the people. The democratisation and humanisation of the state is a pre-condition for the respect for and the protection of rights.

5.2. The state, which claims to have the primary responsibility for the development and wellbeing of the people, should be humane, open and accountable. The corollary of the respect for human rights is a tolerant and pluralistic system, in which people are free to express their views and to seek to persuade others and in which the rights of minorities are respected. People must participate in public affairs, through the electoral and other decision-making and implementing processes.

The Right to Cultural Identity

6.1. The right to life involves not only material but also the moral conditions which permit a person to lead a meaningful existence. This meaning is not only individually determined but is also based on shared living with other human beings. The Asian traditions stress the importance of common cultural identities. Cultural identities help individuals and communities to cope with the pressures of economic and social change; they give meaning to life in a period of rapid transformation. They are the source of pride and security. There are many vulnerable

communities in Asia as elsewhere whose culture is threatened or derided. Asian peoples and governments must respect cultures and traditions of its diverse communities.

6.2. The plurality of cultural identities in Asia is not contrary to the universality of human rights but rather as so many cultural manifestations of human dignity, enriching universal norms. At the same time we Asian peoples must eliminate those cultural features in our own cultures which are contrary to the universal principles of human rights. We must transcend the traditional concept of the family based on patriarchal traditions so as to retrieve in each of our cultural traditions, the diversity of family norms which guarantee women's human rights. We must be bold in reinterpreting our religious beliefs which support gender equality. We must also eliminate discriminations based on caste, ethnic origins, occupation, place of origin and others, while enhancing in our respective cultures all values related to mutual tolerance and mutual support. We must stop practices which sacrifice the individual to the collectivity or to the powerful, and thus renew our communal and national solidarity.

The Right to Development and Social Justice

7.1. Every individual has the right to the basic necessities of life and to protection against abuse and exploitation. We all have the right to literacy and knowledge, to food and clean water, shelter and to medical facilities for a healthy existence. All individuals and human groups are entitled to share the benefits of the progress of technology and of the growth of world economy.

7.2. Development, for individuals and states, does not mean merely economic development. It means the realisation of the full potential of the human person. Consequently they have the right to artistic freedom, the freedom of expression and the cultivation of their cultural and spiritual capacities. It means the right to participate in affairs of the state and the community. It implies for states the right to determine their own economic, social and cultural policies free from hegemonies pressures and influences.

Rights of Vulnerable Groups

8.1. Asian states should formulate and implement public policies within the above general framework of rights. We believe that in this way we would establish fair and humane conditions for our individual and corporate lives and ensure social justice. However, there are particular groups who for historical or other reasons are weak and vulnerable and consequently require special protection for the equal and effective enjoyment of their human rights. We discuss the situation of several such groups, but we recognise that there are also other groups who suffer from discrimination and various forms of oppression. They include people who through civil conflict, government policies or economic hardships are displaced from their homes and seek refuge in other places internally or in foreign lands. Our states and societies have become less tolerant of minorities and indigenous people, whose most basic rights are frequently violated. Various economic groups, like peasants and fishing communities, suffer from great deprivation and live in constant fear of threats to their livelihood from landlords and capitalist enterprises. They are also deserving of special attention. We urge states and communities to give the highest priority to the amelioration of their social and economic conditions.

Women

9.1. In most Asian societies women suffer from discrimination and oppression. The causes of their oppression lie both in history and contemporary social and economic systems.

9.2. The roots of patriarchy are systemic and its structures dominate all institutions, attitudes, social norms and customary laws, religions and values in Asian societies, crossing the boundaries of class, culture, caste and ethnicity. Oppression takes many forms, but is most evident in sexual slavery, domestic violence, trafficking in women and rapes. They suffer discrimination in both public and private spheres. The increasing militarization of many societies in Asia has led to the increase of violence against women in situations of armed conflict, including mass rape, forced labour, racism, kidnapping and displacement from their homes. As women victims of armed conflict are often denied justice, rehabilitation, compensation and reparation of the war crimes committed against them, it is important to emphasise that systematic rape is a war crime and crime against humanity.

9.3. There are few legal provisions to protect women against violations of their rights within the domestic and patriarchal realm. Social measures should be taken to ensure full and equal participation of women in the political and public life of the society. In doing so discrimination should be eliminated to

ensure women the right of participation in the formulation of government policy and to hold public office, in order to perform government functions at all levels.

9.4. To end discrimination against women in the field of employment and the right to work, women should be given the right to employment opportunities, the free choice of profession, job security, and equal remuneration; the right to protection of health and safe working conditions, especially in safeguarding of the function of reproduction and special protection in times of pregnancy from work that proved harmful.

9.5. Women should be given the full right to control their sexual and reproductive health, free from discrimination or coercion, and be given access to information about sexual and reproductive health care and safe productive technology. That the recognition of sexual preference or orientation must be genuine and real, and that all overt and covert ways of denying such preference based on social habits or cultural inhibitions and other forms of social oppression is a basic violation of human rights.

Children

10.1. Children are the second major category of vulnerable groups. As with women, their oppression takes many forms, the most pervasive of which are child labour, sexual slavery, child pornography, the sale and trafficking of children, prostitution, sale of organs; conscription into drug trafficking; the physical, sexual and psychological abuse of children within families; discrimination against children with HIV/AIDS; forced religious conversion of children; the displacement of children with and without their families by armed conflicts, discrimination, and environmental degradation. An increasing number of children are forced to live on the streets of Asia's cities and are deprived of the social and economic support of families and communities;

10.2. Widespread poverty, lack of access to education and social dislocation in rural areas, are among the causes of the trends which increase the vulnerability of children. Long-established forms of exploitation and abuse, such as bonded labour or the use of children for begging or sexual gratification, have been extended in degree and kind. Female infanticide due to patriarchal gender preference, and female genital mutilation are widely being practised in some Asian countries.

10.3. Asian states have failed dismally to look after children and provide them with even the bare means of subsistence or shelter. We call on Asian states to ratify and implement the Convention on the Rights of the Child. We also call on communities to take the responsibility for monitoring violations of children's rights and to press for the implementation of the UN Convention in appropriate ways in their own social contexts.

Disabled Persons

11.1. Traditionally Asian societies cared for those who were physically or mentally handicapped. Increasingly our communal values and structures, under the pressure of new forms of economic organisations, are less tolerant of such persons. They suffer enormous discrimination in access to education, employment and housing. They are unable to enjoy many of their human rights due to prejudice against them and the absence of provisions to meet their special demands. Their considerable abilities are not properly recognized and they are forced into jobs which offer low pay and little prospects of promotion. They have the right to provisions which enable them to live in dignity, with security and respect, and to have opportunities to realise their full potential.

11.2. The need to treat such persons with respect for their human rights is evident in the way Asian states treat those with HIV or AIDS. There is considerable discrimination against them. A civilised society which respects human rights would recognise their right to live and die with dignity. It would secure to them the right to adequate medical care and to be protected from prejudice, discrimination or persecution.

Workers

12.1. The rapid industrialization of Asian societies has undermined traditional forms of the subsistence economy and destroyed possibilities of their livelihood. Increasingly people are forced into wage employment, often in industry, working under appalling conditions. For the majority of the workers there is little or no protection from unfair labour laws. The fundamental rights to form trade unions and bargain collectively are denied to many. Their wages are grossly inadequate and working conditions are frequently dangerous. Globalization adds to the pressures on workers as many Asian states seek to reduce the costs of production, often in collusion with foreign corporations and international financial institutions.

12.2. A particularly vulnerable category of workers are migrant workers. Frequently separated from their

families, they are exploited in foreign states whose laws they do not understand and are afraid to invoke. They are often denied equality of rights and conditions with local workers, without access to adequate accommodation, health care, or legal protection. In many cases they suffer racism and xenophobia, and domestic helpers are subjected to humiliation and frequently sexual abuse.

Students

13.1. Students in Asia struggled against colonialism and fought for democratization and social justice. As a result of their fearless commitment to social transformation they have often suffered from state violence and repression and remain as one of the key targets for counter-insurgency operations and internal security laws and operations. Students are frequently denied the right to academic freedom, to the freedom of expression and association.

Prisoners and Political Detainees

14.1. In few areas is there such a massive violation of internationally recognised norms as in relation to prisoners and political detainees.

14.2. Arbitrary arrests, detention, imprisonment, ill-treatment, torture, cruel and inhuman punishment are common occurrences m many parts of Asia. Detainees and prisoners are often forced to live in unhygienic conditions, are denied adequate food and health care and are prevented from having communication with, and support from, their families. Different kinds of prisoners are frequently mixed in one cell, with men, women and children kept in proximity. Prison cells are normally overcrowded. Deaths in custody are common. Prisoners are frequently denied access to lawyers and the right to fair and speedy trials.

14.3. Asian governments often use executive powers of detention without trial. They use national security legislation to arrest and detain political opponents. It is notabie that, in many countries in Asia, freedom of thought, belief and conscience, have been restricted by administrative limits on freedom of speech and association.

The Enforcement of Rights

15.1. Many Asian states have guarantees of human rights in their constitutions, and many of them have ratified international instruments on human rights. However, there continues to be a wide gap between rights in these documents and the reality of the exercise or enjoyment of rights. Asian states must take urgent action to implement the human rights of their citizens and residents.

Principles for Enforcement

15.2. We believe that systems for the protection of rights should be based on the following principles.

15.2.1. The promotion and enforcement of rights is the responsibility of all groups in society, although the primary responsibility is that of the state. There is a clear and legitimate role for NGOs in raising consciousness of rights, formulating standards, and ensuring their protection by the governments and other groups. Professional groups like lawyers and doctors have special responsibiilities connected with the nature of their work to promote the enforcement of rights and prevent abuses of power.

15.2.2. Since rights are seriously violated in situations of civil strife and are strengthened if there is peace, it is the duty of the state and other organisations to find peaceful ways to resolve social and ethnic conflicts and to promote tolerance and harmony. For the same reasons no state should seek to dominate other states and states should settle differences among themselves peacefully.

15.2.3. Rights are enhanced if democratic and consensual practices are followed and it is therefore the responsibility of all state and other organisations to promote these practices in their work and in their dealings with others.

15.2.4. Many individuals and groups in Asia are unable to exercise their rights due to restrictive or oppressive social customs and practices, particularly those related to caste, gender, or religion. Therefore the immediate reform of these customs and practices is necessary for the protection of rights. The reforms must be enforced with vigour and determination.

15.2.5. A humane and vigorous civil society is necessary for the promotion and protection of human rights and freedoms, for securing rights within civil society and to act as a check on state institutions. Freedoms of expression and association are necessary for the establishment and functioning of institutions of civil society.

15.2.6. The enjoyment of many rights, especially social and economic, require a proactive role of the governments.

Strengthening the Framework for Rights

15.3.1. It is essential to secure the legal framework for rights. All states should include guarantees of rights in their constitutions. They should also ratify

international human rights instruments. They should review their legislation and administrative practices against national and international standards with the aim of repealing provisions which contravene these standards, particularly legislation carried over from the colonial period.

15.3.2. Knowledge and consciousness of rights should be raised among the general public, and state and civil society institutions. Awareness of the national and international regime of rights should be promoted. Individuals and groups should be acquainted with legal and administrative procedures whereby they can secure their rights and prevent abuse of authority. NGOs should be encouraged to make familiar with and deploy mechanisms, both national and international, for monitoring and review of rights. judicial and administrative decisions on the protection of rights should be widely disseminated, nationally and in the Asian region.

15.3.3. Numerous violations of rights occur while people are in custody and through other activities of security forces. Sometimes these violations take place because the security forces do not realise the permissible scope of their powers or that the orders under which they are acting are unlawful. Members of the police, prison services and the armed forces should be provided training in human rights norms.

The Machinery for the Enforcement of Rights

15.4.1. The judiciary is a major means for the protection of rights. It has the power to receive complaints of the violation of rights, to hear evidence, and to provide redress for violations. including punishment for violators. The judiciary can only perform this function if the legal system is strong and well organised. The members of the judiciary should be competent, experienced and have a commitment to human rights, dignity and justice, and appointed by an independent judicial service commission. They should be independent of the legislature and the executive, and their tenure should be safeguarded in the constitution. The legal profession should be independent. Legal aid should be provided for those who are unable to afford the services of lawyers or access to courts, for the protection of their rights. Rules which unduly restrict access to courts should be reformed to provide a broad access. Social and welfare organisations should be authorised to bring legal action on behalf of individuals and groups who are unable to mobilize the courts.

15.4.2. All states should establish Human Rights Commissions and specialised institutions for the protection of rights, particularly of vulnerable members of society. These bodies supplement the role of the judiciary. They enjoy special advantages: they can help establish standards for the implementation of human rights norms; they can disseminate information about human rights; they can investigate allegations of violation of rights; they can promote conciliation and mediation; and they can seek to enforce human rights through administrative or judicial means. They can act proactively.

15.4.3. They can provide easy, friendly and inexpensive access to victims of human rights violations.

15.4.4. Civil society institutions can help to enforce rights through the organisation of People's Tribunals, which can touch the conscience of the government and the public. The establishment of People's Tribunals emphasises that the responsibility for the protection of rights is wide, and not a preserve of the state. They are not confined to legal rules in their adjudication and can consequently help to uncover the moral and spiritual foundations of human rights.

Regional Institutions for the Protection of Rights

16.1. The protection of human rights should be pursued at all levels, local, national, regional and international. Institutions at each level have their special advantages and skills. The primary responsibility for the protection of rights is that of states. Therefore priority should be given to increase state capacity.

16.2. Asian states should adopt regional or sub-regional institutions for the promotion and protection of rights. There should be an inter-state Convention on Human Rights, formulated in regional forums with the collaboration of national and regional NGOs. The Convention must address the realities of Asia, particularly obstacles to the enjoyment of rights. At the same time it must be fully consistent with international norms and standards. It should cover violations of rights by groups and corporations in addition to state institutions. An independent commission or a court must be established to enforce the Convention. Access to the commission or the court must be open to NGO's and other social organisations.

The Asian Human Rights Commission has circulated the above draft of the proposed Asian Human Rights Charter, titled "Our Common Humanity". Endorsements may be sent to Mr. Basil Fernando, Executive Director, Asian Human Rights Commission, Flat E, 3/F, Kadak Building, 171 Sai Yee Street, Kowloon, Hongkong. Fax (852) 2698 6367. email: ahrc@HK.Super.Net.

C-2

Subject: Harvard Survey
Date: Mon, 25 Sep 2000 16:07:21 -0400
From: FXB Center <fxbcenter_survey@hsph.harvard.edu>
To: fxb@hsph.harvard.edu

Dear Colleague:

The François-Xavier Bagnoud Center for Health and Human Rights (FXB Center), with support from the World Health Organization (WHO), is currently assembling a database of organizations working in the area of health and human rights. The aim of this project is gather information on current sources of institutional experience and information in support of efforts to "mainstream" the consideration of health and human rights in national and international programs and policies. To that end we are inviting your organization, as one working in the areas of health, human rights or human development, to complete a brief survey about your overall focus and your programs in the areas of health and human rights.

Programs or policies in the area of health and human rights include those that recognize, and incorporate into their designs, implementation and evaluation one or more of the following considerations: the effects of health policies and programs on human rights; the health consequences of human rights violations; and the linkage between promoting and protecting health and promoting and protecting human rights.

A text file containing the survey (Harvard.txt) is attached to this message. The text file or a version of the survey in Microsoft Word may also be downloaded from our website at www.hsph.harvard.edu/fxbcenter/survey.htm. We appreciate your participation in this process and look forward to receiving additional information on your organization. We would also be grateful if you would forward copies of the survey to your branch offices, representative or affiliated organizations. The survey should be returned to the FXB Center by October 10, 2000.

The FXB Center for Health and Human Rights would like to make a portion of the information gathered through the survey available to the public in a directory of health and human rights organizations, produced in print or through the Center's website. Additionally, the information will be coordinated and provided to WHO to facilitate its efforts to integrate human rights into its programs and governance.

If you have any question about the survey, please feel free to contact me at the electronic mail address listed below.

Sincerely,

Scott Gordon
Research Specialist
International Health and Human Rights Program
François-Xavier Bagnoud Center for Health and Human Rights
Harvard School of Public Health
E-mail: fxbcenter_survey@hsph.harvard.edu

For more information on the François-Xavier Bagnoud Center for Health and Human Rights please visit our website at www.hsph.harvard.edu/fxbcenter.htm.

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Name: Harvard.txt
Type: Plain Text (text/plain)
Encoding: quoted-printable

___ An inter-governmental organization
___ An international network, consortium, federation, etc.
___ A national network, consortium, federation, etc.
___ An international non-governmental organization
___ A national non-governmental organization
___ An independent national human rights institution (e.g. human rights commission or ombudsperson)
___ An independent national health or development institution
___ A university/university facility/university-affiliated research institute
___ A training/research institute
___ Other (specify):

15) What is the mission or aim of your organization?

16) What are your organization's current programs or what services does your organization provide? (please list program titles and/or provide brief descriptions - attach extra sheet if necessary)?

17) What year was your organization founded?

18) Please indicate the number of staff and regular volunteers for your organization:
____ Paid staff (in country of headquarters)
____ Paid staff (in other countries)
____ Regular/substantive volunteers (in country of headquarters)
____ Regular/substantive volunteers (in other countries)

19) Please list the names of the current officers of your organization, including senior members of your executive staff:

20) Is your organization a member of any federations or umbrella organizations?
Yes ___ No ___

a) If yes, please list the name of the federations or umbrella organization and describe the relationship between your organization and the federations or umbrella organizations:

21) Does your organization have any regional, national or local branch offices or chapters?
Yes ___ No ___

a) If yes, please describe the scope and nature of the relationship between offices or chapters (please include a description of the levels of coordination and/or autonomy and indicate the numbers and locations of offices and chapters)

22) If your organization is a member of any networks or consortiums, please list their full names and acronyms:

23) Does your organization have members?
Yes ___ No ___

a) If yes, please specify type of membership
___ Individuals
___ Organizations
___ Other (specify):

24) Please indicate the percentage of funding received in 1999 from the following sources (optional):
____% Private (funding received through fundraising, individual donations, grants and membership fees)
____% Governmental (funding received from national, federal, or local governments/authorities)
____% International (funding received from intergovernmental organizations or international non-governmental organizations)
____% Self-financed (funding from organizations activities such as sales of products or fees for consulting services)

25) Does your organization prepare and distribute an annual report?
Yes ___ No ___

a) If yes, is the annual report is available the World Wide Web
Yes ___ No ___

i) If yes, please indicate website address for annual report, if different from organizations website:

26) Please describe the relationship of your organization, other than financial, with any government with respect to your organization's activities or management.

27) Does your organization have status with any specialized United Nations agency?
Yes ___ No ___

a) If yes please, describe the nature of this relationship.

28) Does your organization have status with any other inter-governmental organizations?
Yes ___ No ___

a) If yes please, describe the nature of this relationship.

Part III. Organization's Primary Focus
In this section, please respond about the general nature of the work of your organization.

29) Which of the following issues areas are most central to the mission of your organization? (check no more than 2):
___ Human rights promotion and protection for general population (or range of sub-populations)
___ The health consequences of human rights violations
___ Development (non-medically-oriented) conditions or needs of general population (e.g. housing)
___ The needs or condition of a specific population(s) - multiple issues (including health and/or human rights)
___ The linkage between promoting and protecting health and promoting and protecting human rights
___ The health and/or human rights conditions or needs concerning specific health or medical issue (e.g. HIV/AIDS)
___ The health or medical conditions or needs of general population (or range of health or medical conditions)
___ Other (specify):

30) Which of the following strategies are employed in pursuing your organization's mission? (check all that apply):
___ Monitoring, documentation or data collection regarding human rights, disease or health conditions
___ Policy/legislation monitoring, review or advocacy
___ Development of advisory guidelines or standards (external to organization)
___ Provision of material assistance (e.g. provision of vehicles, computers, pharmaceuticals)
___ Provision of technical assistance (e.g. provision of trainers, staff, volunteers, consultants or direct services)
___ Provision of financial assistance
___ Facilitation of networking or collaboration
___ Other (specify):

31) What populations are of primary concern to your organization in fulfilling its mission? (check no more than 5 boxes):
___ General population (or more than 5 groups)
___ Women
___ Men
___ Children
___ Male children
___ Female children
___ Adolescents
___ Elderly

___ Racial minority
___ National ethnic minority
___ Linguistic minority
___ Indigenous populations
___ Religious
___ Sexual orientation
___ Political or other opinion
___ Property/homeless
___ Workers
___ Economically impoverished
___ Disability
___ Mental disability
___ Physical disabilty
___ Migrants
___ Refugees
___ Internally displaced populations
___ Prisoners/detainees
___ Other (specify):

32) Do the populations of focus vary by program?
Yes ___ No ___

33) What is the geographic focus of your organization's programs?
(check no more than 2):
___ National
___ Regional
___ Sub-Regional
___ Diaspora
___ International

34) Does the geographic focus vary by program?
Yes ___ No ___

35) What are the countries where your organization works (attach additional page if necessary)?

36) Please list of your organization's relevant publications (magazines, newsletters, working papers) in the area of health and human rights released since 1997 and indicate all language versions and whether publications are annual (attach additional page if necessary):

Part IV. Health Program Areas

Please indicate whether your organization works within each of the following health program areas according to the following activity classifications and estimate the percentage of your organization's overall work in each of the health areas. Parts V-IX of the survey will ask you to provide more information on each of the activity classifications listed below.

NOTE: Additional information about each of the health program areas can be found on the website of the François-Xavier Bagnoud Center for Health and Human Rights (www.hsph.harvard.edu/fxbcenter/survey.htm). There are significant levels of overlap between the issue areas and it is not necessary to select only one area for the total percentages to equal 100% (either within program areas or cumulatively).

(check all that apply):

Access, quality and rational use of medicines:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Blood safety and clinical technology:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Child and adolescent health:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Communicable diseases:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Disability/injury prevention and rehabilitation:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Emergency preparedness and response:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Food safety:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Health and development:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Health and the environment:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

HIV/AIDS:
Research ___ Documentation/Monitoring ___

Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Immunization and vaccine development:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Information for health policy:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Malaria:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Maternal and infant health:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Mental health and substance abuse:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Non-communicable diseases:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Nutrition:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Organization of health services:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Reproductive and sexual health:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Research policy and promotion:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Tobacco control:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___

Client Services ___ Percent of Organization's Work ___%

Tuberculosis:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Women's health:
Research ___ Documentation/Monitoring ___
Advocacy & Awareness Raising ___ Training & Education ___
Client Services ___ Percent of Organization's Work ___%

Part V. Research
Considering the overall work of your organization, please answer the following questions concerning your organization's research activities in the area of health and human rights.

Areas of research concerning health and human rights are defined for this survey as including, but are not limited to, the following: access to medical care or other health and social services; differential impacts of diseases, health policies or programs on populations at risk; factors interfering with or promoting populations' ability to fully realize health and/or human rights; health or medically-related human rights abuses; the impacts/benefits of utilizing a health and human rights approach to policy development or implementation.

37) Does your organization undertake research concerning health and human rights?
Yes ___ No ___
a) If yes, please answer the following questions
b) If no, please go to section VI.

38) What types of research does your organization undertake?
(check all that apply):
___ Surveys
___ Interviews
___ Data analysis (existing national or local data)
___ Conduct of interventions/trials
___ Evaluation of interventions/trials
___ Policy evaluation (through data collection and analysis)
___ Program evaluation (through data collection and analysis)
___ Epidemiologic surveillance
___ Other (specify):

39) Who conducts your organization's research?
(check all that apply):
___ Organization staff/volunteers
___ Affiliated institutions/universities
___ Consultants/contractors
___ Other (specify):

40) What percentage of your organization's programs/work is comprised of the conduct of research?

Part VI. Documentation and Monitoring
Considering the overall work of your organization, please answer the following questions concerning your organization's documentation and monitoring activities in the area of health and human rights.

Subject areas for documentation and monitoring activities for health and human rights are defined in this survey as including, but are not limited to, the following: access to medical care or other health and social services; differential impacts of diseases; health policies or programs on populations at risk; factors interfering with or promoting populations' ability to fully realize health and/or human rights; health or medically-related human rights abuses; the impacts/benefits of utilizing a health and human rights approach to policy development or implementation.

41) Does your organization undertake documentation or monitoring activities concerning health and human rights?
Yes ___ No ___

a) If yes, please answer the following questions
b) If no, please go to Part VII.

42) What are the principle sources of data or information for your organization's documentation or monitoring activities?
(check all that apply):
___ Secondary data from government data collection mechanisms (e.g. census, demographic and health surveys, government records)
___ Secondary data from member or partnering organizations (non-governmental)
___ Primary data from key informant interviews
___ Primary data from focus groups
___ Primary data from surveys
___ Other (specify):

43) Does your organization maintain a documentation center or database?
Yes ___ No ___

a) If yes, please indicate type and nature of center or database.

44) Does your organization belong to an international documentation network(s)?
Yes ___ No ___

a) If yes, please specify name and type of network.

45) What percentage of your organization's programs/work is comprised of documentation or monitoring activities?

Part VII. Advocacy and/or Awareness Raising
Considering the overall work of your organization, please answer the following questions concerning your organization's advocacy and/or awareness raising activities in the area of health and human rights.

Advocacy and awareness raising activities for health and human rights are defined in this survey as the use of information to effect policy or legislative changes or to foster public awareness or understanding of issues, conditions or needs concerning health and human rights.

NOTE: the use of information to train or educate individuals is covered in Part VIII (Training and Education).

46) Does your organization undertake advocacy and/or awareness raising activities concerning health and human rights?
Yes ___ No ___

a) If yes, please answer the following questions

b) If no, please go to section VIII.

47) Which of the following best describe the thematic nature of your organization's advocacy and/or awareness raising activities concerning health and human rights?
(check no more than 2):
___ The promotion and protection of human rights
___ The health consequences of human rights violations
___ The effects of human rights on the health of populations
___ The linkage between promoting and protecting health and promoting and protecting human rights
___ The effects of health policies and programs on human rights
___ The human rights implications of specific diseases or health conditions
___ The promotion of health and/or social services
___ Other (specify):

48) What are your organization's activities concerning government policies or legislation?
(check all that apply):
___ Conducting public hearings/workshops/conferences
___ Direct lobbying (meetings/discussions with legislators or influential parties)
___ Public referendums
___ Direct action
___ Letter campaigns
___ Media campaigns
___ Other (specify):

49) Who are the target audiences for government policy/legislative related activities?
(check all that apply):
___ Legislators or executive
___ Judiciary (i.e. courts or lawyers)
___ Civil service
___ International (intergovernmental organizations or international NGOs)
___ Other governments (governments other than those responsible for policy/legislation)
___ General public (domestic electoral pressure)
___ Other (specify):

50) What are your organization's activities concerning non-governmental policies or standards (e.g. developing or reviewing standards of practice)?
(check all that apply):
___ Conducting public hearings/workshops/conferences
___ Direct lobbying (meetings/discussions with committees or associations)
___ Public referendums
___ Letter campaigns
___ Media campaigns
___ Other (specify):

51) Who are the target audiences for non-governmental policy/standard related activities?
(check all that apply):

___ Civil service/regulatory agencies
___ Professional associations (e.g. medical association)
___ Health or legal professionals
___ Business/industry
___ Specific population(s) (specify if different from those indicated in question 29):
___ General public
___ Individuals (e.g. patients or clients)
___ Other (specify):

52) What are your organization's awareness raising (public campaigns) activities?
(check all that apply):
___ Media campaigns
___ Public education campaigns
___ Individual education/counseling
___ Event coordination
___ Other (specify):

53) Who are the target audiences for your organization's awareness raising activities?
(check all that apply):
___ Government (legislators/civil service)
___ International (other governments, intergovernmental organizations or international NGOs)
___ Businesses/industry
___ Professional associations (e.g. medical association)
___ Media
___ Specific population(s) (specify if different from those indicated in question 29):
___ Domestic general public
___ International general public
___ Individuals (e.g. patients or clients)
___ Other (specify):

54) What percentage of your organization's programs/work is comprised of advocacy or awareness raising?

Part VIII. Training and Education
Considering the overall work of your organization, please answer the following questions concerning your organization's training and/or education activities in the area of health and human rights.

Training and education activities for health and human rights are defined in this survey as the coordination and/or conduct of training or educational programs and/or the development of educational curricula or and/pedagogical materials regarding health and human rights.

55) Does your organization undertake training and/or education activities concerning health and human rights?
Yes ___ No ___

a) If yes, please answer the following questions

b) If no, please go to Part IX.

56) Which of the following topic areas best reflect the training and education activities of your organization concerning health and human rights?
(check all that apply):
___ Human rights - general (general population or range of human rights areas)

___ Human rights monitoring, research or evaluative skills
___ The health consequences of human rights violations
___ The effects of human rights on the health of populations
___ Professional standards and human rights (e.g. rights of patient or client)
___ The linkage between promoting and protecting health and promoting and protecting human rights
___ The effects of specific health policies (or diseases) on human rights
___ The effects of general health policies and programs on human rights
___ Health research or evaluative skills
___ Health - general (general public health or a range of health issues)
___ Other (specify):

57) Who are the principal target audiences for your organization's training and education activities?
(check all that apply):
___ Policy makers (e.g. legislators or executive)
___ Judiciary (e.g. courts)
___ Civil service
___ Health professionals
___ Legal professionals
___ Human rights professionals
___ Specialized groups (e.g. trade unions, religious groups)
___ Educators
___ Primary and secondary level students
___ University level students(general)
___ Medical-related students
___ Public health students
___ Law students
___ Media
___ Specific population(s) (specify if different from those indicated in question 29):
___ General public
___ Other (specify):

58) What types of professional training and educational activities does your organization undertake?
(check all that apply):
___ Conference/workshop coordination (including collaborative coordination)
___ Special training/courses
___ Review/design of professional standards
___ Provision of specialized internships/fellowships/residencies
___ Development of bibliographies or collection of reference materials

59) What types of training or educational courses does your organization incorporate into existing educational programs (e.g. medical or secondary schools)?
(check all that apply):
___ Independent academic unit (e.g. university course on health and human rights)
___ Academic module (e.g. portion of course)
___ Review/design of general curricula (e.g. degree requirements or school policies)
___ Conference/workshop coordination (including collaborative coordination) for targeted students
___ Special training/courses
___ Provision of specialized internships/fellowships/residencies
___ Development of bibliographies or collection of reference materials

60) Does your organization develop curricula or pedagogical materials for training or educational programs?
Yes ___ No ___

61) What percentage of your organization's programs/work is comprised of training or educational activities?

_____

Part IX. Client Services

Considering the overall work of your organization, please answer the following questions concerning your organization's provision of direct client services to individuals (regardless of setting) in the areas of health, human rights or health and human rights.

62) Does your organization provide direct client services to individuals?
Yes ___ No ___

a) If yes, please answer the following questions

b) If no, please go to Part X.

63) What types of client services are provided by your organization?
(check all that apply):
___ Client representation
___ Pursuit of claims
___ Referral services
___ Individual education
___ Linking medical and legal services
___ Counseling (clinical or outreach programs)
___ Commodities assistance (e.g. provision of medicines)
___ Medical treatment/clinical services provision
___ Other (specify):

64) What percentage of your organization's programs/work is comprised of the provision of client services?

_____

Part X. Additional organizations

65) Please provide the names and addresses (if possible) of other organizations you feel should receive copies of this survey:

We would also be grateful if you would forward copies of this survey to your branch offices, representative or affiliated organizations.

Thank you for taking the time to complete this survey. Completed surveys may be returned via email to:
fxbcenter_survey@hsph.harvard.edu

or may be returned by post to the following address:
François-Xavier Bagnoud Center for Health and Human Rights

Attn: Health and Human Rights Survey
Harvard School of Public Health
651 Huntington Avenue, 7th Floor
Boston, MA 02115 USA
Tel: (1) 617.432.0656
Fax: (1) 617.432.4310

Community Health Cell

From: "Caroline Bernier" <cbernier@idrc.ca>
To: "IDRC Reports Distribution List" <reports-dl@lyris.idrc.ca>
Sent: Friday, November 10, 2000 11:30 AM
Subject: November 10 REPORTS-DL

The following news and feature articles are currently published on the IDRC Reports web site at http://www.idrc.ca/reports/. To view an article, simply click on the matching hypertext link shown at the bottom of this message.
If you do not have web access but are limited to e-mail, you can request any of the articles present on this page by referring to the hypertext link.
Simply send an e-mail to www4mail@unganisha.idrc.ca, leave the subject field blank, and type the command GET http:// [followed by the requested URL (filename)] in the body of the message.

REPORTS
SCIENCE FROM THE DEVELOPING WORLD

November 10, 2000

[5]Restoring Degraded Soils in India using Urban Wastes

November 10, 2000 Canadian and Indian researchers are combining fly ash from electricity generating plants, municipal sewage sludge, and in some cases the water hyacinth plant to produce a potent soil replacement for Indian communities. Each of these, on its own, is an environmental menace. Together, they could hold huge benefits for worn-out soil.

[6]Butterfly Garden: A Healing Program for War-Affected Children in Sri Lanka

November 8, 2000 You are invited to attend a presentation by Dr Robert Chase of McMaster University on the 'Butterfly Garden' program in Sri Lanka. The presentation will take place from 1:30-3:00 p.m. on Wednesday, November 15, 2000, 14th floor Auditorium, IDRC headquarters, 250 Albert Street, Ottawa.

[7]Nepal Conducts Consultation on National ICT Policy

November 7, 2000 The Government of Nepal recently opened the floor to the public to debate the country's proposed national Information and Communication Technology (ICT) Policy and Strategy. Led by the National Planning Commission, a public consultative process addressed the use of ICTs specific to the Nepalese context.

[8]EEPSEA Case Study: Forests for the Future: Creating Awareness in Malaysia

November 6, 2000 For environmental economists, putting a value on the services provided by forests is by now standard practice. To government officials and the general public, though, it is still a rather new idea. In Malaysia, Mohd. Shahwahid Haji Othman a member of the Economy and Environment Program for Southeast Asia is working to spread the message.

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[9]Assessing Tobacco Control Strategies in Turkey

November 3, 2000 Smoking is a serious public health problem in Turkey. Among males over 15 years old, the incidence can rise as high as 65 % in some regions. And conservative estimates place the annual number of smoking related deaths at over 70,000. With funding from Research for International Tobacco Control, a team of Turkish investigators has conducted two surveys on behaviours and attitudes toward smoking. The

team is also examining people's reactions to anti-smoking legislation.

[13]IDRC Web Site

[14]The Bellanet Initiative

[15]News from The Micronutrient Initiative

[16]News from The Model Forestry Secretariat

[17]Pan Asia

[18]IISDnet

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[19]REPORTS Online

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L-2

Community Health Cell

From: "Caroline Bernier" <cbernier@idrc.ca>
To: "IDRC Reports Distribution List" <reports-
Sent: Friday, November 17, 2000 11:00 AM
Subject: November 17 REPORTS-DL

The following news and feature articles are currently published on the IDRC Reports web site at http://www.idrc.ca/reports/. To view an article, simply click on the matching hypertext link shown at the bottom of this message.
If you do not have web access but are limited to e-mail, you can request any of the articles present on this page by referring to the hypertext link.
Simply send an e-mail to www4mail@unganisha.idrc.ca, leave the subject field blank, and type the command GET http:// [followed by the requested URL (filename)] in the body of the message.

REPORTS
SCIENCE FROM THE DEVELOPING WORLD

November 17, 2000

[5]Preventing Gully Erosion in Nigeria

November 17, 2000 Once a densely forested region, southeastern Nigeria is now sparsely covered with vegetation. And what is left of the land could soon become largely unsuitable for cultivation and dangerous for humans. The culprit is 'gully erosion'. Gully erosion takes place when wear-and-tear on the surface land causes rainwater to accumulate in one area, causing loss of vegetation cover, localized erosion, and the formation of gullies. But this phenomenon can be prevented through a combination of better engineering and changes in human behaviour, says Dr Frank Simpson, one of the members of a Nigerian/Canadian research team funded by IDRC.

[6]EEPSEA Case Study: Watershed Management: Paying for Conservation in the Philippines

November 16, 2000 One of the goals of environmental economics is to facilitate the proper pricing of natural resources to promote their sustainable use. Thanks to the joint efforts of several institutions under the leadership of the Deputy Director of the Economy and Environment Program for Southeast Asia Herminia Francisco of the University of the Philippines, Los Banos this approach is being successfully implemented in one of the Philippines' most important nature conservation areas.

[7]What's New at Cities Feeding People?

November 14, 2000 Check out this website for information about new publications and upcoming events related to IDRC's Cities Feeding People program initiative.

[8]EEPSEA Case Study: Integrated Pest Management in Indonesia: The Cost of Chemicals

November 13, 2000 Excessive use of pesticides in Indonesia during the 1970s and 1980s created many serious environmental problems. These included pesticide poisoning, the contamination of agricultural products, the destruction of beneficial natural parasites and pest predators, and the development of pesticide resistance in pests. In response, the Indonesian government has actively pursued a strategy of integrated pest management since 1989.

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[9]Restoring Degraded Soils in India using Urban Wastes

November 10, 2000 Canadian and Indian researchers are combining fly ash from electricity generating plants, municipal sewage sludge, and

in some cases the water hyacinth plant to produce a potent soil replacement for Indian communities. Each of these, on its own, is an environmental menace. Together, they could hold huge benefits for worn-out soil.

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C-2

By the first of May 2001, we will be at our new office!

Del primero de mayo 2001 estaremos en nuestra nueva oficina!

Le 1er mai 2001, nous installer dans nos nouveaux locaux!

Women's Global Network for Reproductive Rights - WGNRR
Red Mundial de Mujeres por los Derechos Reproductivos - RMMDR
Réseau Mondial des Femmes pour les Droits sur la Reproduction - RMFDR

Vrolikstraat 453-D
1092 TJ Amsterdam
the Netherlands
phone (31-20) 620 96 72
fax (31-20) 622 24 50
email office@wgnrr.nl
website http://www.wgnrr.org

and say goodbye to our old place after 12½ years

y decimos adiós al lugar donde hemos trabajado por 12 años y medio

douze ans et demi pour nous prendrons congé du bureau où nous avons travaillé pendant

Library

C-3

Subject: [mfriendcircle] Draft Delaration on Human Rights and Health Practice
Date: Fri, 01June 2001 23:57:36 +0530
From: "Amar Jesani" <jesani@vsnl.com>
Reply-To: mfriendcircle@yahoogroups.com
To: "MFC-eGroup" <mfriendcircle@yahoogroups.com>

Dear All,

There is an international effort on to draft a Declaration on Human Rights and Health practice. The first draft of it is presently being circulated, with the following covering letter from Drs. Iacopino and Marks, in order to get comments and suggestions for changes from all concerned, and to get participation of more individuals and organisations. The said draft declaration is attached herewith.

I suggest that those who can send their suggestions/amendments should send them directly to the persons concerned at the email IDs given below the letter; and mark a copy to the eGroup. The last date for sending comments on the first draft is June 15. I do not know whether it would be possible for the MFC as an organisation to be a part of this international initiative -independently or through PHA However, if the convenor and executive committee want to consider such possibility, then they may directly contact Iacopino and Marks. If you need help in such work, please do not hesitate in letting me know.

Besides, the individual MFC members connected to organisation(s) may also consider this draft in their own organisation(s) and if they want to be a part of such initiative, they should make contact as mentioned above.

Amar.

THE FOLLOWING IS COVERING LETTER TO THE DRAFT DECLARATION

----- Original Message -----
From: Viacopino@aol.com
Subject: UPDATE: Delaration on Human Rights and Health Practice

May 10, 2001
To: Participants of the Declaration on Human Rights and Health Practice Project
From: Vincent Iacopino and Stephen Marks
Re: Update on Project Issues

Dear Colleagues:

We would like to thank those of you who have confirmed your participation in the international effort to draft a Declaration on Human Rights and Health Practice and provided comments on the first draft of the text (see attachment). We presented an outline of the project at the Global Assembly on "Advancing the Human Right to Health" meeting in Iowa City on April 22nd and it was well received. There are a number of issues we would like to bring to your attention at this time:

1. Confirmation of Participation: If you have not confirmed your intention to participate in this project, or are unable to do so, please contact Vincent Iacopino as soon as possible. We anticipate that participation will not involve a major time commitment on your part. As indicated in the Preliminary Timetable below, we will request participants to offer comments and suggestions on several draft Declarations via electronic communications and

to attend an international meeting sometime in 2002 to finalize the content of the Declaration. If you expect your level of participation to be limited, for example, to reviewing and endorsing the draft documents, please let us know what to expect.

2. Comments on Draft #1: If you have not already provided your comments on the first draft of the Declaration (see attachment), please do so by June 15th. After receiving participant comments on draft #1, we will revise the Declaration and circulate the comments and suggestions of all participants to inform the second round of drafting. If you are unable to provide your initial comments by June 15th, please indicate when they may be available.

3. Preliminary Timetable: A preliminary timetable is included for your consideration; however, the schedule is likely to change based on our collective productivity and funding for the international meeting. As you can see, the plan calls for at least two rounds of drafting via electronic communications and an international meeting in 2002 to finalize the content of the Declaration. The international meeting will also enable us to discuss strategies for an endorsement process among health and human rights organizations. The endorsement process will enhance the credibility and relevance of the Declaration, while raising awareness among health and human rights constituencies.

2001 June 15 Comments due on Draft #1
July 1 Distribution of Draft #2 and Participant Comments
July 15 Establish Planning Committee
August 1 Submit Funding Proposals for the International Meeting
September Planning Committee Meeting
October 1 Comments due on Draft #2
October 1 Distribution of Draft #3 and Participant Comments
Nov/Dec Plan International Meeting to Finalize Declaration and Endorsement Process

2002 International Meeting
Endorsement Process (UN, WMA, WHO, NGOs, Others)
Dissemination and Advocacy

4. Drafting Process: Presently, we have invited approximately 65 individuals from 35 different countries to participate in the project. The strength and credibility of this project depends on consensus we develop and the extent of representation among participants. If you have suggestions in this regard, please let us know. Also, we are in the process of forming a Planning Committee to deal with organization and administration of the project, and later editing issues.

5. Funding: We are in the process of identifying possible sources of funding for the international meeting. If you have any suggestions, please let us know.

Thank you for your consideration of these issues. Please contact us if you have any questions or concerns. In the meantime, We look forward to working with you on this historic project.

Sincerely Yours,

Vincent Iacopino, MD, PhD
Senior Medical Consultant,
Physicians for Human Rights
Tel: + 702 547 1683
Fax: + 702 547 1684
E-Mail: viacopino@aol.com

Stephen P. Marks, Docteur d'État, Dipl. IHEI
François-Xavier Bagnoud Professor and Director
François-Xavier Bagnoud Center for Health and Human Rights
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Elements for a Draft Declaration on~~Health and~~ Human Rights and Health Practice
March 8, 2001

Preamble

We, physicians, nurses, health practitioners, health administrators, relief workers, human rights professionals, ethicists, scholars, public officials, representatives of civil society, and activists, from all regions of the world,

Recalling that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity,[1]

Recalling further that the recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,[2]

Reaffirming that everyone has the human right to the highest attainable standards of physical and mental health, in accordance with the International Covenant on Economic, Social and Cultural Rights,[3]

Noting with satisfaction ~~the~~ clarification and amplification on the scope and application ~~of that right provided~~the adoption by the Committee on Economic, Social and Cultural Rights ~~in its~~of General Comment ~~No.14, adopted on March …, 2000,~~No. 14 (2000) on the right to the highest attainable standard of health (art. 12 of the International Covenant on Economic, Social and Cultural Rights),[5]

Bearing in mind the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms,[6]

Considering also the World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide,[7]

---

[1] WHO, Declaration of Alma Ata, 1978.

[2] Preamble, Universal Declaration of Human Rights, 1948.

[3] International Covenant on Economic, Social and Cultural Rights, Article 12.

[4] General Comment No.14…

[5] E/2000/22-E/C.12/1999/11, annex IX.

[6] General Assembly resolution 53/144 of 9 December 1998.

[7] World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide, Adopted by the 51st World Medical Assembly, Tel Aviv, Israel, October 1999: 1. Whereas Medical Ethics and Human Rights form an integral part of the work and culture of the medical profession; and 2. Whereas Medical Ethics and Human Rights form an integral part of the history, structure and objectives of the World Medical Association; 3. It is hereby resolved that the WMA strongly recommends to Medical Schools world-wide that the teaching of Medical Ethics and Human Rights be included as an obligatory course in their curricula.

Deeply concerned that human rights violations and ~~unrealized~~unmet human needs cause profound human suffering, including the intolerably low health status of over one billion ~~people~~people in the world,

Noting with alarm that 27 per cent of the world's population lacks access to health services,[8]

Convinced that health and well-being requires respect for all human rights consistent with the interdependent and interrelated character of human rights,

Convinced further that those who devote their professional lives as health professionals to alleviating human suffering, have special responsibilities to include a human rights perspective in all aspects of their work,

~~It is hereby resolved by the International Consortium on Health and~~Adopt the following Declaration on Human Rights that: and Health Practice

Article 1 – General Commitment to Human Rights

Health practitioners have a duty to protect and promote human rights as articulated in international human rights and humanitarian law, and in accordance with the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms.

Article 2 – Interdependence of Human Rights

1. Human rights are interdependent and indivisible. Therefore, the realization of any one right depends on the realization of other rights and cannot be considered in isolation of other rights. These rights include, but are not limited to:[9]

a. Freedom from racial and equivalent forms of discrimination
b. Rights to life, liberty and the security of the person
c. Freedom from torture and cruel, inhuman or degrading treatment or punishment
d. Freedom from arbitrary arrest, detention exile
e. The right to a fair and public trial
f. Freedom from interference in privacy and correspondence
g. Freedom of movement and residence, and to emigrate
h. Freedom of thought, conscience and religion
i. Freedom of opinion and expression, peaceful assembly and association

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[8] UNDP. Human Development Report 2000. p. 171.

[9] Principles of interdependence and indivisibility refer to all international human rights provisions. The rights outlined here have been excerpted from both the International Convention on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights for the purpose of illustration.

j. The right to participate in government, directly or through free elections.
k. The right to marry and found a family
l. The right to social security
m. The right to work and protection against unemployment, to form and join trade Unions
n. The right to rest and leisure, including periodic holidays with pay
o. The right to standard of living adequate for the health and well-being of self and family including food, clothing, housing and medical care and necessary social services
p. The right to education
q. The right to protection of one's scientific, literary, and artistic production
r. The right to a social and international order in which the above rights can be fully realized

2. All the above rights are relevant to the promotion of the health of individuals and populations and are, therefore, matters that fall within the competence of health practice.

Article 3 - Duty to Avoid Human Rights Violations

Wherever health practice may, willingly or by coercion, be utilized in any way that participates in or supports violations of human rights, health professionals shall refuse any involvement whatsoever in acts or omissions that may result in human rights violations, whether against the physical integrity of individuals or in support of policies and practices that deprive populations of their internally recognized human rights.

Article 4 - Non-discrimination

Health practitioners have a duty to alleviate and prevent human suffering without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 5 – Advocacy for Human Rights as Part of Health Practice

1. Advocacy for human rights in the context of health practice should be non-partisans and consider the health and well-being of all members of the human family. Health professionals who advocate for human rights shall be fully protected from all attempts to prohibit their legitimate activities for or to harass them in any way for their activities in support of human rights.

2. It is particularly appropriate for health practitioners to advocate publicly, as non-partisans, for the protection and promotion of human rights without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

1. Human rights may only be limited by the State for imperative reasons required in a democratic society to protect public order, public health, public morals, national security, public safety, and the rights and freedoms (reputation) of others. These limitations may be applied only where explicitly recognized in applicable international human rights texts.

2. It is part of health practice to assess the extent to which the conditions required for the imposition of limitations have been met and to seek the lifting of limitations where not justified.

Article 6 –Non-state Actors

While States commit most human rights violations, it is also necessary to hold multinational corporations, civil society, and private individuals accountable. It is therefore, incumbent on the health practitioner to seek opportunities to intervene in ways that will deal with obstacles to the protection and promotion of human rights created by non-state actors, whether corporations or private individuals.

Article 7 - Bioethics

Because international principles of bioethics have focused primarily on codes of conduct for health practitioners in individual encounters with patients, these principles generally do not refer explicitly to relationships between health and human rights, nor do they provide a mandate for the protection and promotion of human rights as conditions for the health and well-being of individuals and communities. The human rights responsibilities of health practice, therefore, include preventing the medicalizing of social causes of human suffering, and applying not only bioethics principles but also all relevant human rights and humanitarian law standards.

Article 8 - Research and Documentation

Health practitioners possess the knowledge and skills of the medical and health sciences to research and document the health consequences of human rights violations and unmet human needs, to study and, where appropriate, to prescribe effective remedial interventions for the health and dignity of individuals and communities.

Article 9 - Human Rights Education

1. Community based and non-formal human rights education as well as formal education about human rights should be promoted in public and private education, as well as throughout continuing professional education for health professionals.

2. The realization of rights ultimately depends on the development of a "culture of human rights." Human rights education is a long-term strategy for human development; it is a proactive way of promoting the health and well-being of a global civil society.

3. Health practitioners have a duty to integrate human rights concerns in the curricula/ studies of health practitioners as outlined in the World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide (see Appendix below).

Article 10 - Environmental Issues

1. In accordance with the Ottawa Charter for Health Promotion, presented at the first International Conference on Health Promotion in 1986, human rights, an ecologically sound environment, sustainable development and human security are interdependent and indivisible, and all persons have the right to an environment adequate to meet equitably the needs of present generations and that does not impair the rights of future generations to meet equitably their needs. To this end, health practice should avoid harming the health of individuals, protect the environment and ensure sustainable use of resources, restrict production of and trade in inherently harmful goods and substances such as tobacco and armaments, and discourage unhealthy marketing practices.

2. It is therefore the responsibility of health practitioners to safeguard both the citizen in the marketplace and the individual in the workplace though such instruments as human rights impact assessments as an integral part of health and development policies.

Article 11 - Poverty

Given the profound health consequences of poverty and increasing global inequity between the rich and poor, health practitioners working in the context of development have a special responsibility to apply their professional capabilities to understanding the nature of this problem and prescribing effective remedial interventions.

Adopt an holistic approach to health care.

Pondicherry Declaration on Health Rights Responsibilities

This consensus statement and Charter on Patients Rights and Responsibilities was adopted by the participants attending a workshop on "Medicine, Media and Consumer Education" held in Pondicherry, December 1-4, 1993. Thirty participants from three countries attended the workshop, organised by the Educators for Quality Update of Indian Physicians (EQUIP) with the support of the International Organisation for Consumers Unions (IOCU).

This Workshops Evolved the Following Guiding Principles :

- The work of rational drug use groups should be expanded to include diagnostics and non-drug therapy.
- The concept of continuity of care through the family physician should be encouraged by consumer education and medical education.
- A Charter of Patient's Rights and Responsibilities should be widely adopted by professional and consumer groups.

1. We call on Central and State Governments to :

- Bring all issues pertaining to drugs under the purview of Ministry of Health & Family Welfare.
- Enunciate and effectively implement a rational drug policy.
- Promote the concept of essential drugs and ensure their availability at affordable cost.
- Promote use of generic names of drugs.
- Regulate and monitor all promotional measures and advertising materials.
- Establish a National Drug Authority of India consisting of governmental, non-governmental organisations as well as professionals bodies.
- Establish and support a drug information and usage monitoring system to facilitate and implement an effective rational drug policy. This should include systems for monitoring adverse drug reactions.
- Integrate the concept of rational drug use, including drug information into health and medical education.
- Introduce within the formal and non-formal educational system information on health related issues.
- Promulgate the Charter of Patients Rights and Responsibilities and Physicians' Rights and Responsibilities.

2. We call on Health Professionals to:

- Adopt an holistic approach to health care.
- Develop two way linkages between different levels of health care.
- Promote prudent use of diagnostic aids and therapy.
- Endorse and respect the Charter of Patients Rights.
- Acquire communication skills to interact with patients, the mass media and the public.
- Periodically update their professional knowledge and improve their skills.

3. We call on Professional Groups, Non-Governmental and Voluntary Organisations to :

- Promote the adoption of a Charter of Patients Rights and Responsibilities.
- Establish networks at all levels in order to facilitate health information, communication and education.
- Encourage multi-and inter-disciplinary research on health related issues.
- Facilitate periodic updates for health knowledge.

4. We call on the Mass Media to :

- Recognize their far-reaching influence on the level of public awareness and assume a more active and responsible role in informing the public on health issues.
- Use a resource network of competent health experts to ensure objective and balanced reporting of health issues.
- Establish regular communication with health professional and consumer groups.
- Participate in the screening of advertisements on health- related issues of unsubstantiated claims and unethical promotion.

5. We call on the Health and Pharmaceutical Industry to :

- Develop and enforce a code of marketing, promotion and dissemination of information, in participation with governmental and non-governmental organisations.
- Recognize their social responsibility to the public with regard, not only to the safety and efficacy of their products and services but also to their cost and societal impact; to devise and to disseminate health information accordingly.

Patients Rights

PART 1 : PATIENTS RIGHTS

Section-1: Right to Health Care and Humane Treatment

1. Every individual shall have access to adequate and appropriate health care and treatment.
2. Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind.
3. A patient has the right to be treated by fully qualified health care professional in private or public health care facilities.
4. A patient has, wherever possible, the right to be treated at a hospital of his choice and to be referred to a consultant of his choice.
5. Every individual shall have the right to prompt emergency treatment from the nearest government or private medical and health facility.
6. Patients have the right to humane terminal care and to die in dignity.
7. A patient can be transferred to another health care establishment, only after an explanation of the need for this transfer and after the other establishment has accepted the patient.
8. A patient has the right to have all identifying information, results of investigations, details of his condition and his treatment kept confidential and not made available to anyone else without his consent.

Section-2 : Consent

1. Before any treatment or investigation, a patient shall have the right to a clear, concise explanation in lay terms of the proposed procedure and of any available alternative procedure. Where applicable, the explanation shall include information on risks, side effects, or after-effects, problems relating to recuperation, likelihood of success, and risk of death. Informed consent of the patient must be obtained prior to the conduct of a treatment or a procedure. In the case of a minor, consent has to be obtained from the parent or guardian. If a patient is incapacitated and any delay would be dangerous, a doctor is entitled to carry\out any necessary treatment or operation after a second opinion is obtained.
2. A patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his decision.
3. Explicit, informed consent is a prerequisite for participation in scientific experimentation. Experimentation must not be carried out on a patient who is unable to express his will.

Section-3 : Right to Information

1. Information about health services (including recent developments in the field) and how best to use them is to be made available to the public in order to benefit all those concerned.
2. Information may be withheld from patients in cases where there is good reason to believe that this information would affect the patient's health adversely but, however, the information must be given to a responsible relative.
3. A patient has the right to know the identity and the professional status of the individuals providing

and Responsibilities

service to the patient and to know which professional is primarily responsible for the patient's care.

4. Patients should have the right to seek a second opinion from another physician.
5. Patients should upon request, be able to obtain a copy of a summary of their diagnosis, treatment and care including diagnostic results on discharge from a hospital or other establishment. They shall also have the right to authorize another medical professional to obtain a copy of the same and to inform the patient of the contents.
6. A patient shall have the right to examine and receive an explanation of his bill after any treatment and consultation.

Section-4 : The Right to Adequate Prescribing Information

1. While prescribing medication, the patient shall be informed about the following : expected outcome, adverse and after- effects, chances of success, risks, cost and availability.
2. All drugs dispensed shall be of acceptable standards in terms of quality, efficacy and safety.
3. All medicines shall be labelled and shall include the pharmacological name of the medicine.

Section 5: Right to Health Education

Every individual shall have the right to seek and obtain advice with regard to preventive and curative medicine, after-care and good health.

PART 2 : PATIENT'S RESPONSIBILITIES

1. The patient shall ensure that she knows and understands what a patient's rights are and shall exercise those rights responsibly and reasonably.
2. The patient shall ensure that she understands the purpose and cost of any proposed investigation or treatment before deciding to accept it.
3. The patient shall accept all the consequences of the his own informed decisions.
4. The patient shall provide accurate and complete information which the health professional requires, about his health and ability to pay for health services.
5. The patient shall establish a stable relationship with and follow the treatment determined by the health professional primarily responsible for the patient's care.
6. The patient shall inform the health professional if he is currently consulting with or under the care of another health professional, in connection with the same complaint or any other complaint.
7. The patient shall so conduct himself or herself so as not to interfere with the well being or rights of other patients or providers of health care.
8. Every individual has a responsibility to maintain his own health and that of society by refraining from indulging in high risk behaviour, detrimental to health.
9. Every individual has a responsibility to accept all preventive mensures sanctioned by law.

Note: (For 'he' or 'his' in this document, please read "he or she", and 'his or her'.)

C - B

HeRWAI

Health Rights of Women Assessment Instrument
An instrument in development

january 2004 ©

The Humanist Committee on Human Rights (HOM), the Netherlands is developing an assessment instrument for the human rights of women in development co-operation, based on human rights instruments. The instrument will focus on women's right to health. Six NGO's from different parts of the world participate in the development of the instrument[1].

The Health Rights of Women Assessment Instrument (HeRWAI) is being developed for NGO's in the South and the North who are interested in women's health. It aims to help them analyse the interrelation between national and international policies and their combined impact on women's health. The analysis can focus on existing policy or policy under development. It can be health policy, or policy which does not focus on health, but which can be expected to influence women's health rights. With the outcome of the analysis, NGO's can lobby for measures that better protect women's health rights. First of all they would direct their lobby at their government. But they can also decide to approach donor agencies or international organizations which influence the national policymaking. HeRWAI further aims to bring together NGO's working for development and health with those working on human rights. The NGO's will be stimulated to use human rights standards when analysing what policies do to women's health. Human rights add strength to the arguments of NGO's, because they are universal and not limited to a certain group or area. This means that NGO's can hold their government accountable. They can ask for changes not 'just' because they think it is important, but also because their government is obliged to protect their rights. Most countries have ratified the *Convention on the Elimination of All forms of Discrimination Against Women* and the *Covenant on Economic, Social and Cultural Rights*. This means that they are obliged to protect women's health rights. HeRWAI makes use of these treaties and other widely accepted texts describing women's health rights.

The instrument is still under development and far from completion. In its draft outline, the instrument consists of two main phases. The first phase of HeRWAI is a so-called quick scan. A series of questions guides the NGO's to consider if HeRWAI is appropriate for their situation. If, on the basis of the quick scan, the NGO's decide to undertake the analysis, they start with the actual impact assessment. The NGO's will describe and analyse a certain policy, and suggest alternative strategies with a better impact on women's health rights. HeRWAI provides a structure for the collection of information, which helps the NGO's to look at the human rights aspects of health and at the interlinkage between national and international policy. The results of the analysis may show that as a result of the policy, women's health will deteriorate, or that the policy misses an opportunity to improve women's health rights. In the lobbying process that follows the analysis, the NGO's will not only focus on the shortcomings of the policy, but also develop suggestions for improvement.

The draft outline of the tool needs to be developed further, especially the parts on indicators for women's health and the user guides. It may change according to further discussions and pre-testing. HOM and its partner organizations will continue this process in the coming period. The aim is to reach a pre-testing stage by the end of this year and to have a draft version of the tool ready by April 2004.

For more information, please go to http://www.hom.nl/eng/index.html or contact s.bakker@hom.nl

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[1] Naripokkho, Bangladesh; IWRAW-AP, Malaysia; Fida-Kenya, Si Mujer, Nicaragua; Wemos and WGNRR, the Netherlands

L-3

People's Right to Health as a Global Concern

Health and International Policies

Wemos Programme 2003-2005

3402RAP02001/02
November 2002

INTRODUCTION

Wemos was founded in 1981 by medical students who were of the opinion that too little attention was paid to structural causes of ill health and international health issues. In the course of the past two decades, Wemos has developed into a professional organization with twenty paid employees, working on the improvement of people's health in developing countries from the office in Amsterdam. In 2002 the budget of the organization amounted to 1.6 million Euros. The main funders of the 2002 activities of Wemos are the Netherlands Ministry of Foreign Affairs, Cordaid, Hivos, the European Commission, Stichting Doen, the Nationale Commissie voor Internationale Samenwerking en Duurzame Ontwikkeling (the National Commission for International Collaboration and Sustainable Development—NCDO), as well as some private donations.

Health is a prerequisite for the alleviation of poverty. The improvement of people's health is internationally recognized as one of the most important development goals. Health as a key factor in the lives of all people in this world is reflected in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and in other human rights principles and treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women, in which it is stated that *the highest attainable standard of health is a fundamental human right*. This statement forms the Wemos mission. In this era of globalization, the possibilities of men and women to enjoy their right to health are increasingly determined by international standards, regulations and agreements. Wemos believes that these international policies should protect, respect and fulfil the right to health and the Wemos general objective therefore is: *to contribute to the realization of the right to health of men and women in developing countries through influencing international policies*. To achieve this objective Wemos activities are and have always been concentrated around lobbying among national and international policy makers, collaboration with Southern partners, and campaigning among health professionals in the Netherlands in order to mobilize public support for policy changes. Wemos considers itself to be part of international civil society and joins others in the fight for the improvement of people's health in developing countries.

In 2001 an evaluation of Wemos was carried out on behalf of the Ministry of Foreign Affairs. The outcome of this evaluation and the need felt within the organization to come to a more integrated way of working resulted in a series of discussions with staff members, the Wemos board, Southern partners and a number of outsiders. The strategy plan 2002-2005 (see summary in Annex on page Error! Bookmark not defined.), developed in 2001, is a reflection of this process. In this plan changes in the organizational structure, the financial structure and the content of the projects are outlined and the Wemos strategy is presented. Major changes concern the transition from nine smaller projects to three bigger ones, the appointment of a project co-ordinator responsible for the streamlining of the different project activities, and the intention to obtain funding based on an integrated Wemos programme rather than on separate projects.

The year 2002 has been used to make a start with the implementation of these changes. The nine projects around the themes baby food, access to medicines, older women's health and the impact of economic policy on health are being concluded or partly included in the new projects. Three project teams were formed and expert advice was sought to further develop a rights-based approach to health which includes a gender approach.[1] In May a consultation with Southern partners was organized in which major international developments were discussed and ideas concerning the three new projects were shared. The analysis of the most important developments in health and international policies in recent years and other input from Southern partners, members of the Wemos board and some external

[1] The staff training programme on a human rights approach to health and on gender, started in 2002 will further be developed in 2003.

traders resulted in the formulation of three new projects: *health and trade, health and poverty reduction strategies* and *health and global public-private initiatives*.

These projects are a reflection of the increasing importance attached to the collaboration with Southern partners: in all projects Wemos works closely together with groups of Southern NGOs. Based upon existing contacts, in the *health and trade* and in the *health and public-private initiatives* projects these groups will be formed in the first phase of the project. The *health and poverty reduction strategies* project builds on an already existing network. Part of the collaboration with Southern partners concerns the conducting of case studies in order to monitor the consequences of international policies for the enjoyment of the right to health of people in developing countries. In these studies special attention will be paid to women's rights to health. Another important feature of the collaboration is the strengthening of the capacity of the members of the groups or network. Based on the needs of these organizations, in the coming three years trainings will be organized around specific themes and activities.

Through collecting information, collaboration with Southern partners and other NGOs, lobbying national and international policy makers and campaigning in the Netherlands, Wemos wants to contribute to the fulfilment of the right to health of men and women in developing countries. The new organizational structure and the three new projects will hopefully assist us in becoming more effective in achieving this objective.

This document contains an overview of what Wemos considers to be the most important trends in international health issues and an introduction to a human rights and gender approach to health. Thereafter, the Wemos strategy is outlined and the three projects are presented. The annex contains a list of criteria for collaboration between Southern partners and Wemos, a list of abbreviations, references and the summary of the strategy plan.

WEMOS VIEW ON INTERNATIONAL DEVELOPMENTS AND HEALTH

The health situation[1] of women, men and children in developing countries is a matter of great concern. Millions of people do not have access to sufficient food, safe drinking water and adequate housing, and live in unhealthy environments. Furthermore, large numbers of people die every day of treatable illnesses. The main cause of this bad health situation is poverty[2] and at the same time this bad health is a major obstacle for poverty alleviation. People deprived of their health are limited in their capabilities to earn a living, to develop themselves and to contribute to society. The majority of the world's poor are women and girls. However, women not only suffer from poverty-related health problems. Women's low status in society, their lack of autonomy over their sexual and reproductive lives, the inequitable distribution of food within the household, and women's limited control over resources have a negative impact on their health, too.

Health as a human right

Every human being has the right to the highest attainable standard of physical and mental health, conducive to living a life in dignity.[3] The right to health does not imply the right to be healthy but concerns the right to the highest attainable standard of health. This right is one of the fundamental human rights and is closely related to and dependent upon the realization of other human rights, including the rights to food, housing, work and education.[4]

Human rights empower the poor by granting them rights that are legally guaranteed, while at the same time imposing obligations on governments and public bodies such as international organizations. Because human rights are legally binding, these bodies are accountable for ensuring that these entitlements cannot be reduced to mere privileges or luxuries or left to the whim of markets (see box on page 5 for more information about the obligations of these different bodies).

[1] Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100 and entered into force on 7 April 1948.)

[2] From a human rights perspective poverty constitutes the non-fulfilment of a person's rights to a basic set of capabilities – to do and be the things that he has reasons to value (UHCHR 2002a). While culture specific, a common set of capabilities is considered basic in most societies, including the capabilities of being adequately nourished and sheltered, having basic education and being able to earn a livelihood.

[3] The right to health is part of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and numerous other human rights documents.

[4] This is consistent with the so-called expansive interpretation of the right to health used by the UN committee on ESCR. (Hunt 2002)

Obligations regarding the right to health[6]

According to human rights law states have to take concrete steps to progressively realize the right to health, taking into account the limits of available resources. It is also the responsibility of the government to refrain from denying or limiting equal access for all women, men and children. Recognition of the importance of the human rights of women is, amongst others, reflected in the fact that many members of the United Nations have become parties to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Retrogressive measures by states are not allowed, unless the government can show there is no alternative. Governments should *respect* the right to health and avoid adverse health impacts of *all* their policies and actions. Governments have to *protect* their population against adverse health impacts from others, e.g., polluting industries, unhealthy work conditions in factories, etc. They are required to adopt a national strategy, indicating concrete and detailed objectives, policies, indicators and benchmarks to *fulfil* the right to health in the shortest possible time. This should ensure the availability, accessibility, acceptability and quality of health facilities, goods and services; health financing systems that are affordable to all and equal access to health determinants such as water, adequate housing and food security. The Alma-Ata declaration on Health for All by the year 2000 and the Primary Health Care strategy adopted by WHO member states in 1978, the Programme of Action of the International Conference on Population and Development in 1994 and the Action Plan of Beijing in 1995 provide compelling guidance on the core obligations of states regarding the right to health. According to the same human rights law, developed countries are obliged to assist poorer countries through economic and technical support. In addition, as members of international organizations and as major shareholders in the Multilateral Development Banks, developed countries have to ensure that these organizations take due account of the right to health and other human rights in their policies and programmes. Since human rights are the first responsibility of states, all other international agreements and regulations, including trade agreements, have to be consistent with and interpreted in accordance with international human rights law. All members of the international community, including international organizations, have the duty to ensure the protection of human rights, including the right to health, in the processes of global, regional and national economic liberalization (UNHCHR 2002c). They also have to take adequate measures in order to remove global structural obstacles that hamper the eradication of poverty and the improvement of health in developing countries, such as unsustainable foreign debt, the widening gap between rich and poor and the absence of an equitable multilateral trade, investment and financial system (CESCR 2001). The WHO is assigned a key role in providing technical assistance and collaboration at the international, regional and national level.

The realities of the health crisis

For millions of people the enjoyment of the right to health remains a distant goal. In the least developed countries over a third of the population is undernourished and of every 1000 children born, 98 die before they reach their first birthday. Child immunization rates in Sub-Sahara Africa have fallen under 50%; by the end of 2000, 20 million people in the world had died of AIDS and 40 million were living with HIV/AIDS, of which 75% were in Sub-Sahara Africa (UNDP 2002). Other communicable diseases, such as malaria, tuberculosis, acute respiratory infections, diarrhoeal diseases, measles and other vaccine preventable diseases also contribute to the high toll of illness and premature death among the poor. Insufficient reproductive health, nutritional deficiencies and lifestyle-related illnesses, gender inequality, lack of access to affordable safe water and sanitation, and the increasing use of pesticides are other important factors affecting health negatively.

[6] For a full description of the normative content of the right to health and of the obligations of states and other actors, we refer to General Comment number 14 (CESCR 2000).

As mentioned above, ill health is closely related to poverty. While poverty is difficult to capture in statistics, figures can provide an indication of the severity of the situation. Of the world's six billion people, 1.2 billion people live in extreme poverty, defined as living on less than one US dollar (USD) a day. Twenty countries in Sub-Sahara Africa, including more than half of the region's population, are poorer now than they were in 1990, while 23 are poorer than in 1975 (UNDP 2002). The average income in the richest 20 countries is now 37 times that in the poorest 20. This ratio has doubled in the past 40 years. Similar increases in inequality are found within countries (World Bank 2002).

Expenditures on health are far too limited to conquer the present health crisis. The median public expenditure on health in Sub-Sahara Africa is only USD 6 per capita per year (World Bank 2000). The World Health Organization (WHO) has calculated that an investment of USD 60 per capita is needed to finance a sustainable health system (WHO 2000). Concerted efforts are required by both national governments and donors to fight the health crisis. The WHO Commission on Macroeconomics and Health calculated that about 27 billion US dollars of donor support is needed, amounting to 0,1 per cent of the Gross Domestic Product (GDP) of donor countries, for a worldwide scaling up of health investments for the low income countries. These concerted efforts would not only improve people's health but 'would also translate into hundreds of billions of dollars per year of increased income in the low-income countries' (Commission on Macroeconomics and Health 2001)

Major investments are needed in integral health systems which offer sufficient and accessible health care for all and to improve the other determinants of health. Many of the public health systems in low-income countries are under severe pressure. They receive few resources to implement preventive and promotional activities and local hospitals often lack equipment, medicines and trained personnel, and experience regular electricity and water cuts. The strategy of primary health care, adopted by the WHO in the Alma-Ata declaration of 1978, can still make a major contribution to the objective of health for all.[1] In achieving this objective investments in other factors determining health such as sanitation, water supply and education are equally important. Special attention should be given to women in fighting the health crisis. The denial of reproductive rights, maternal deaths, high rates of child mortality and malnutrition are all issues that can only be solved when special attention is paid to the rights and needs of women.

Global trends impacting on health

Policies and actions of governments, civil society, transnational corporations and international organizations are all affecting the health of people in developing countries and all play a role in fighting the present health crisis. Governments of developing countries have the obligation to protect, respect and fulfil the right to health of their citizens, but often fail to do so because of lack of funds, corruption and mismanagement. Donor governments are spending money in health but, as mentioned above, these amounts are too limited to fulfil their obligation to contribute to the right to health (see box on page 5). Furthermore, coordination among donors is often absent and expenditures are in many cases donor driven.[2] International and national NGOs, church-related health institutions and other civil society organizations are among the most important health care providers in many developing countries. These bodies often fill the gap left by the severely under funded public health sector. Civil society at local, national and international levels actively lobby for the development and implementation of international agreements and policies which do include the fulfilment of basic human rights of people in developing countries.

At the international level, some of the main factors affecting health are trade policies, poverty reduction strategy policies and the increasing influence of transnational corporations.

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[1] The importance of the strategy of PHC to achieve health for all has been confirmed in the Ottawa Charter for Health Promotion of 1986 (WHO 1986) and reaffirmed in a resolution of the 52th World Health Assembly in 1998 (resolution number WHA51.7).

[2] Donor driven implies that donors decide how money is being spent, without paying much attention to the specific needs of different developing countries.

Globalization, health and trade

Since the 1980s a rapid integration of the world's economy has taken place in which companies, governments and individuals make international transactions in goods, services, finance and information. Important features affecting the right to health are: increased foreign trade and investment, growth and increasing power of transnational corporations, the emergence of a global civil society and the global spread of communicable diseases, such as HIV/AIDS.

The increase in trade and foreign investments has consequences for the right to health of people in developing countries. According to free-market theory and neo-liberal thinking, trade and capital liberalization would lead to economic growth for all on the basis of comparative advantages, leading to better income distribution and decreased poverty, thereby positively affecting health. There is, however, growing evidence that in reality the benefits of this process are unevenly distributed, leading to more *inequality*, both within and between countries. It appears that the effect of increased trade depends on a country's initial income level. At a very low average income level, it is only the rich who benefit from openness (Milanovic 2002).

The World Trade Organization (WTO) is the only global international organization dealing with the rules of trade between nations. At its heart are the WTO agreements negotiated and signed by the bulk of the world's trading nations and ratified in their parliaments. The goal of the WTO is to encourage and facilitate free trade in the world.

In the preamble to the WTO Agreement, which establishes the framework for the entire WTO system, it is stated that the objectives of the system are the fulfilment of basic human values, including the improvement of living standards for all people and sustainable development. The term human rights is not mentioned but it is suggested that trade is not an end in itself and that human values, i.e., human rights, should therefore prevail over trade law. However, important WHO resolutions that promote the right to health are not sufficiently protected in these agreements and the implementation of several agreements conflicts with the right to health. For example, the Trade Related Aspects of International Property Rights (TRIPS) Agreement. This agreement sets the rules for the patent rights on pharmaceuticals and grants 20 years patent protection to companies that have made new inventions. As a consequence, some life-saving medicines are very expensive and unaffordable for developing countries. The WTO ministerial conference of November 2001 addressed this dilemma in the Declaration of TRIPS and Public Health. This declaration explicitly reconfirms WTO members' right to protect public health. It can be considered as a first sign of political commitment that trade rules need to respect human rights obligations. Implementation of the health safe guards in the TRIPS agreement is, however, still lacking.

Another example is the General Agreement on Trade in Services (GATS). The goal of this agreement is the progressive liberalization of trade in all services, including health services. As a consequence, the possibilities governments have to protect the public health sector may become limited and access to care for all may be threatened. Finally, the Agreement on Agriculture limits the possibilities of governments of developing countries to regulate the domestic agricultural sector in order to protect it from international competition. This may have serious consequences for the food safety of small farmers and thus for the right to health.

Another problem in relation to the right to health of men and women in developing countries is the undemocratic nature of the WTO. Within the WTO decisions are taken in small group meetings which are heavily influenced by Canada, the European Union (EU), Japan and the United States of America (USA) (UNDP 2002). They primarily defend their own interests, including the interests of the business sector. The vital interests of developing countries are often marginalized. It is very difficult for these countries to go against the power of the developed world since they are in many ways dependent on these countries for foreign aid and investment. Furthermore, non-compliance with WTO agreements is

not an alternative, since non-adherence can lead to trade sanctions, which may have severe economic consequences.

From structural adjustment to poverty reduction strategies

The availability of health care services for people in developing countries has declined over the past two decades. This has been caused by, amongst other factors, the International Monetary Fund (IMF)/World Bank Structural Adjustment Programmes which forced poor countries to downsize and reform public sector services, including health care. The encouragement of privatization of basic services, the introduction of user fees, the opening up of markets for foreign investors and products, and the creation of export-oriented economies were all part of these policies. Their objective was poverty reduction but in many developing countries income gaps increased and, due to diminishing government involvement and public funding, health systems collapsed. The negative consequences of these policies were especially felt by women because of the higher prevalence of poverty and economic dependence among them and because women play a crucial role as care takers of the health of the family. Accessibility of general health services for women has often to be investigated.

By the end of the 1990s the World Bank and IMF recognized that structural adjustment policies had failed and that economic growth and sound macro-economic policies in themselves would not lead to the reduction of poverty. As a response, in 1999 Poverty Reduction Strategy Papers (PRSP) were introduced. To avoid mistakes made with the implementation of Structural Adjustment Programmes, important commitments were made. Firstly, all policies, including macro-economic and adjustment policies, would have to contribute to poverty reduction. Economic targets would no longer be the final objective. Secondly, civil society participation was acknowledged as crucial for developing and implementing poverty reduction plans. All policies, including the macro-economic framework should be made subject to public debate. Thirdly, country ownership became an important objective. The World Bank and IMF would no longer prescribe policies, but rather assist countries in developing and implementing their PRSP. Together with other donors, adequate financing would be provided, in the form of debt relief and Official Development Assistance (ODA), to achieve the objectives.

PRSPs could make a contribution to the enjoyment of the right to health by ensuring that health policies and other reform policies and investments in sectors that have an impact on health address the constraints the poor experience in accessing health services and other health determinants. Furthermore, the participation of civil society and other stakeholders in the process ideally allows room for the involvement of health NGOs and the health care sector. However, recent reviews of the PRSP process indicate that, in spite of some progress made, in most PRSPs health continues to be marginalized and under resourced, and that proposed health sector interventions are in most cases not explicitly pro-poor. The links between health and poverty and between the health sector and other sectors of the economy are often neglected.

Moreover, despite the fact that country ownership is one of the pillars, the needs of the people in the countries concerned are still not at the core of these PRSPs. Because PRSPs are connected to debt relief, soft loans and bilateral donor assistance, developing countries have to comply with what they perceive as externally imposed conditions that reflect the worldview and interests of the creditors. This new form of conditionality is partly due to power relations within the World Bank and the IMF. Nearly half of the voting power in both institutions rests in the hands of seven countries. Informally the EU and the US exercise an even greater power, as in, for example, nomination of the heads of both institutions. Within both institutions a new kind of division has developed between creditor countries on the one hand and borrowing countries on the other. The creditor countries enjoy increased decision-making power and have used it to expand conditionality (UNDP 2002).

Transnational corporations and the WHO

Primarily because of the devastating effects of the HIV/AIDS pandemic in Africa, and the increasing prevalence of other infectious diseases such as tuberculosis and malaria, in recent years health has become a major topic on the international development agenda. It has been discussed at the G8, the United Nations (UN) and development fora like the World Social Summit for Sustainable Development in Johannesburg, July 2002. Of the Millennium Development Goals adopted at the UN Millennium Summit in September 2000, several are directly related to health.[9]

The discussions about possible solutions to the present global health crisis do not only take place in government and UN circles; transnational corporations (TNCs) have also entered the debate. The power of these companies has increased as a result of the globalization process described above and so has their influence in developing countries: private foreign capital flows are much higher than ODA.

In many developing countries, TNCs are providing some form of health care for their workers. Because of the international scale of their operations they are often able to avoid national regulations and can set up their own health care projects. These projects can contribute to the improvement of the health of the workers but raise questions about equal access to care, both in general and in regards to gender, and the role of governments in the fulfilment of the right to health.

At the international level, TNCs are getting involved in what is called new global initiatives, in which UN bodies such as the WHO join forces with private companies.
Examples of these initiatives are the International Aids Vaccine Initiative (IAVI), the Global Alliance for Vaccines and Immunization (GAVI) and the Stop TB partnership.
For the WHO and for the recipient countries, these initiatives provide much needed financial resources. For the TNCs collaboration with the WHO is a way to respond to concerns for corporate responsibility and accountability and a means to get a voice in international decision making. Because of their increasing role in the world economy many of these companies are looking for ways to get a stronger say in international decision making within institutions such as the WTO and the EU. Important new sources of funding for UN partnerships are those from the new philanthropists (i.e., Bill Gates, George Soros, Ted Turner).

The WHO perceives partnerships with the corporate sector as an opportunity to join forces to fight the health crisis and as a synergy between public and private aims. This assumption has yet to be proven true. There is a risk that the corporate sector's growing influence will put the WHO's critical functions and attributions, such as its authority in the promotion of the right to health and equity, its function as global standard setting body in health and its supportive collaboration at country level, under pressure. The current reality is that a patchwork of separate and ad hoc alliances and partnerships in health has developed, each having its own structures, procedures and goals. In addition, no rules and regulations exist that ensure democratic decision making and public control.

Concluding remarks

This chapter started with the statement that the health situation of women, men and children in developing countries is a matter of great concern. We outlined the three major international trends which, according to us, have consequences for the health of people in developing countries. We are aware of the strong processes underlying these trends and how they are rooted in the persistent inequalities both in economic and political power, between North and South. In addition we realize how determining gender inequalities are for the differences in health, and access to health care, between men and women. Wemos is of the opinion that only through a rights-based approach can sustainable improvement in health be achieved.

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[9] Goal 1: halving the people living in extreme poverty and hunger, 2: achieving universal primary education, 3: promoting gender equality and empowering women, 4: reducing child mortality, 5: improving maternal health, 6: combating HIV/AIDS, malaria and other diseases, 7: ensuring environmental sustainability, 8: developing a global partnership for development (UNDP 2002).

Civil society organizations can make a contribution to the realization of human rights in several ways. One important task is to empower people, by informing them of their human rights and by increasing their capacity to claim these rights. An equally important task is to continuously remind governments and international organizations of their duty to respect, protect and fulfil the internationally agreed upon human rights, and to monitor whether they act accordingly.

Based on its capacities, capabilities and mission, Wemos wants to focus on the realization of the right to health through influencing international policies. Based on our analysis of the current trends we envisage working in three areas in the coming years: *health and trade, health and poverty reduction strategies, and health and public-private initiatives*. In all three areas we want relevant policy makers in the North and the South to take concrete steps, small as they might be, to bring the realization of the right to health closer. In order to achieve this goal, we closely collaborate with Southern partners that share the same vision. Through this collaboration we also contribute to our partners' goals and processes, supporting them in their efforts to influence their governments and organizing support in their societies. But this is not enough: in order to get leverage, we also need to build coalitions in our own society and mobilise public support among the health sector here. Therefore, awareness raising and campaigning in the Netherlands are an integral part of each of the projects.

In the next chapter details about the different aspects of the Wemos strategy to achieve our general objective are provided. Afterwards, the three Wemos projects are presented.

WEMOS STRATEGY

A combination of activities is required to effectively work on the achievement of the Wemos general objective – to contribute to the realization of the right to health of men and women in developing countries through influencing international policies - and the related project purposes.

The Wemos strategy

- lobby and advocacy
- knowledge gathering
- collaboration with Southern partners and capacity strengthening
- collaboration with other NGOs, networks and institutes
- awareness raising and campaigning in the Netherlands among health professionals

The Wemos strategy consists of five elements (see box) which are mutually reinforcing and are most effective in combination. Lobby and advocacy activities are more successful coming from a professional and well-informed staff and when it is clear that the claims made in the lobbying follow from the collaboration with Southern partners and have the support of other NGOs and networks and health professionals in the Netherlands. The five elements of the Wemos strategy thus form the basis of the three Wemos projects.

Lobby and advocacy

Wemos' lobby and advocacy activities concentrate on the WHO, the World Bank/IMF and the WTO. Lobby activities towards national delegations, which play a key role in the formulation of policies and agreements within these institutions, are carried out by Wemos in the Netherlands and the EU. Wemos partners lobby their own governments. Furthermore, both Wemos and its partners establish formal and informal contacts with staff members of the above mentioned institutions.

Wemos closely monitors policy agendas to obtain in-depth knowledge about the relevant discussions and trends regarding international policies and health. Activities undertaken are:

- writing position papers on topical issues
- attending international conferences to meet policy makers, relevant NGOs and others, and other formal and informal contacts with relevant policy makers
- organizing seminars
- dissemination of the results of case studies, conducted to obtain information about the consequences of international policies for the health of men and especially women in developing countries
- press releases and letters to ministers, members of parliament and directors and staff of the relevant international institutions.

Knowledge gathering

Knowledge gathering covers a wide range of activities:

- collecting information about, amongst other things, relevant international discussions and policies, human rights and health, international agreements on women's rights and valuable initiatives in the field of women's right to health
- in-depth analysis of international trends and their impact on health and of the outcomes of existing impact assessment and evaluation studies
- the development of methodologies to systematically gather data on local consequences of international policies in developing countries
- collecting information resulting from case studies conducted as part of the collaboration with Southern partners (see below).

In the Wemos documentation centre, which is currently being updated and improved, background articles, development reports, publications of other NGOs, policy papers, relevant academic studies and publications on human rights and gender and the publications of the WHO, World Bank/IMF and the WTO are available, as well as information about relevant websites, list serves and e-mail newsletters.

Internal meetings are held every month in which topical issues are discussed, relevant information is exchanged and the results from the project case studies are presented. Time is allocated for project staff to attend courses on relevant international (health) issues. In the coming years further in-house training will be provided on human rights and gender issues.

The Wemos website will be updated to include relevant information on gender equality issues and human rights issues in relation to health. This information will hopefully assist Wemos and its partners in the implementation of the project activities.

Collaboration with Southern partners and capacity strengthening

The collaboration with Southern partners is based on partnership, ownership and mutual benefit. This provides the opportunity to complement and strengthen each other's capacities, stand stronger together, network, and address health concerns from different perspectives and at different levels.

A distinction is made between so-called institutional Southern partners and other Southern partners. The first category includes partners with whom intensive relations exist and which are involved in at least two of the three Wemos projects (see annex on page Error! Bookmark not defined. for criteria). At this moment, two organizations are institutional partners, Consumer Information Network (CIN) in Kenya and Accion Internacional para la Salud Bolivia (AIS) in Bolivia. In the coming years attempts will be made to identify one more institutional partner, preferably an Asian organization. The second category concerns other partners. These partners usually only work within one of the three projects and the relationship with Wemos is less intensive (see annex on page Error! Bookmark not defined.)

Both institutional and other partners can be supported in their lobby, advocacy and awareness raising activities in their own countries. This support can consist of finances for the conducting of activities by partners, it can also consist of and advice and guidance from Wemos, when requested. Other important aspects of the collaboration with partners are the conducting of case studies about the consequences of international policies on the health situation of men and especially women, and capacity strengthening in the form of training on specific issues and/or lobby activities. Institutional strengthening is part of the collaboration with institutional partners, in case other partners want to

work on institutional development. Wemos will assist these organizations in finding suitable advisers and/or courses.

The intensification of the relations with Southern partners is described in detail in the three projects. In the choice of new partners Wemos will pay special attention to their level of gender and human rights sensitivity. Wemos will put gender systematically on the agenda during field visits and will facilitate learning and exchange among partners by providing and collecting regular information on gender and human rights developments.

Collaboration with other NGOs, networks and institutions

International policies can only be influenced when civil society in different parts of the world joins forces and makes sure it is heard. International networks such as the International Baby Food Action Network (IBFAN), the Health Action International (HAI), the People's Health Movement (PHM) and the International People's Health Council (IPHC) provide the opportunity to link with organizations all over the world working on similar issues. These networks also offer the possibility to coordinate positions, develop joint lobby strategies and are important sources of information.

In the last couple of years Wemos participated in a number of European networks with which joint EU-funded projects were carried out (Health Counts, EU donation project and EU baby food project). These projects provided the opportunity to learn from each others activities and to broaden the scope of the work to European policy makers and health professionals. Collaboration with European partners will remain important in the three new projects.

Wemos is strongly embedded in the Dutch NGO sector, and joint lobby and campaigning activities such as press conferences and seminars are organized. Health NGOs are members of a 'klankbordgroep' (advisory board) and coalitions are formed around specific campaigns, such as the Jubilee campaign in which Wemos played a leading role. In some cases these coalitions and platforms are formed in response to topical issues; in other cases joint activities form part of a long-term agreement between Wemos and a Dutch NGO which includes financial support and the undertaking of joint activities.

Contacts with university departments and institutes will be intensified to link up with existing impact assessment studies, to obtain knowledge about methodology for the case studies to be carried out as part of the three projects and to be well aware of academic studies carried out about international policies and health.

To broaden the expertise on human rights and gender in relation to health issues, in the coming years Wemos will expand its present national and international network to include new contacts with human rights and gender experts and organizations all over the world.

Awareness raising and campaigning in the Netherlands

To be effective in lobbying which leads to political solutions that are sustainable, it is necessary to mobilize public support through public awareness raising and campaigning. Public opinion creates the leverage which enables policy makers and politicians to act on these issues.

Wemos raises awareness among Dutch health professionals (doctors, paramedics and other health workers), NGOs involved in health and development collaboration, politicians and policy makers at the national and EU level and the wider public. They will be informed about the fulfilment of the right to health in developing countries.

Furthermore, national and international coalitions will be built in order to strengthen advocacy efforts and make stronger plea for policy changes. Individual health professionals will know about issues

Wemos addresses in the three projects through materials such as articles, leaflets, background documents, a newsletter, electronic mailing list and website. We will give workshops and attend fairs and conferences. Of great importance are also well-established relations with the media in the Netherlands.

Besides general awareness raising activities, every year Wemos will mobilize the support of Dutch health professionals for a specific lobby goal through a campaign. To reach the objectives of the campaign, a Wemos campaign logo and slogan plus action pack with background information will be developed. These materials are closely related to topical debates and issues, and closely linked to the level of knowledge among the target groups. Wemos disseminates the action materials through networks of health professionals, Dutch NGOs, professional magazines, and through visiting fairs in order to collect the support of individuals and their organizations.

An important part of the campaign is to organize an event to show the collected support for policy changes. Results in terms of policy changes and effects for the enjoyment of the right to health in developing countries will be communicated. The awareness raising activities will contribute to the campaign's development.

The Wemos campaign will be organized by the Health and Poverty Reduction Strategy project in 2003, the Health and Trade project in 2004 and the Health and Public-Private Initiatives in 2005.

Concluding remarks

The Wemos strategy concerns activities in which Wemos has been involved in during the last two decades. Based on the outcome of the evaluation carried out on behalf of the Ministry of Foreign Affairs in 2001, the strategy has been refined and forms an integral part of all Wemos projects. In other to embed the strategy in the organization, five staff members have been allocated time to work on the integration of the strategy's five different aspects and to further develop a typical and recognizable Wemos way of working : The lobby expert will, for example, share her experiences with other project staff and assist them in improving their lobbying skills.

The human rights and gender approach are also an integral part of the Wemos strategy. Whenever possible, activities, themes and messages will contribute to expanded chances and choices for women and the enjoyment of equal rights to health by women and men. During the period 2003-2005, further human rights and gender staff training will be organized. Partner organizations with specific knowledge and expertise on these issues will be asked to share their experiences with Wemos and its other partners.

Health and Global Public-Private Initiatives

Context

Many people in developing countries do not have sufficient access to health care for several reasons. In some more remote areas health care facilities are not available. Where health services are available user fees can form a major obstacle. In many countries privatization of parts of the health care sector has resulted in a decrease in the accessibility of health care services. The financing of a public health care sector which provides services for all is one of the major problems governments of developing countries are facing. Low incomes in combination with high debt repayments cause national budgets to be inadequate to guarantee a minimum level of health care, which is accessible for all. At the same time, some Southern NGOs claim that their governments do not pay sufficient attention to health and do not use scarce resources in an efficient manner. Furthermore, some governments make policy choices which are not based on the basic needs of their own people.

Despite the increased attention for health during all kinds of international meetings, international commitments such as the allocation of 0.7% of GDP of developed countries to Official Development Assistance (ODA) are not met and international budgets are far too limited to improve the health of women, men and children in developing countries. The WHO, responsible for the development and implementation of international health policies that promote the right to health, has also very limited resources and is unable to fulfil its obligations. One of the responses to the enormous health problems in developing countries is the establishment of a number of so-called New Global Initiatives in recent years. These initiatives include so-called Global Public Private-Initiatives (GPPIs), a form of collaboration between a UN body or a government (as a public body) and private enterprises (the private for profit bodies). The corporation between private and the public sector in health is not new. What is new is the international dimension of these initiatives.

The definition of GPPIs used in this proposal is:
Heath GPPIs are collaborative relationships that transcend national boundaries and bring together at least three parties – among them a corporation and/or industry association and an inter-governmental organization – so as to achieve a shared health creating goal on the basis of mutually agreed and explicitly defined division of labour (adopted from Buse and Walt 2000).

At the global level, there are about 80 PPIs. Examples of these initiatives are the International Aids Vaccine Initiative (IAVI), the Global Alliance for Vaccines and Immunization (GAVI), and the Stop TB Partnership.

Building on previous work of Wemos and partners

Wemos has been involved in the area of public-private interactions within different projects. In the pharmaceutical programme staff members initiated discussions on the role of the private sector in combating the diseases of the poor and on corporate social responsibility (CSR) with Nefarma (the organization of research based pharmaceutical companies in the Netherlands). Furthermore, Wemos is a member of the Dutch platform of NGOs which has been working on a frame of reference for corporate social responsible behaviour. Wemos investigated the operations of Philips medical systems -a department of the Dutch multinational Philips- in the health care system in India. This work forms the basis for the underlying project as its preliminary results give reason for a longer term involvement to closely monitor the activities of the public-private mix in the health area. The focus on global public-private initiatives is, however, new for Wemos.

Since this is a new project the first period will be used to gather information and to find Southern partners interested in the issue of GPPIs and able to conduct case studies in their countries about the consequences of these global initiatives. So far, one of Wemos institutional partners is interested in participating. Because of Wemos activities within a number of international networks and the wide

spread interest in the issue of GPPIs among health NGOs, we will be able to form a network of at least six partners in the course of the first year.

Overall objective

Global Public-Private Initiatives in health will contribute to the fulfilment of the right to health.

Project purpose

Key policy and decision makers at national and international levels are of the opinion that GPPIs must have a positive effect on national health systems and will contribute to the fulfilment of the right to health.

The extent to which GPPIs contribute to the right to health will in this project be assessed along the following criteria:
Effective: GPPIs should address the most pressing health needs of the population and contribute to integrated national health systems which guarantee access to health for all.
Sustainable: in case one of the participants steps out, the service, good or facility should be continued and equal access should be guaranteed.
Empowering: GPPIs should contribute to the empowerment of the users of the service or facility created or good distributed.
Accountable: stakeholders involved in a GPPI are accountable to local and national governments, through the political process.
Non-discriminatory: the goods, facilities or services delivered within the framework of GPPIs should be equally accessible for women and men.
Participatory: GPPIs should be developed and implemented with the participation of the men and women they are meant to serve.
Integral: GPPIs should approach health issues in an integral manner, taking into account the underlying causes of the health problems, along the lines of International Covenant on Economic, Social and Cultural Rights.

Justification

According to the General Comment no. 14, States have the obligation to respect, protect and fulfil the right to health. This obligation is not only for the benefit of the states' own citizens, but also – by way of international collaboration and assistance – for the benefit of citizens of states which do not have the means or capacity to meet this obligation (amongst others, through ODA). This general comment assigns a key role to the WHO in providing technical assistance and collaboration at the international, regional and national level. The WHO is established to function as the world's health conscience (e.g., human rights and equity), providing a normative framework and agenda for health.

GPPIs are, amongst others, a response to the lack of finances of the WHO. For the WHO, collaboration with private-for-profit parties brings with it opportunities to set up programmes that were unaffordable before and may contribute to the WHO's objective to achieve health for all. The WHO recognizes that risks are involved and has established some guidelines for its staff members in dealing with enterprises: 'in developing relationships with commercial enterprises, WHO's reputation and values must be ensured. Scientific validity must not be compromised. Staff should always consider whether a proposed relationship might involve a real or perceived conflict of interest, either for the staff member or for the work of the organization' (EB107/20 2000, still in use). Some argue that these guidelines contain some flaws such as the lack of a clear definition on conflict of interests and that they do not make provisions for independent evaluation of potential donors (Health Action International 2001).

For governments of developing countries GPPIs offer the opportunity to obtain funds to finance their health care system. Procedures to obtain these funds are usually short and money is available much more quickly than is the case with other international or national funds, because procedures can be less

bureaucratic. The newly elected Dutch government attaches great importance to the role of the private sector in international collaboration and is involved in a number of GPPIs as a donor.

The participation of private enterprises in global initiatives is a reflection of their increasing power at the world stage. For them, GPPIs offer the opportunity to assist in solving the major health problems in this world, and to present themselves as corporate socially responsible companies. This corporate social responsibility (CSR) is a frequently debated issue. Several companies such as Heineken have set up HIV/AIDS programmes for its workers in a number of African countries, while others are participating in GPPIs. According to critics, companies 'use these partnerships as a marketing and public relations device' (Richter 2002), or have purely economic reasons for their involvement in health. This has nothing to do with CSR behaviour.

According to Wemos it is important to obtain insight into the motives and role of the corporate sector in GPPIs and we will continue to stress the importance of accountability. Besides this, it is necessary to develop internationally agreed standards of CSR behaviour, with companies' involvement, and to ensure that corporations comply with them.

Wemos is convinced that an integrated approach to health is the only way to reach health for all. Do GPPIs fit in this approach? This question still needs to be answered, and thorough research is needed. Various articles highlight the following risks:

1) lack of transparency on how decisions are taken and who is responsible for the implementation of the GPPI
2) the recipient's attempts to please the donor when applying for funds instead of focusing on their own health policy priorities
3) the influence of the recipient country in the design of the GPPI
4) the absorbing of scarce resources by national governments, for example, for the distribution of vaccines provided through a GPPI.

If well designed, these initiatives may lead to improved health care systems. However, if these GPPIs do not comply with the criteria mentioned under the project purpose, they may result in a large number of different initiatives leading to an even more fragmented care serving only small segments of the population. These possible distorting effects of GPPIs on national health systems are a concern, and it is the duty of civil society to remind the states and the WHO of their obligation as stated in the general comment.

Expected results and indicators

In- depth case studies have been conducted in three countries by at least six NGOs on the effects of GPPIs on national health systems.

Indicators:

- TOR for the case studies have been developed
- three reports of the cases studies are available and summary recommendations formulated
- information from the case studies is used for lobby purposes
- information is used on websites and in articles.

A well informed group of at least six NGOs is formed, working closely on all aspects of the project.

Indicators:

- the group develops joint lobby papers and implements a joint lobby strategy for national and international lobbying
- several trainings on GPPIs and health and on capacity strengthening in lobbying have been organized
- information about 12 GPPIs is collected and exchanged and the CSR debates and discussions are followed

- detailed knowledge is available about health systems in the countries where the case studies take place
- at least one participant in the network has a gender-specific approach and makes its knowledge available for other participants within the network.

National policy and decision makers in the participating countries are aware of the case studies and developed a position based on the outcomes of the case studies.
Indicators:
- they accept and/or initiate dialogue with the NGO representatives
- they voice their opinion related to the outcome of the case studies in their deliberations around the GPPIs and national health systems
- they reflect their opinion in their participation at the WHA by making a statement coherent with the dialogues with NGOs.

The WHO staff is aware of the projects results and takes them into account in the staff deliberations on GPPIs.
Indicators:
- the WHA 2005 allows for presentation of the case studies results in a workshop in which WHO staff is involved
- dialogue with relevant WHO staff at head quarters is ongoing
- dialogue with WHO staff at national/local level is ongoing.

At the national level in the countries where the case studies will be conducted and in the Netherlands, health professionals have a better understanding of the consequences of GPPIs for national health systems.
Indicators for the Dutch campaign:
- number of health professionals reached
- participants in the event
- financial contributions to the campaign
- increasing number of visits to the Wemos website.

Indicators for awareness-raising work by Southern partners:
To be defined by partners in their work plans.

Strategy

Lobby and advocacy

Since this is a new project, the first eighteen months will be used to work towards common lobby positions and strategy, based on the acquired general information (WHO, board of GPPI) and specific information derived from the case studies. The project can only be successful in its lobbying if the evidence for it is systematically gathered and based on a common position of all project partners. The project will work from a team-spirit with Northern and Southern partners. The content of the lobby will be guided by the analyses of the general debates and events and results from the case studies. The focus of the lobby will always be linked to the effects of GPPIs on the national health systems and the realization of the right to health. Do they make a contribution to integral national health systems? If not: how can they be developed in order to support integral national health systems? Do they increase the enjoyment of the right to health for men and women equally?

This lobby position will highlight to what extent GPPIs are effective, sustainable, empowering, accountable, non-discriminatory, participatory, and integral. Emphasis in the lobby will also be placed on the importance of co-ordination of the large number of different international initiatives. The lobby

will be directed towards influential players at national and international decision-making levels, such as politicians and the higher civil servants levels in the participating countries, the European Union, GPPI boards and the WHO. It will also consist of contacts with other UN bodies involved in GPPIs.

Knowledge gathering

Information will be systematically gathered and analysed on national health policies and health systems in the participating countries, on policies of the WHO and other relevant UN bodies regarding GPPIs, on the policies of private actors in GPPIs and on the consequence of GPPIs for people's access to health, with a special focus on access of women. This information will be obtained:

- through contacts with government representatives and WHO officials
- by collecting articles, reports and studies from relevant international bodies, universities and NGOs.
- during international meetings, events and seminars
- from the results of the case studies conducted in the participating countries.

More specifically, information will be collected about the 12 GPPIs in which the WHO is involved. Background documents as well as other sources will be used, for example, WHO Guidelines, the WHO internations documents about relations with private-for- profit partners. Attendance at the debates at the World Health Assembly and the Executive board meetings of the WHO will be important in collecting information and building links with WHO staff. The outcomes of the GPPIs board meetings and the interviews with some of the stakeholders will provide additional information from people closely involved in the issue. The compiled information will be shared between all project partners (through e-mail and websites) and used as a flow of information to keep the project staff updated and the network involved in the project's activities.

Southern partners and capacity strengthening

Closely working with representatives from different continents can be fruitful and inspirational for all. Through the consultations with a few partners with whom Wemos has worked for a couple of years, it became clear that such a model is effective and satisfactory to all. In this project, between six to10 partners (in three countries and the Netherlands) will participate: two in each country, who are assisted by an expert. These partners must therefore be located in countries where the GPPIs under study are implemented. The Netherlands will be approached as a donor country and is therefore an important player and policy setter.

The Southern partners and Wemos together, will form the core group of the project. Some experts from universities in the South as well as in the Netherlands will be asked for advice and guidance in the research indicators and assist in design, implementation and interpretation of the case study. In collaboration with experts in the area of international health issues they will form the advisory board of the project. In each of the three Southern countries and in the Netherlands such a board will be formed.

In one country, two organizations will assess the impact of one or two GPPIs. These GPPIs will also be investigated in two other countries (in a different continent), by two organizations. Through this system, the two partners in a country will support each other. The South-South exchange will be encouraged through regular e-mails and conference calls. A form of communication which is working for all will be developed. This will guarantee similar approaches in the different countries. Field visits will take place at least once every six months. In each of the countries the effects of GPPIs on the national health systems will be closely followed and will be used as input for the lobby.

Wemos and its Southern partners will:

- work towards capacitating each other and establish a division of roles based on specifics in condition and location
- put in place a system to check progress, based on agreements between all project partners

- all project partners will be members of national regional/international networks and therefore can disseminate the information. These partners will be members from networks such as IPHC, PHM, HAI, Consumers International (CI), the Women's Global Network on Reproductive Rights (WGNRR), and others. At least two of the partners have expertise in gender issues which will serve as an input provider for the other organizations.

So far one current partner has shown interest in participating in the project. Discussions with this partner on further selection are ongoing. Since this project is just taking off, and selection of good partners is essential for the results, that part of the work is described as one of the crucial activities to start with. For Wemos itself and the Southern partners the aspect of strengthening each other's capacity is of crucial importance. The project's work should lead to more credibility for all NGOs involved and has an added value at least at the national level. For all NGOs the knowledge obtained will increase its expertise in the area of health.

Collaboration with other organizations and networks

Wemos will continue its collaboration with Cordaid and Farmacie Mondiaal in the dialogue with Nefarma (the umbrella organization of research-based pharmaceutical companies in the Netherlands). Wemos will also continue its activities in the platform of NGOs working on CRS issues and will follow the debates in the Netherlands and elsewhere. In November 2002 a seminar is organized about public-private collaboration in health in which a number of organizations will sit together to discuss the risks and opportunities of GPPIs.

At the European level Wemos will continue to participate in the European health consortium with Difam from Germany and Prosalus from Spain. This consortium can provide the European link of the project. Discussions about the form of collaboration will be concluded in 2002.

Some of the NGOs in international networks of which Wemos is a member are also interested in the issue of GPPIs. Further links will be established with these organizations and networks.

Awareness raising and campaigning in the Netherlands

The project team will inform Dutch health professionals about the possible consequences of GPPIs on national health systems through the Wemos newsletter and website. Articles will also be written and workshops will be organized. Joint activities with the platform of NGOs in the Netherlands working on CSR are also a possibility to inform a wider audience.

The assessment process will lead to a Wemos campaign which will take place in 2005. Dutch health professionals will get insight into the trend to secure access to certain parts of health care through GPPIs and its effect on overall health policies. Through the case studies of the consequences of a GPPI in different countries, the advantages and risks will be presented in an accessible and action oriented manner.

Activities

Lobby and advocacy

- preparatory meetings with national delegates for the WHA and WHA EB 2003-2005
- establish and maintain contacts with WHO and UN staff and government officials
- prepare position papers and develop lobbying messages based on case studies
- organize workshop at the WHA -2004/2005
- prepare common positions for the WHA, PPI board meetings.

Knowledge gathering

- gather and analyze information on health policies in respective Southern countries

- gather and analyze information on 12 GPPIs
- gather and analyze information on CSR in the Netherlands and Europe
- investigate the health policy in three Southern countries
- analyze outcomes of WHA and EB for its impact on the GPPIs processes
- analyze outcomes of case studies
- discuss GPPIs with experts from universities
- gain knowledge about specific consequences of GPPIs for access to health of women

Collaboration with Southern partners and capacity strengthening

- select new Southern partner's
- work visits to participating countries
- select regions in the participating countries for case studies
- develop method for the studies based on the seven criteria
- develop electronic method for easy communication; organize chats, conference calls
- select members for project advisory board
- organize regional conferences in the South for sharing results in three regions
- write report on case studies with the Southern partners
- organize training on GPPIs and on capacity strengthening based on partners' needs.

Collaboration with other NGO, networks and institutes

- dialogue with partners at the national level and Nefarma
- participate and/or organize EU meetings with consortium partners
- link up with the broader networks IPHC, HAI and women's and health organizations
- seek advice from experts and form national advisory boards
- organize bi-monthly advisory board meetings
- select and interview GPPI stakeholders government officials.

Awareness raising and campaigning in the Netherlands

- publish articles in the press and media, including international
- develop a leaflet about GPPIs and health
- continuous update of website
- participate in fairs with booth, materials and messages from the project
- speak at events covering broader health issues
- organize campaign year, with several highlights and campaign day (2005)
- organize workshops in the Netherlands.

L-2 Lib

L-2.

Subject: Fw: restrictions to foe
Date: Sun, 12 Mar 2000 13:11:59 +0530
From: "Pradeep Joshi" <pjoshi@giasdl01.vsnl.net.in>
To: <il-rti@ilban.ernet.in>

-----Original Message-----
From: Maja Daruwala <majadhun@giasdl01.vsnl.net.in>
To: CHRI INDIA <chriall@giasdl01.vsnl.net.in>; Abha Joshi <abha@vsnl.com>
Date: Saturday, March 11, 2000 3:38 PM
Subject: FW: restrictions to foe

STEPH AND ABHA DO YOU THINK THIS IS SOMETHING WE CAN JOIN ART 19 ON?md

> -----Original Message-----
> From: debra@oln.comlink.apc.org [mailto:debra@oln.comlink.apc.org]
> Sent: 10 March 2000 11:32
> To: majadhun@giasdl01.vsnl.net.in
> Subject: TZA: restrictions to foe
>
>
> Edited/Distributed by HURINet - The Human Rights Information Network
> ---
> ## author : ifex@web.apc.org
> ## date : 28.01.00
> ---
> IFEX- News from the international freedom of expression community
> _____
> PRESS RELEASE - TANZANIA (ZANZIBAR)
>
> 26 January 2000
>
> Zanzibar treason trials challenged; call for removal of
> restrictions to freedom of expression
>
> SOURCE: ARTICLE 19, London
>
> (ARTICLE 19/IFEX) - The following is an ARTICLE 19 press
> release:
>
> 26 January 2000 - for immediate release
>
> ZANZIBAR TREASON TRIALS CHALLENGED BY INTERNATIONAL RIGHTS
> GROUP
>
> As the politically-motivated treason trial of 18 members of
> the Civic United Front (CUF) resumes in Zanzibar on Thursday
> 27 January, ARTICLE 19, The International Centre Against
> Censorship, adds its voice to those calling for the
> immediate and unconditional release of the defendants and an
> end to official harassment against the political

lib - human rights

To 14/3

1547

13/3 To TN

> opposition.1
>
> A court hearing of this case last week saw a heavy police
> crackdown against demonstrators, with at least 40 people
> arrested. There were also house-to-house searches for
> others, including raids on the homes of CUF public office
> holders. ARTICLE 19 today cautioned that international
> efforts to end the long-running political crisis before this
> year's elections will fail unless the authorities change
> their approach.
>
> Andrew Puddephatt, Executive Director of ARTICLE 19 said:
>
> "The Attorney-General of Zanzibar has had over two years to
> investigate the alleged offences of these CUF members and
> prepare the case against them. Instead, the authorities have
> repeatedly requested adjournments. It is becoming obvious
> that the government is spinning out the trial process in
> order to deny the accused, who include four members of the
> House of Representatives, the right to participate in the
> general elections in October."
>
> The trial arises out of the CUF's initial refusal to
> recognise the results of the very closely contested 1995
> elections in Zanzibar - elections which were also questioned
> internationally. To break the political deadlock which
> resulted, the Commonwealth brokered discussions which led to
> an agreement in April 1999. Under the terms of the
> agreement, the ruling Chama Cha Mapinduzi (CCM) and CUF
> agreed to work out a process of reforms which would build
> respect for human rights and lay the groundwork for
> elections in 2000 where the outcome was recognised and
> respected by all parties. To date, progress on the terms has
> been slow.
>
> Mr Puddephatt added:
>
> "It is urgent that diplomatic efforts are intensified to
> ensure rapid implementation of the reform process. Essential
> steps towards this are an end to these politically-motivated
> trials, and recognition by the authorities that citizens
> have a right to freedom of association and peaceful
> protest."
>
> ARTICLE 19 is also calling for reform of the Constitution
> and archaic laws which restrict freedom of expression as
> part of a wider package of measures to ensure that Zanzibar
> fully upholds its obligations under international law.
>
> Contact: Rotimi Sankore on +44 20 7278 9292 or
> press@article19.org

Pondicherry Declaration on Health Rights and Responsibilities

This consensus statement was adopted by the participants attending a workshop on "Medicine, Media and Consumer Education" held in Pondicherry, India December 1-4, 1993. Thirty participants from 3 countries attended the workshop organised by the Educators for Quality Update of Indian Physicians with the support of the International Organisation of Consumers Unions.

THIS WORKSHOP EVOLVED THE FOLLOWING GUIDING PRINCIPLES

- the work of rational drug use groups should be expanded to include diagnostics and non-drug therapy.
- the concept of continuity of care through the family physician should be encouraged by consumer education and medical education.
- a Charter of Patients' Rights and Responsibilities should be widely adopted by professional and consumer groups.

1. We call on CENTRAL AND STATE GOVERNMENTS to:

1.1 bring all the issues pertaining to drugs under the purview of Ministry of Health and Family Welfare;

1.2 enunciate and effectively implement rational drug policy;

1.3 promote the concept of essential drugs and ensure their availability at affordable cost;

1.4 promote the use of generic names of drugs;

1.5 regulate and monitor all promotional measures and advertising materials;

1.6 establish a National Drug Authority of India consisting of governmental, non-governmental organisations as well as professionals bodies;

1.7 establish and support a drug information and usage monitoring system to facilitate and implement an effective rational drug policy. This should include systems for monitoring adverse drug reactions;

1.8 integrate the concept of rational drug use, including drug information into health and medical education;

1.9 introduce within the formal and non-formal educational system information on health-related issues;

1.10 promulgate the charter of patients rights and responsibilities and physicians' rights and responsibilities.

2. We call on HEALTH PROFESSIONALS to:

2.1 adopt an holistic approach to health care;

2.2 develop two way linkages between different levels of health care;

2.3 promote prudent use of diagnostic aids and therapy;

2.4 endorse and respect the charter of patients rights;

2.5 acquire communication skills to interact with patients; the mass media and the public;

2.6 periodically update their professional knowledge and improve their skills.

3. We call on PROFESSIONAL GROUPS, NON-GOVERNMENTAL and VOLUNTARY ORGANISATIONS to:

3.1 promote the adoption of a charter of patients' rights and responsibilities;

3.2 establish networks at all levels in order to facilitate health information, communication and education;

3.3 encourage multi- and inter-disciplinary research on health related issues;

3.4 facilitate periodic updates for health knowledge.

4. We call on the MASS MEDIA to:

4.1 recognise their far-reaching influence on the level of public awareness and assume a more active and responsible role in informing the public on health issues;

4.2 use a resource network of competent health experts to ensure objective and balanced reporting of health issues;

4.3 establish regular communication with health professionals and consumer groups;

4.4 participate in the screening of advertisements on health-related issues for unsubstantiated claims and unethical promotion;

5. We call on the HEALTH AND PHARMACEUTICAL INDUSTRY to:

5.1 develop and enforce code of marketing, promotion and dissemination of information in participation with governmental and non-governmental organisations;

5.2 recognise their social responsibility to the public with regard not only to the safety and efficacy of their products and services but also to their cost and societal impact and to devise and to disseminate health information accordingly.

PATIENT'S RIGHTS AND RESPONSIBILITIES

PART 1: PATIENT'S RIGHTS:

Section 1: RIGHT TO HEALTH CARE AND HUMANE TREATMENT:—

1. Every individual shall have access to adequate and appropriate health care and treatment.
2. Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind.
3. A patient has the right to be treated by fully qualified health care professionals in private or public health care facilities.
4. A patient has, wherever possible, the right to be treated at a hospital of his choice and to be referred to a consultant of his choice.
5. Every individual shall have the right to prompt emergency treatment from the nearest government or private medical and health facility.
6. Patients have the right to humane terminal care and to die in dignity.
7. A patient can be transferred to another health care establishment only after an explanation of the need for this transfer and after the other establishment has accepted the patient.
8. A patient has the right to have all identifying information, results of investigations, details of his condition and his treatment kept confidential and not made available to anyone else without his consent.

Section 2: CONSENT:—

1. Before any treatment or investigation, a patient shall have the right to a clear, concise explanation in lay terms of the proposed procedure and of any available alternative procedure. Where applicable, the explanation shall include information on risks, side effects, or after-effects, problems relating to recuperation, likelihood of success, and risk of death. Informed consent of the patient must be obtained prior to the conduct of a treatment or a procedure. In the case of a minor, consent has to be obtained from the parent or guardian. If a patient is incapacitated and any delay would be dangerous, a doctor is entitled to carry out any necessary treatment or operation after a second opinion is obtained.
2. A patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his decision.
3. Explicit, informed consent is a prerequisite for participation in scientific experimentation. Experimentation must not be carried out on any patient who is unable to express his will.

Section 3: RIGHT TO INFORMATION:—

1. Information about health services (including recent developments in the field) and how best to use them is to be made available to the public in order to benefit all those concerned.
2. Information may be withheld from patients in cases where there is good reason to believe that this information would [illegible] the patient's health adversely but, however, the information must be given to a responsible relative.
3. A patient has the right to know the identity and the professional status of the individuals providing service to the patient and to know which professional is primarily responsible for the patient's care.
4. Patients should have the right to seek a second opinion from another physician.
5. Patients should upon request, be able to obtain a copy of a summary of their diagnosis, treatment and care including diagnostic results on discharge from a hospital or other establishment. They shall also have the right to authorise another medical professional to obtain a copy of the same and to inform the patient of the contents.
6. A patient shall have the right to examine and receive an explanation of his bill after any treatment and consultation.

Section 4: THE RIGHT TO ADEQUATE PRESCRIBING INFORMATION:—

1. While prescribing medication, the patient shall be informed about the following:—
   Expected outcome, adverse and after effects, chances of success, risks, cost and availability.
2. All drugs dispensed shall be of acceptable standards in terms of quality, efficacy and safety.
3. All medicines shall be labelled and shall include the pharmacological name of the medicine.

Section 5: RIGHT TO REDRESS GRIEVANCES:—

1. A patient shall have access to appropriate redressal procedures.
2. A patient shall have the right to legal advice as regards any malpractice by the hospital, the hospital staff or by a doctor or other health professional.

Section 6: RIGHT TO HEALTH EDUCATION:—

1. Every individual shall have the right to seek and obtain advice with regard to preventive and curative medicine, after care and good health.

PART 2: PATIENT'S RESPONSIBILITIES:

1. The patient shall ensure that he or she knows and understands what a patient's rights are and shall exercise those rights responsibly and reasonably.
2. The patient shall ensure that he or she understands the purpose and cost of any proposed investigation or treatment before deciding to accept it.
3. The patient shall accept all the consequences of the his/her own informed decisions.
4. The patient shall provide accurate and complete information which the health professional requires about his or her health and ability to pay for health services.
5. The patient shall establish a stable relationship with and follow the treatment determined by the health professional primarily responsible for the patient's care.
6. The patient shall inform the health professional if he or she is currently consulting with or under the care of another health professional in connection with the same complaint or any other complaint.

7. The patient shall so conduct himself or herself so as not to interfere with the well being or rights of other patients or providers of health care.
8. Every individual has a responsibility to maintain his or her own health and that of society by refraining from indulging in high risk behaviour detrimental to health.
9. Every individual has a responsibility to accept all preventive measures sanctioned by law.

*

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Chairman

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(Attn:C.H.SHASHINDRAN)

PONDICHERRY DECLARATION ON HEALTH RIGHTS AND RESPONSIBILITIES

EQUIP-IOCU WORKSHOP ON
MEDICINE, MEDIA and
CONSUMER EDUCATION'
DEC 1-4, 1993, PONDICHERRY, INDIA