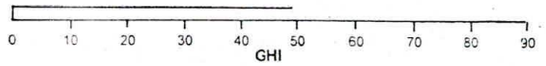

...Gender related health Index (GHI) is a simple average of the indices which measure the male-female gap in education, infant mortality and expectation of life at birth. On a 0 to 100 scale, it varies from 89 in Kerala to 34 in M.P., with the India Index for being 49. This is similar to gender related development index (GDI) of UN, but gives more weight to health than UN's index since IMR differential is reflected in life expectancy also..

...The high correlation of TFR with GHI and HDI indicates that higher the human development and gender related health development lower will be the fertility. In other words, efforts to promote human development and gender development will contribute to reduction in fertility...

States	Population, 1991 (000)	Women in Reproductive age group 1991(000)	Percent Urban 1991	Sex Ratio 1991 (F/M)	Birth Rate 1994	Death Rate 1994	Total Fertility Rate, 1993	Middle School Enrolment Ratio 1993			Adult literacy rate, (15+), 1991			Infant Mortality Rate, 1993			Expectation of life at birth, 1989-93			Per Capita SDP, 1993	Couple Protection Rate, 1993	Birth Order (4+) 1993	Birth Interval (36+) 1993	Medical Attention at Birth, 1993	
								Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons					Inst.	Tr. Prof
India	846,303	200,743	26.1	927	28.6	9.2	3.5	69.6	47.9	59.1	62.4	33.9	48.7	73	75	74	59.0	59.7	59.3	6255	43.5	23.5	32.0	24.5	24.3
Andhra Pradesh	66,508	16,513	26.9	972	23.7	8.3	2.7	58.3	39.9	56.0	52.4	27.3	40.1	78	57	64	59.5	61.5	60.5	5718	45.3	12.1	35.7	38.1	24.8
Assam	22,414	5,202	11.1	923	30.7	9.1	3.3	57.9	48.6	53.4	62.4	33.9	49.4	81	81	81	54.6	55.3	54.9	5310	25.2	25.1	33.6	18.4	13.1
Bihar	86,374	19,244	13.1	911	32.5	10.4	4.6	45.4	19.9	32.9	55.3	18.2	38.7	68	72	70	59.7	57.2	58.5	3084	24.0	33.7	40.8	11.9	16.0
Gujarat	41,310	10,277	34.5	934	27.1	8.7	3.2	78.3	56.7	67.7	70.4	41.8	56.7	58	58	58	59.0	61.1	60.0	7175	54.5	18.1	27.5	24.8	35.6
Haryana	16,464	3,640	24.6	865	30.5	7.8	3.7	77.8	58.4	68.6	64.3	27.0	49.9	68	73	66	62.5	63.7	63.1	9171	52.7	21.9	20.6	21.8	64.7
Himachal Pradesh	5,171	1,320	8.7	976	26.2	8.6	2.8	115.9	85.6	100.0	64	35.5	50.9	72	53	63	63.6	63.6	63.6	5979	56.5	13.1	21.0	22.1	24.7
Karnataka	44,977	11,118	30.9	960	24.9	8.1	2.9	74.2	59.3	67.0	65.3	37.7	52.2	68	66	67	60.2	63.5	61.8	6443	48.2	19.7	24.6	42.8	25.3
Kerala	29,099	8,106	26.4	1036	17.3	6.0	1.7	100.6	100.5	100.6	91.7	80.6	86.0	16	10	13	68.8	74.7	71.8	5768	53.4	6.5	45.5	92.3	5.5
Madhya Pradesh	66,181	15,221	23.2	931	32.8	11.5	4.2	69.4	39.4	55.0	56.6	24.3	41.8	106	106	106	54.1	53.8	54.0	4733	37.9	25.7	28.7	13.5	14.6
Maharashtra	78,937	19,134	38.7	934	24.9	7.4	2.9	89.7	73.0	81.6	74.4	44.2	60.3	50	50	50	63.0	65.4	64.2	9628	53.2	18.9	32.2	36.8	16.3
Orissa	31,660	7,715	13.4	971	28.0	11.1	3.1	61.8	38.7	50.0	62.5	29.0	46.4	118	101	110	55.7	55.3	55.5	4097	38.1	24.4	31.2	11.8	19.6
Punjab	20,282	4,853	29.6	882	25.0	7.6	3.0	69.9	61.0	65.6	60.5	41.8	51.8	49	62	55	65.2	67.6	66.3	11106	70.9	17.3	23.2	8.3	89.4
Rajasthan	44,006	9,738	22.9	910	33.7	8.9	4.5	67.8	23.4	46.2	52.7	17.5	36.1	82	81	82	57.4	58.5	57.9	5086	29.3	27.2	20.3	5.2	19.7
Tamil Nadu	55,859	14,986	34.2	974	19.0	7.9	2.1	113.5	92.7	103.4	65.0	35.8	50.6	57	56	57	61.4	63.4	62.4	6663	54.5	9.2	31.0	61.3	19.1
Uttar Pradesh	139,112	30,242	19.8	879	35.4	11.0	5.2	60.5	31.3	46.6	53.6	20.6	38.4	87	100	93	56.5	55.1	55.8	4273	33.2	34.8	30.7	5.3	29.4
West Bengal	68,078	16,277	27.5	917	25.1	8.3	3.0	60.6	45.2	53.1	69.3	42.8	57.1	57	59	58	60.8	62.3	61.5	5775	34.3	24.0	35.4	31.2	11.3

A. - Not Available Source : Enrolment Ratio - Sixth All India Educational Survey, 1993; Estimates of Adult Literacy Rate based on 1991 Census are not yet available. The Estimates are as prepared by Mr. A.K. Shiva Kumar, EPW, April, 1996, by applying the proportion of adult li onomic Survey, 1996; Reproductive Health Index etc. - Population Foundation of India, 1996; Other Cols. - Office of the Registrar Gen ral, India; The projected population figures are provisional; CPR - Ministry of Health and Family Welfare.

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Madhya Pradesh

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INSTITUTE OF HEALTH & COMPARITIVE MEDICINE, YOGA THERAPY CENTRE

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Forum Interview

Ethics and health

Zbigniew Bankowski

World Health Forum *asked Dr Eilif Liisberg to talk to Professor Bankowski, Secretary-General of the Council for International Organizations of Medical Sciences (CIOMS), about the ethical considerations that have guided the development of medicine and public health and about their place in today's society.*

Professor Bankowski, medical ethics has been largely dominated by the Hippocratic Oath. What were its basic principles, and are they still valid in modern society?

In my opinion the Hippocratic Oath, although formulated about 2400 years ago, will be pertinent for a long time to come. The Oath itself is a very short statement and nobody knows who really wrote it; it is probably based on writings by Hippocrates and others, so I would prefer to refer to the writings rather than the Oath alone. The Hippocratic writings placed certain obligations on doctors, such as beneficence, non-maleficence, and confidentiality, as well as some prohibitions – for example, those against euthanasia – which are still followed today.

Perhaps at this stage we should define what we mean by ethics, as this is important for the rest of our discussion.

Ethics is a branch of philosophy dealing with the distinction between right and wrong, and the moral consequences of our actions. Nearly all philosophical systems include an ethical component. We in CIOMS look at ethics from this same viewpoint of right and wrong. Then immediately other questions arise: right and wrong for whom? where? and when? Those who support relativism in ethics say it depends mainly on the circumstances, whereas others hold the view that a moral ethical principle has universal value.

In some cultures there is emphasis on the family and the wider circle beyond the individual. Do the Hippocratic writings have a different connotation in different societies?

Looking at the development of medical ethics from a historical point of view, we see that our Western civilization is based on Graeco-Roman and Judeo-Christian traditions. Our so-called Western culture is unified by these common roots, which for medical ethics are the Hippocratic writings. Other cultures have different roots – the Chinese and Hindu traditions, for example. The limited contacts between civilizations in the past had little effect on each one's traditions, culture, and ethical principles. Recent intercultural debates about ethical issues immediately bring to light these differences.

Dr Liisberg, an international public health consultant, was previously Editor of *World Health Forum*. His address is 43 avenue du Lignon, 1219 Le Lignon, Geneva, Switzerland

Have any of the other ethical principles been codified? In Chinese medicine, for example?

Not as far as I know. I am in close contact with the Chinese medical profession and they are very interested to know how we codify our ethical guidelines, and are considering developing ethical principles adequate for the needs of their society. For example, the principles of informed consent and natural rights are valued differently, compared with Western culture, but this does not mean that China has no ethical rules – it certainly has!

Do you think it is possible to have a set of basic, universally accepted principles in ethics?

My personal opinion is that, at present, we are not ready to try to develop a universal code of ethics – not specifically health or medical ethics, but just ethics broadly speaking. It may take centuries to reach such a consensus. Still, there are already some principles which are universally recognized. In most animal societies it is a basic principle not to kill another of its species. This is a biological instinct and, as we are animals, the principle applies to us too, though it is not accorded the same importance by all human societies.

In the field of ethics, as with any controversial issue in society or between different cultural settings, dialogue must come first to share ideas and concerns about the issues inherent in the interaction of health and ethics, and to collaborate in devising and applying means of resolving them.

A great step forward has been the Universal Declaration of Human Rights which was developed by the United Nations after the Second World War. Human rights are universal in the sense that society accepts them as such, despite cultural differences in that what

Professor Zbigniew Bankowski was born in Warsaw, Poland, in 1925 and is a naturalized Swiss citizen. His medical education and postgraduate studies were completed in Poland where he acquired his M.D. and Ph.D. at the Faculty of Medicine, Lublin. He has held several teaching and research positions in experimental pathology in the Polish universities of Lublin, Lodz and Warsaw as well as in Paris and Tunis. Between 1965 and 1972 he was responsible for the coordination of research and training programmes of the World Health Organization, Geneva. Since 1975 he has been Secretary-General of the Council for International Organizations of Medical Sciences (CIOMS), Geneva, Switzerland. He is the author of many scientific papers in the fields of radiobiology and cancer and numerous articles and reviews dealing with bioethics, drug safety, and medical terminology.

is a high priority in one society may be less important in another. Although it is certainly feasible to develop a universal code of ethics, there are substantial differences in values that are dear to each of us, and we do not like others to interfere. In the field of ethics, as with any controversial issue in society or between different cultural settings, dialogue must come first to share ideas and concerns about the issues inherent in the interaction of health and ethics, and to collaborate in devising and applying means of resolving them. CIOMS always encourages long debate along ethical lines before starting to draw up any normative guidelines.

An economist in Copenhagen once said in the **Forum** *that there was a contradiction in the doctors' role to do their best for individual patients and their social responsibility to promote the common good (1). What do you think about this dilemma?*

This is a typical example of the conflict that exists in ethical thinking, between the interests and rights of the individual and the interests

and rights of the community. The interests of individuals do not necessarily coincide with those of the community – very often the interests of the community are contrary to those of the individual. Such conflict exists and needs to be considered from all points of view to see if it is possible to work out a compromise.

In health ethics, as with any ethical problem, the first step is to initiate dialogue, to try to understand what others are saying in order to find a common denominator. I don't agree with the relativist position that there are different ethics: basic ethical principles are the same for all, but the problem is that it means different things to different people. If decisions about health in the community are taken by politicians and others, then the medical profession has to say forcefully that it has always been guided by ethical principles. Medical ethics is at the root of the Hippocratic writings, and we in our particular society are obliged to follow this same ethical code.

So you see the doctor as one who defends the rights of his patients as individuals.

Yes! Doctors have a very special relationship with their patients: the patient comes to the doctor in full confidence that he or she will be helped; that creates a strong, intimate relationship between doctor and patient, whether it is one person, a family, or a small community group.

Doctors have sometimes found themselves in difficult situations, such as assisting in capital punishment or certifying that a person can tolerate physical maltreatment or torture.

There is a UN Convention against torture to which CIOMS contributed: we were requested by WHO to draw up a code of ethics for health personnel who might find themselves involved in torture or maltreatment of prisoners. It was a very controversial issue and necessitated a long study. CIOMS evolved six principles which were presented by WHO to the United Nations; these were adopted and included in the Convention. They postulate that physicians and other health workers are professionally trained solely to maintain or improve the health of those for whom they exercise professional responsibility, and that it is unethical to use their professional skills to allow any action that may harm physical or mental health. Of course, it is easier for physicians to take a decision in line with their individual conscience in a democratic society; in a totalitarian one, a refusal to do what was asked could very easily put them in danger. The Convention came into effect only after two-thirds of the Member States of the UN had signed it but the UN has very little authority to enforce it. However, it does exist and is there for anybody to refer to as an international legal instrument.

Conflicts in medicine are inevitable when one cannot satisfy the needs of all who suffer.

As for the involvement of medical personnel in the execution of a death sentence, I should perhaps mention that the leading organization for medical ethics is the World Medical Association. The Association has developed a very sensitive and well-elaborated declaration and code of ethics which condemns the participation of physicians in capital punishment.

Would you say that the Nuremberg trials of war criminals after the Second World War were a major breakthrough for ethical principles?

Certainly, as far as Europe and North America are concerned. The atrocities which

were committed shook our consciences. The Nuremberg trials and the code which was developed on this occasion with the involvement of the medical profession are an extremely important milestone. The Nuremberg Code is the origin of informed consent and is based on the ethical principle of autonomy. At first it was related only to experimental research on human subjects and now, as you know, it is integrated into medical practice. But there is no doubt that this is a product of our culture: informed consent is not always applicable in other circumstances. For example, in Africa a patient expects the doctor to decide for him, and in Japan the patient may not be told the results of investigations or the diagnosis.

> **We should not forget that in our everyday lives we all have ethical choices — between what is good and what is wrong.**

Can you explain the origin of the word "bioethics"?

Although at CIOMS we are resisting the tendency to create new words, bioethics does seem to have become a generally accepted term. It was coined in the early 1960s in the USA when there were many more people with renal failure than dialysis machines available, so doctors were obliged to take difficult decisions about allocating treatment. Thus, bioethics was introduced as a response to the tremendous scientific and technological developments which created new situations for doctors with regard to their patients.

And health-policy ethics?

Health-policy ethics may be seen as an aspect of bioethics concerned particularly with the organization, financing and delivery of health care; it is a concept developed by CIOMS within the framework of its International Dialogue on Health Policy, Ethics and Human Values. Let me tell you how this came about. In 1983 and 1984 the World Health Assembly debated whether a spiritual dimension should be introduced into all health programmes coordinated by WHO. There was much discussion involving politics and religion so that the issues became blurred. I discussed it afterwards with Dr Halfdan Mahler, who was at that time Director-General of WHO, and I suggested that CIOMS could take up the subject. This was the origin of our programme of health policy, ethics and human values. Professor Jack Bryant was a key collaborator in initiating dialogue on this programme internationally.

Nowadays there is a lot of talk about training in ethics. Looking back to my days in medical school I remember we were just supposed to imitate the way our professors and other doctors behaved. Is it necessary to have special courses?

Several years ago UNESCO and WHO studied how ethics was being taught in medical schools: it was generally not obligatory in Europe, more widespread in the USA, and the developing countries usually followed the European lead. I believe we should sensitize the students – our future physicians – to all ethical issues. Many medical schools teach ethics in an integrated way as cases arise, and the professors are sensitive to the need to identify the related ethical question in clinical situations.

I think that's how we learned but we didn't know it was ethics!

Exactly, and that is the best way to teach the principles, without calling it ethics. The word itself creates mystery, being heavy with emotional overtones. We should not forget that in our everyday lives we all have ethical choices – between what is good and what is wrong.

Human rights and ethics

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."
(*Constitution of the World Health Organization*, 1946)

"The voluntary consent of the human subject is absolutely essential."
(*Nuremberg Code on Human Experimentation*, International Military Tribunal, 1946)

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."
(Article 25, item 1, *Universal Declaration of Human Rights*, 1948)

"The Declaration of Geneva of the World Medical Association binds the physician with the words, 'The health of my patient will be my first consideration', and the International Code of Medical Ethics declares 'A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient'."
(*World Medical Association Declaration of Helsinki*, 1964)

"All research involving human subjects should be conducted in accordance with three basic ethical principles, namely respect for persons, beneficence, and justice."
(*International Ethical Guidelines for Biomedical Research Involving Human Subjects*, CIOMS, 1993)

Ethics is directly related to our behaviour, and much more should be done to demystify it.

You once said that WHO had introduced a new principle in health ethics – the equity principle or the health-for-all strategy, which resulted from the 1978 Alma-Ata Conference. Could you explain its importance?

In the revolutionary health-for-all concept, "all" means all human beings. This statement of equity has a very strong ethical value behind it: the justice of distribution – that is, health services seen as something good which should be distributed to everyone. The fact that health for all is recognized worldwide and has tremendous influence in both developed and developing countries shows, in my opinion, the exceptional value of the World Health Organization from an ethical point of view.

Would you say that equity is a major target in health development?

Certainly on the global level, because it deals with mankind as a whole. The global approach for everyone's benefit is very important, and WHO's promotion of health for all has very strong ethical connotations.

Health Policy, Ethics and Human Values – An International Dialogue

Many, perhaps most, health policy decisions raise ethical questions. Different national, cultural and religious traditions yield different ethical value systems, and their interactions with health policy-making will therefore vary from country to country.

The CIOMS programme on Health Policy, Ethics and Human Values – An International Dialogue had its origin in the XVIIIth CIOMS international conference held in 1984 in Athens. The purpose of the conference was to discuss in an international and intercultural context the ethical questions raised by health policy-making and policy decisions.

The *health policy* of a nation or a community is its strategy for controlling and optimizing the social uses of the available medical knowledge and resources. *Human values* are the essential guides for people when choosing the goals, priorities and means for that strategy. *Ethics* is the link between health policy and human values. It examines the moral validity of the choices that must be made, seeks to resolve conflicts which inevitably occur when making choices, and orders the choices in accordance with accepted norms.

A strong recommendation of the Athens Conference was for a continuing international intercultural dialogue to improve understanding of the relationship between health policy-making, ethics and human values in different cultures. CIOMS implemented this recommendation through its programme, which had the following objectives:

- to strengthen national capacities for addressing and making decisions about the ethical and human-values issues involved in health policy;
- to contribute to improved understanding of the concepts inherent in WHO's goal of health for all, particularly in terms of its values content;
- to develop transcultural and transdisciplinary approaches and methods for working in this field;
- to use improved understanding of the approaches of various societies to the ethical and human-values aspects of health policy as a way to promote deeper human understanding of human values across cultural and political lines.

The main means for implementing this programme is the organization by CIOMS of international, intercultural conferences with a global orientation. Some regional conferences, not organized directly by CIOMS, were concerned with the interaction of health policy-making, ethics and human values in largely homogeneous cultures. During the last decade the following conferences were organized:

Health Policy, Ethics and Human Values – An International Dialogue, Athens, 1984;
Battered Children and Child Abuse, Berne, 1985;
Health Policy, Ethics and Human Values – Indian Perspectives, New Delhi, 1986;
Health Policy, Ethics and Human Values – European and North American Perspectives, Noordwijk, 1987;
Ethics and Human Values in Family Planning, Bangkok, 1988;
Health Policy, Ethics and Human Values: An Islamic Perspective, Cairo, 1988;
Health Technology Transfer – Whose Responsibility? Geneva, 1989;
Genetics, Ethics and Human Values: Human Genome Mapping, Genetic Screening and Gene Therapy, Tokyo and Inuyama City, 1990;
Ethics and Epidemiology: International Guidelines, Geneva, 1990;
Ethics and Research on Human Subjects: International Guidelines, Geneva, 1992;
Poverty, Vulnerability, the Value of Human Life, and the Emergence of Bioethics, Ixtapa, 1994.

Do you think that all health ministries now think in terms of equity when they analyse problems and prepare their interventions?

It is difficult for me to know this, but it seems there are two aspects. One is the development of guiding principles such as the health-for-all strategy. The other is its implementation. Policy decision-makers in many countries are certainly moving in the direction of extending services to those who have only limited or no access to existing services. It is obviously very difficult to provide health services to all human beings in the world, and the aims will vary according to what is feasible and necessary for different countries or societies. For me it is important to see WHO, as a UN specialized agency, working steadily to introduce equitable policies, following ethical and moral principles which are universally recognized. This is something which must not be forgotten.

How do you see WHO's role in the ongoing development of health ethics?

First of all I think it is important to continue what was started, namely, to continue to promote health for all – this is a unique role for WHO. The Organization is well placed to convince politicians and to stimulate the political will for translating this commitment into action. In my opinion WHO is doing this very well because there are continually new developments in global thinking in this field.

Another area is local action. "Think globally, act locally" was the slogan of World Health Day in 1990 about the environment; I have it displayed in my office as a reminder of the importance of different levels in discussion. Global thinking is health for all; local action depends on local circumstances, and must be adapted not only to varying economic, financial, historical and traditional situations but also to moral and ethical circumstances.

We are always urging that moral and ethical aspects should be taken into consideration in health policy-making, not just in order to prevent abuses but because we know from experience that some apparently excellent programmes were not implemented because society rejected them for moral or ethical reasons. It is important to discover why and try to find another way of presenting the proposals or make alternative ones. Cultural differences are central in international work: we should always keep in mind that people are different and we must endeavour to understand them.

The fact that health for all is recognized worldwide and has tremendous influence in both developed and developing countries shows the exceptional value of the World Health Organization from an ethical point of view.

I believe CIOMS, with WHO's cooperation, has recently evolved a global agenda for bioethics?

Yes, CIOMS's long-term programme on health policy, ethics and human values culminated in a conference held at Ixtapa, Mexico, in April 1994 on "Poverty, Vulnerability, the Value of Human Life and the Emergence of Bioethics". The participants requested CIOMS to draft a declaration on a global agenda for bioethics for adoption by the conference (see pages 123–124). Participants in the conference believed the time was ripe for the establishment of a global agenda for bioethics, and the Declaration of Ixtapa constitutes a first step in that direction. The world needs the moral affirmation and ethical guidance that such an agenda can bring to the health sector in all countries, and the participants at Ixtapa and CIOMS welcomed WHO's role as leader in the pursuit of such a goal.

Has the AIDS epidemic influenced the whole debate on ethics?

No doubt about it. The AIDS epidemic is stimulating everybody to do as much as possible to see that ethical values are respected. With a disease for which no adequate treatment exists, a diagnosis can be a death sentence for the patient. It was previously so with cancer. Now AIDS patients are in the same tragic situation. Top politicians are aware of the effects of this social problem and are looking for solutions which will be as ethically valid in the USA as in Africa. Such common ground is not easy to find.

Scientific progress in medicine and new developments in therapy and diagnosis will most likely continue in the so-called "developed" countries in Europe and elsewhere; but will these advances be applicable to the people living in the developing part of the world – more than 80% of our population? Often what is affordable by certain countries may not suit others. Take drug treatment for HIV/AIDS patients, for example. CIOMS was requested by the Global AIDS Programme to develop ethical guidelines relevant to the AIDS situation on a global basis. In order to develop the proper treatment and prevention strategies for AIDS you need to study the target populations, collect epidemiological information, and test potential vaccines and drugs. Intercultural differences may mean that approaches developed in Europe or North America are not easily acceptable in other countries, sometimes for political reasons, yet everything must be done according to ethical principles.

> ***Cultural differences are central in international work: we should always keep in mind that people are different and we must endeavour to understand them.***

In CIOMS in 1985 we saw that two aspects had to be addressed. The first was the formulation of ethical guidelines for epidemiological study: this is when you identify the problem and how the disease spreads, which is essential basic information. The second was concerning research involving human subjects: experimental vaccine testing, for example. The U.S. authorities were particularly keen for CIOMS to develop guidelines which would be internationally recognized. These two sets of CIOMS guidelines have been translated into many other languages and are now widely used *(2,3)*.

I am concerned that although universal rights have been formulated, less attention is paid to universal responsibilities.

It is true that if you say somebody has rights, then they also have responsibilities. These have not been defined up to now, but perhaps sets of responsibilities of human beings as a social group should be developed. Certainly many people are concerned by what is really needed now for mankind. Fifty years ago the development of human rights was first priority. That was followed by the rights of different categories of society – patients, women, children, etc. – which are good but, at the same time, there must also be responsibility. The constitution of many countries specifies its citizens' rights and also their responsibilities. In my opinion, this practice should be followed internationally.

Because of social obligations?

Exactly. This is the social aspect of ethics: it is about relations with other people. There is nowadays a strong trend to look at everything from the ethical point of view because increased mass media exposure brings us all closer to each other. Previously individuals just considered their families, then their villages, and then their countries, but now we

A global agenda for bioethics: summary of the Declaration of Ixtapa

- Bioethics in the health sector should be guided by the following generally accepted principles:
  - an adequate level of health care should be recognized as a universal human right;
  - equity should be considered to be a fundamental principle for health policy, which should be based on the concepts of health for all as endorsed in the Declaration of Alma-Ata;
  - health services should be effective, efficient, accessible, affordable, compassionate, and socially acceptable; and
  - mechanisms should be established to ensure that communities are able to participate meaningfully in the development of health policy and services, and communities and individuals should be involved in determining the nature and quality of health care.
- The principles of bioethics entail concrete obligations on the part of international agencies, governments, health care providers, professional associations, and society at large, as well as individuals and specific groups. Ethical norms and values differ significantly from culture to culture; nevertheless, there are fundamental principles that promote human rights and welfare and which can be applied across all cultures.
- Efforts should be made to promote and strengthen the continuing development of national and international capacities for the ethical analysis of current and emerging changes in health care. In certain countries where customs may be practised that threaten the health and/or social well-being of women, ethical analysis and appropriate remedial action can serve to enhance women's status.
- New methods for estimating the burden of disease for use in making decisions about resource allocation and health care planning make it essential that further refinement of these methods be guided by the principles of equity and non-discrimination.
- Efforts should be made to develop further the protection of the most vulnerable. This will involve, *inter alia*, organizing and assisting individuals, groups, communities, and governments to enhance their understanding of the causes and circumstances of different forms of vulnerability.
- There is a pressing need for the elucidation and universal adoption of basic bioethical principles, acknowledging the world's diverse moral and cultural perspectives, priorities, and values. A significant step would be to set up bilateral and multilateral links between institutions and professional societies dealing with bioethics in industrial countries and their counterparts in developing countries.

(continued overleaf)

A global agenda for bioethics: summary of the Declaration of Ixtapa (continued)

Human rights bodies

- Important opportunities exist for applying bioethics concepts in developing human rights in relation to health, health protection, and health care. Such rights can be divided into the following categories:
  - rights to health care and to the benefits of scientific progress;
  - rights relating to information, association, and freedom of action that could empower groups to protect and promote their health; and
  - rights relating to an individual's self-determination and integrity, including rights concerned with liberty, security, and private life.

Development banks

- The World Bank and regional development banks should consider incorporating bioethical perspectives into development design and assessment, particularly in relation to health, environment, poverty, and education.

International organizations

- Intergovernmental organizations engaged in international health work should pay attention to bioethical issues in planning and implementing their policies and programmes. Emphasis needs to be placed on the full involvement of all concerned, including scientific and lay organizations, in discussions of the ethical issues raised by the introduction of new health and biomedical technologies. Countries should be sensitized to pressing bioethical issues, notably those raised in the primary health care context; a North-South dialogue should be fostered to achieve universal consensus on the essential principles of contemporary bioethics and their implementation in health and related sectors.
- Appropriate UN agencies, CIOMS, the World Medical Association, the International Council of Nurses, the International Confederation of Midwives, the International Association of Bioethics, and the International Association of Law, Ethics, and Science can play an important role in soliciting and promoting contributions from developing countries to the issues covered by the Declaration.
- CIOMS should monitor the impact of the International Dialogue on Health Policy, Ethics, and Human Values on the emergence and sustainable development of bioethics, particularly in developing countries.

Source: *Bulletin of the World Health Organization*, 1994, 72: 998–999.

are all aware of what is happening all over the world. And so ethics is now a main issue in political debate. The aim of CIOMS in the 10 years of its health policy, ethics and human values programme was to sensitize health policy-makers to the ethical issues. The Director-General of WHO is convinced of the importance of ethics, and now some Member States are saying that WHO should be more involved in this field and that its role should be established at the highest level. To me it is a measure of progress that we are able to bring health policy-makers from different countries together to discuss ethical issues for a frank exchange of views.

Well, WHO certainly has moral authority.

Yes, and that raises an interesting point: the moral authority comes from the fact that WHO, as a public-health-oriented organization, is devoted to helping the public at large, which is an extremely ethical role. People sometimes ask me why ethical issues need to be discussed at all, because WHO's role in helping poor countries is by definition ethical. This is certainly true, and because of its moral authority the role of WHO in promoting dialogue on the global agenda for bioethics is crucial. The importance of intercultural debate among like-minded people cannot be emphasized enough. Dialogue, and yet more dialogue, is the way forward. ■

If you say somebody has rights, then they also have responsibilities.

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L2 - 4

Point of View

Graham Evans

Health and security in the global village

With the ecological stability of the world under threat, no country can stand alone. National security should no longer be viewed in a purely military light but rather as a matter demanding cooperation between all countries on a broad range of vital issues, not least those related to health and the environment.

Every political system has, or claims to have, a final arbiter, namely a government, which settles disputes and allocates resources; this is the defining characteristic of politics within the state. In international politics, however, there is no single government to regularize relationships between the participating states. Consequently, the concepts of self-help and self-defence enjoy a much more legitimate status than they do within the state; and power becomes the ultimate arbiter.

Health care: in whose interest?

Formerly, health care was only a peripheral matter among the concerns of politicians. During the nineteenth century it was introduced not for humanitarian reasons but because industrialists realized that healthy workers were more cost-effective than unhealthy ones.

In general, health was considered important only to the extent that it touched on matters of national importance. In domestic politics, health care provision became a function of a particular ideological orientation and its ability to impact on the political process, whereas in world politics it has always been intimately associated with the fabric of security challenges to the state. In both contexts, the spur was provided by pragmatism, not idealism.

The issue of global health, like that of the environment, has become more prominent on the political stage as the dictates of interdependence among states have imposed themselves.

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Health practitioners and political scientists now basically agree on the desirability of removing inequities in health care, particularly in the context of North–South relations. Yet unless the questions of health begin to impinge directly on states'

The health-for-all goals are bound to remain beyond reach until political will has been summoned up, especially in the developed countries.

conceptions of national interests, particularly security, they are likely to remain unresolved. The health-for-all goals are bound to remain beyond reach until political will has been summoned up, especially in the developed countries. Success is only likely to come if there is a clear recognition that the security and prosperity of the developed world are at stake.

On its own, moralistic pressure cannot be expected to bring about a transfer of resources from the military to the health sector. Even the so-called peace dividend that many people expected after recent events in eastern Europe and the former Soviet Union has failed to materialize. The potential dangers perceived by states militate against change in this direction. Yet expenditure on health care should now be seen as a contribution to security rather than as an alternative to it.

Security has always been the central element in international affairs, and the principal instruments for achieving it have been military and diplomatic. The ability to resist, deter or overcome an opponent has depended on visible military capability built on a solid economic base. Security has thus been regarded as an end-product of a particular kind of policy-making, usually involving arms races.

Security: the broad view

In the world of the 1990s, however, security is no longer just an end-product resulting from a perceived capacity for retaliation but is a process reflecting a much wider view of threat than that traditionally recognized by governments of nation states.

Of course, the nuclear menace still exists, but if we shift our focus from states to peoples and from independence to interdependence the nature of the security issue begins to look different. People everywhere face many hazards, among them AIDS, drugs, pollution, starvation, population growth and environmental degradation, which fail to appear in traditional analyses. Military power has not become unimportant, but its dominance at the centre of things has been challenged. Nature does not recognize international boundaries, and the emphasis now is on the connectedness and interdependence of things. Thus, parallelling developments in social medicine, the new strategic approach is to embrace the whole picture rather than isolated parts.

Security, as defined in 1982 by the Palme Commission on Disarmament and Security, requires physical and economic well-being, human rights, civil and political liberties, a sustainable environment, and a programme of social justice seeking the transfer of resources from the North to the South. In the field of strategic or peace studies, threat assessment exercises, which previously focused primarily on economic and military capability, now also cover the larger ecological and environmental dangers that

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INDIAN SOCIETY OF HEALTH ADMINISTRATORS, (ISHA), BANGALORE

in Collaboration with

NATIONAL LAW SCHOOL OF INDIA UNIVERSITY, BANGALORE

One Day Meeting on RIGHT TO HEALTH - March 15, 1997
Venue: Committee Room:Director's Office Building, NIMHANS

Health for All and the National Health Programmes: Major Issues

I. Issues identified in National Health Policy for HFA. Health Status of the population (around 1983).

1. The high rate of population growth continues to have an adverse effect on the health of our people and quality of their lives.

2. Mortality rates for women and children below the age of five years, are very high.

3. High infant mortality, around 129 per 100 live births.

4. Extent and severity of malnutrition continuing to be high.

5. Communicable diseases yet to be effectively brought under control - leprosy, TB continuing to show high incidence.

6. Blindness continuing to show high incidence.

7. Only 31% of rural population had access to potable water supply and 0.5% to basic sanitation.

8. High incidence of diarrhoeal disease, other preventive and infectious diseases specially among infants and children, lack of safe drinking water, poor environmental sanitation, poverty and ignorance are among the major contributory causes of high incidence of diseases and mortality.

II. Health Systems and Manpower issues.

1. The existing situation has been largely engendered by the almost wholesale adopting of health manpower development policies and establishment of curative centres based on western models, which are appropriate and irrelevant to the real needs of our people and the socio-economic conditions in the country.

2. The hospitals-based disease and cure-oriented approach towards establishment of medical services, had provided benefits to the upper crusts of society, specially those residing in the urban areas, at the cost of providing comprehensive primary health care services to the entire population whether residing in urban or rural areas.

3. High emphasis on curative approach has led to neglect of the preventive, promotive, public health, and rehabilitative aspects of health care.

4. Instead of improving awareness and building up self-reliance, the existing approach has tended to enhance dependency and weaken the community capacity to cope with problems.

5. Prevailing policies in education and training of medical and health personnel have resulted in a cultural gap between the people and personnel providing care.

6. The various health programmes have failed to involve individuals and families in establishing a self-reliant community. This is in view of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in identification of health needs and priorities and in implementation of the national health programmes.

III. Medical Education

Keeping in view the above issues, the National Health Policy called for the:

i. Review of the entire basis and approach towards medical education in the light of national needs and priorities, and a restructuring to produce personnel of required professional and social skills and competence, motivated to achieve results, within existing constraints.

ii. A National Medical Education Policy which

a. sets out changes in curricular contents and training programme of medical and health personnel at all levels.

b. Takes into account the need for establishing the extremely essential inter-relations between functionaries of various grades.

c. provides guidelines for production of health personnel on the basis of realistically assessed manpower requirements.

d. seeks to resolve existing sharp regional imbalances in their availability.

e. ensures that personnel at all levels are socially motivated towards the rendering of community health services.

IV. Immediate Priorities

The National Health Policy identified the following priority areas to be urgently attended to:

i. Nutrition: Raising the nutritional level of all segments of population, on a time-bound bases, using every possible strategy.

ii. Prevention of food adulteration and maintenance of quality of drugs.

iii. Water supply and sanitation - provision of facilities together with health education for effective use towards health and sustainability.

iv. Environmental protection

v. Immunization Programme - achieve cent-percent coverage of target population.

vi. Maternal and Child Health Services: to provide and ensure utilization of all necessary preventive and promotive services nearest to the door-steps of the people, particularly anti-natal, intra-natal and post-natal care.

vii. School Health Programme to reach all school going children.

viii. Occupational Health Services to ensure outreach of services to prevent and treat occupational hazards not only in organized but also unorganized sector such as agriculture.

ix. Health Education: Vital for success of every scheme and programme.

x. Management information system for appropriate decision making and programme planning.

xi. Medical Industry - to ensure adequate availability of life-saving and essential drugs and vaccines produced within the country at affordable prices even for the poor, using available technological and manufacturing capability. To ban hazardous drugs, to make banning effective.

xii. Health Insurance: to enable health for all, in all the above dimensions to become an affordable proposition.

xiii. Health legislation

xiv. Medical research: with the basic objective of transition of available know-how into, simple, low cost, easily applicable, acceptable, appropriate

technologies, devices and interventions to suit local condition, thus placing the latest technological achievements within the reach of health personnel, even in the remotest corners of the country, particularly with regard to

a. Contraception
b. Blindness
c. Leprosy
d. Tuberculosis
e. Other communicable diseases

xv. Inter-sectoral co-operation for health

xvi. Monitoring and Review of Progress

In the light of the National Health Policy, the Family Welfare and Communicable Disease Control Programmes, were sought to be strengthened, and additional Programmes were actively initiated, prominent ones being the Nutrition-related programmes for women and children, Anemia prophylaxis programme and Vitamin A distribution, Immunization Programme, National Blindness Control Programme, and National Goitre Control Programme. All these programmes, specifically the Mother and Child Health Programmes, Family Welfare Programme received a major boost in the decade 1983-93 with significant achievements made. However, some of the programmes such as Malaria Control Programme, T B Control lagged behind the newer priority programmes.

Subsequently, however, following initiation of the national reforms and restructuring process and other complex developments, some of the major issues facing public health and family welfare in India, affecting the implementation of all the Programmes are as follows;

1. Reductions in outlays for health and social sectors (in real terms)

2. Reduced emphasis on health and social sector by the government (as compared with industrial and other economic growth sectors)

3. Inadequate recruitment of personnel at all levels in the health system by all State Governments on the plea of financial tightness. Specifically, gross inadequacy of male health workers, lab technicians at PHCs, health supervisors, male and female, and health educators is evident. Inadequacy is not merely due to increased population; large number of vacancies caused by retirement are not being filled. Almost every public health programme depends on these critical front-line workers.

4. In all States, the system of having Medical Officers of PHCs as the leaders of the health team has, by and large, failed in achieving community health objectives, with MOs largely confined to a curative role at the PHCs/HCs. Resultantly, the paramedical

workers are unable to look to a leader for technical, supervisory, and motivational guidance. In the present framework, in every public health programme, the leadership of the PHC/MO is critical for effective implementation.

5. The issue of whether to have a non-medical leadership for all non-curative/non-surgical aspects of public health and Family Welfare Programmes, needs to be examined. It had been suggested in the late eighties, to have non-medical Community Health Officers, as officers in- charge of the PHCs and Community Health Centres, responsible for providing technical and administrative leadership to all the public health programme manpower, and getting the curative/surgical assistance of the medical doctors.

V. Critical National Health Programmes

A. NATIONAL MALARIA ERADICATION PROGRAMME

The NMEP in India after a spectacular success during the period 1958-65, due to a combination of setbacks showed a major resurgence with its peak in 1976. The annual incidence of cases and deaths were reduced from about 75 million cases and one million deaths prior to 1958, to 0.1 million cases and no death in 1965, and again with resurgence increased to 6.47 million cases in 1976. Since then, with modification of strategies, and fluctuating inputs for implementation of the NMEP, malaria has become chronically endemic in India, with epidemics from time to time in certain pockets. The major problems and issues for effective malaria control are;

Administrative

1. Low priority given to the Programme by the Health administrators at National and State levels, specifically in the contexts of: a) Low priority to health as such, and, b) Increasing priority to MCH and Family Welfare, AIDS etc.

2. Gross inadequacy of field personnel to carry out malaria control activities timely, which is the key to sucess of the programme.

Technical

a. Mosquito Resistance to Conventional insecticides.

3. Relative mosquito resistance to conventional insecticides (currently DDT is the only one implicated since it has been widely used). Resistance would emerge equally rapidly to other insecticides also.

b. Emergence of Drug resistant malaria parasite strains

4. Haphazard, indiscriminate use of anti-malarials by the public, private practitioners, etc, has resulted in emergence of malaria parasite strains resistant to conventional drugs. Again

this is due to inadequacy of systematic malaria control and treatment activities by the Government machinery.

c. Community Participation in the Programme

5. Since malaria prevention is closely linked to lifestyle and people's action, community participation is critical for its success. So far the Health officials at all levels, have been least geared to mobilize community participation for success of the Programmes.

d. Lack of follow-up on alternative strategies such as insecticide-impregnated mosquito bednets

6. Inspite of promising results with field trials of insecticide-impregnated mosquito bednets, there has been no follow-up to assess its potential on a large scale and implement the same.

e. Leadership to the Programme at PHC and District level

Effective committed leadership at PHC and District levels, is critical for malaria control. These two aspects have been the weak links in NMEP.

Among the above issues, the most critical ones are;

a. Gross inadequacy of paramedical and field health staff, specifically lab technicians and male health workers.

b. Leadership factors at PHC and District levels.

B. NATIONAL TUBERCULOSIS CONTROL PROGRAMME (NTCP)

This programme, which did not gain due priority so far, has become critical due to emergence of HIV infection and AIDS. The critical issues facing the TB control programme are;

TB is a silent killer

1. Being a chronic disease it does not cause epidemic cases or deaths. Hence it does not catch the attention of the media and administrators, consequently very low priority to this programme.

A major shift in strategy

2. There has been a major shift in the strategy of India's TB programme, under the aegis of international agencies, just when a widespread awareness of the strategies of the original NTCP had gained momentum. Worldwide, there have been major changes in perceptions about TB treatment, particularly in the context of the developed countries' response to the HIV-TB linkage. As a result, together with considerable World Bank funding for TB Control, there has been a statergic shift, from domiciliary, self administered treatment, to DOTS - a system of supervised

chemotherapy by person to person contact. Although its effectiveness in India was not studied, it gained wide acceptance, resulting in abandoning the former strategy altogether. Lately, the effectiveness and cost benefits DOTS has been called into question by series of studies.

b. Problem of Diagnosis at periphery

2. Diagnosis at the periphery requires sputum examination by microscopy. Culturally sputum has a connotation of being "dirty", compared with blood examination. Besides traditionally, doctors are not oriented to diagnosis of TB by simple sputum examination.

c. Problem of prolonged treatment

3. Due to need for prolonged treatment, patients tend to discontinue treatment or take irregular treatment, a situation which is worsened by poor treatment organization at the periphery.

d. Effective Drugs not available under in the TB programme

4. Even though highly effective drugs for treatment are available, they have not been utilized or misused due to cost and other factors. For a long time, the available drugs under the programme were of low effectiveness, and required very long of treatment, which demoralised the patient and the staff. Since the last eight years, availability of any type of anti-TB drug has been very poor, particularly under the Programme. This has led to a through demoralization of staff who are expected to diagnose cases without the means to treat. Patients are demoralized due to inability to afford on their own, and lack of drugs in the Govt. setup.

5. Lack of effective and continued leadership to this programme at District Level.

The organization of TB Programme requires effective, committed leadership and continuity of leadership at the District level which is a weak link in the system.

6. Lack of clarity on the epidemiological linkages between HIV and TB

C. HIV AND AIDS CONTROL PROGRAMME

HIV - AIDS poses a serious threat to the health of our country, with serious implications for physical, mental, social and economic health. The National AIDS Control Organization, WHO and other agencies have estimated that about 30-40 lakh Indians are currently HIV positive, which may increase to about one crore (10 million or 1% of the population) in 2001.

The major issues related to HIV-AIDS control and management are as follows:

1. Inspite of widespread HIV-AIDS awareness large number of people of all social strata are still getting infected. This raises questions regarding the outreach, intensity, content, and nature of the AIDS educational programmes, vis-a-vis their effectiveness.

2. The issues of stigma and fear related to HIV and AIDS are causing serious constraints in containing the spread of disease and in enabling HIV affected individuals and families adapt to the problem. These issues have not been tackled in the educational effort.

3.. By the year 2000 approximately 10 lakh individuals will need AIDS related inpatient care. But the total bed capacity in the Government sector is about six lakhs. A planned approach to the problem of care of HIV related illness, is critical, considering the magnitude of the problem.

D. FAMILY WELFARE PROGRAMME

a. Political Commitment

1. The most critical issue is lack of adequate political commitment to implement the Programme. How critical is political commitment for its success is evident from the tremendous success achieved by Tamil Nadu in reducing the birth rate from 31 in 1981 to 24 in 1992, improved from, a ranking of 16th to 3rd in India, and achieving one of the lowest decadal population growth rates in India of 21% (next only to Goa and Kerala). All this was achieved due to political commitment of successive Chief Ministers of the State. Family Welfare Programme currently remains, a women's Contraception Programme.

Family planning - perceived as the women's responsibility

2. From the top management level of the Programme upto the peripheral health worker, the basic premise is that family planning and avoidance of pregnancy/ childbearing, is the need and responsibility of the womenfolk. Interventions being researched, put to field trials, and released for mass application, are all methods to be used by women, and consequently the massive IEC strategies in operation are also spreading the message as if Family Welfare means contraception by women. Thus a psycho-social climate has been created in India, that family planning is for the benefit of women and to be practised by women. Keeping in view the social psyche, which treats women as second class beings, the Programme emphasis on female contraception has created a climate of low priority for family planning among rural and urban poor population. This emphasis has to change. Unless Family Planning is projected as a need and responsibility of both spouses, as a means to economic

development of the family, the low priority in rural areas will continue.

b. Delay in mass production and distribution of safe and convenient new contraceptives.

3. The third critical, issue is that safe and convenient contraception methods recently discovered and cleared for field use, are not being manufactured in sufficient quantities for not being distributed through government, PHCs and workers. Particularly, the newer safe methods such as, Saheli which is ideal for temporarily contraception by women independent of their husband's consent, is neither manufactured in sufficient quantity nor distributed through Government agencies; similarly also other contraceptives.

c. Updating IEC to disseminate latest safe contraceptive methods

4. Fourthly, the IEC strategies and content need to be rapidly updated, to include the latest developments in contraception technology (such as Saheli, upgradation of condoms quality in recent times, etc). The updated IEC content needs to be communicated down the line upto Health Educator and Health Worker level, and to the masses through mass media.

5. Lack of dissemination of scientific and authoritative evidence concerning safety of newly discovered contraceptive methods.

Recently engineered contraceptives such as Saheli, Depoprovera, Nor-plant, Birth Control Vaccine, are proven by international and national trains to be safe, convenient and highly advantageous to physical and mental health of women, in comparison with the risks and burdens of repeat child-bearing and care. Inspite of clear, scientific evidence available and the WHOs statements to this effect, GOI and State Governments have not communicated professionally acceptable (scientific) data to all their doctors down the line, and to the public at large, through newspapers, journals of the Ministry, and audio visual media. As a result, a number of NGOs with hardly any appreciation of the issues involved, and many with their own hidden agendas, create adverse publicity for valuable contraceptive methods, thus virtually throttling Government's efforts. The Governments, Central and State, should ensure adequate publicity for scientific information on the benefits, statistically proven risks as well as precautions, to prevent or neutralise undeserved adverse publicity.

d. Lack of IEC emphasis and clarity on safe and acceptable temporary contraceptive methods.

5. IEC efforts, through mass media (TV and radio continue to emphasize only sterilization operations which are either feared or rejected by several sections of the population. Regular IEC

on safe and accessible temporary methods which can be practised by women in their own, is needed, if Family Welfare has to reach the unreached families so far.

e. Ensure Availability of contraceptives right upto village level

6. There is need to ensure availability of safe and acceptable contraceptives right upto PHC and health worker level, appropriately trained to handle the same. In case of orally self-administered ones, products like Saheli could be socially marketed through fair price shops other village shops, bangle sellers in rural areas, and other innovative woman to woman approaches.

The effort for wide spread availability of all types of convenient contraceptive methods for rural population, should go hand in hand with IEC effort.

7. Need to promote vasectomy to dispel myths, popularize noscalpel vasectomy, and train adequate doctors in the procedure

Tubectomy, being an intra-abdominal operation carries far more risk to health of women, as well as chronic pain and other debilitating complications for women, causing many women to hesitate or refuse. Vasectomy, which is now modified to a subcutaneous and safe procedure, should be effectively promoted and doctors right upto peripheral level trained in the procedure.

8. Need for people-friendly Family Programme - pre-operative and follow-up services

The entire family welfare machinery needs to be geared up for an integrated people-friendly approach in providing Family Welfare services. This implies adequate prenatal care/pre-operative care to correct anemias, make the person fit for surgery, and post-operative follow-up care for complications. For effective implementation, these aspects should be monitored as part of the PHC/District/State Family Welfare performance.

9. Role of Financial Incentives in Promotion of Sterilizations

Inspite of a number of studies and expert opinions that incentives are not critical factors in accepting Family Planning, ISHA's interactions with eligible couples show that stoppage of financial incentives for sterilization in some States has been a major barrier to Family Welfare Programme in recent years. Our interactions in Maharashtra State show that rural women undergoing tubectomy are now compelled to go for work to the fields the very day following tubectomy, for economic reasons, thereby going in for life-long abdominal pain and other complications. Thus the image of tubectomy and Family Welfare Programme itself has been tarnished.

It needs to be understood that financial incentive is not the primary factor to induce acceptance of sterilization, but lack of financial compensation would seriously retard the programme. Though it is termed as "incentive" in Family Welfare jargon, in reality it is the compensation for loss of daily wages. This is essential for the family food during the period when the mother has to take rest.

There is urgent need to review the decision on "incentive", and to fix a compensation level equal to wages for the period of rest required. To avoid misuse of cash by family members, equivalent in grain and essential commodities could be provided for.

10. Target setting and Family Welfare monitoring to be refined to included the dimension of parity of acceptors.

Decade after decade, planners and experts are emphasizing the need for quality of target achievements, and not merely quantity. Since sterilization needs to be accepted after two, or maximum three children, to achieve a demographic impact. Mere target achievement by doing sterilization of couples with four or more children, does very little for demographic change. Therefore targets fixed should be linked to parity of acceptors. Similarly also, monitoring and corrective actions should take into consideration parity of acceptors.

L2-5

INDIAN SOCIETY OF HEALTH ADMINISTRATORS, (ISHA), BANGALORE

HEALTH FOR ALL: SOME RECOMMENDATIONS TO ACHIEVE THE GOAL

The Indian Society of Health Administrators, chose the theme of Health for All by 2000 AD for its first annual conference in 1980. Recommendations were made. We need to review how far these recommendations have been implemented at various levels.

1. The present allocation of financial resources for the health system being inadequate in absolute and relative terms and in comparison with other countries, the conference recommended that

   i. The allocation both by the centre and the states be increased substantially forthwith.

   ii. Studies be undertaken to determine the optimum increase, taking into consideration, the economic situation of the country and the possibilities of mobilizing funds for health efforts.

2. Given the fact that the financial resources (inspite of larger mobilization of funds) will continue to be inadequate in the foreseeable future, recommended that

   i. there should be intensive training programmes for health personnel at all levels in order to equip them with modern management techniques for better utilization of funds, and

   ii. priorities must be assigned in the distribution of funds for those programmes which are more cost effective in bringing about better health to larger sections of the people, viz., health education, nutrition, immunization programmes, eradication and control programmes and water supply and sanitation.

3. As the country is still lagging behind in the matter of production, distribution and proper utilization of drugs and pharmaceuticals to ensure the availability of essential drugs at feasible costs,

recommended that the country identifies low cost effective drugs essential for primary health care, produces them in bulk quantities and ensures proper distribution (with distribution systems at the periphery)

4. Free supply of drugs and services being neither feasible nor desirable,

recommended that the beneficiaries be charged for them, according to their capacity to pay.

5. The judicious development of appropriate manpower with respect to types and numbers being imperative,

recommended that steps to be taken to train

i. one community health volunteer for 1000 population or for each village, where the population is less than 1000.

ii. village level worker, as needed depending on the local conditions, and

iii. other identified health personnel such as multi-purpose workers, doctors, nurses, pharmacists, dentists, laboratory technicians and health inspectors, as per the recommendations of the committees which have considered these needs.

6. Since school teacher form a large body of persons who can influence the young minds for better health,

recommended that

i. school teachers be given training in health education, covering all school teachers by 1990.

ii. the syllabus for training of school teachers (B.Ed, B T and other similar courses) should have the theory and practice of health education, and

iii. The school curriculum for the age groups 10 to 15 years should include "Health Education in effective manner".

7. Health being multisectoral and there is need for coordination of all programmes of primary health care,

recommended that the departments of health at the center and the States should coordinate the activities of all implementing departments, such as Industry, Agriculture, Education and Health.

8. Community participation is essential if primary health care is to succeed. To ensure the involvement of the community at all stages of planning, implementation and evaluation,

recommended that health committees

i. be formed at various levels (Village, Block, district, State and linked to the National Development Council);

ii. should include elected representatives of the people and various health functionaries, and

iii. at the village and block levels, they should include local practitioners of medicine, school teachers, representatives of women's organizations and leaders of the local community.

9. Voluntary agencies have an important role to play in primary health care and in order to ensure their participation,

recommended that

i. voluntary agencies be identified and encouraged in their efforts;

ii. they be involved in health activities in any area or sector from the planning stages; and

iii. their activities be fully co-ordinated with government activities and a machinery be devised to ensure co-ordination, to avoid duplication.

10. The planning for primary health care needs proper recording and complication of data at the micro and macro levels. Though a machinery exists, in order to ensure that the compilation is satisfactory,

recommended that the forms of reporting and the mechanics of record keeping be reviewed so that the forms can be simplified and the information is utilized as needed.

11. Primary health care needs are dynamic and changing. In order to respond to these needs,

recommended that there be research and development wings in each state,

i. to monitor these needs and to respond to them adequately, and

ii. to develop appropriate technologies, making use of the local resources and talents to the maximum extent possible.

12. As it is essential to ensure protection of the environment which is threatened by the industrialization and other factors,

recommended that

i. effective legislation be enacted,

ii. suitable machinery be devised to effectively implement the legislation.

HEALTH INDICATORS AND INFRASTRUCTURE CHANGES IN INDIA

		Year	
		1946	1997
1.	Population Served	342 million	970 million
2.	Health manpower (population per unit)		
	a. Doctors	1:6,300	1:2,680
	b. Nurses	1:43,000	1:4,500
	c. Health Visitors	1:4,00,000	1:30,000
	d. Midwives	1:60,000	----
	e. Trained Dais	Nil	5.64 lakh trained since 1974
3.	Beds available/ 1000 population	0.24	0.59

		Year	
4.	Health and Family Welfare Indicators	1946	1993
	a. Crude Death Rate	44	9
	b. Crude Birth Rate	46(1941)	28.3
	c. Infant Mortality Rate (per 1000 lives birth)	162	74
	d. Maternal Mortality Rate (per 1000 lives birth)	20	4.37
	e. Couple Protection Rate(%) (NFHS)	nil	51
	f. Life Expectancy at Birth	32	male 58.6 female 59

Sources:

1. Bhore Committee Report (1946)
2. Statement of National Health Policy Government of India (1983)
3. Health Information India (1988)
4. SRS 1994 (Provisional figures).
5. National Family Health Survey, 1992-93

INDIAN SOCIETY OF HEALTH ADMINISTRATORS, (ISHA), BANGALORE

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Right to Health - Notes prepared for the Meeting on March 15, 1997

1. **World Health Organization: The World Health Report, 1996,** Geneva, Switzerland.

Infectious diseases are attacking us on multiple fronts. Together. they represent the world's leading cause of pre-mature death. The heaviest burdens of ill-health will continue to fall on those who live in developing countries, especially those least able to sustain economic development.

2. **UNICEF. The State of the World's Children 1995.**

An underclass is being created under-educated and unskilled, standing beneath the broken bottom rungs of social and economic progress.

The 1994 International Conference on Population and Development (Cairo Conference) emphasized the need to extend reproductive health services to women in all communities, to raise levels of female education and to accelerate progress towards gender equality.

3. **World Health Forum, 1987, Vol. 8, No. 2, pp 190**

RIGHTS AND RESPONSIBILITIES OF INDIVIDUALS

Individuals and families function best within a particular social, economic and environmental context. To the extent that this framework allows adequate opportunities and resources for all citizens to make free choices, they have both rights and obligations in relation to health, with responsibilities to pursue better health for themselves, their families and the communities in which they live.

Individuals have the right to:

* a social, economic, physical, emotional and legislative environment that is as safe and healthy as it can be made;

* an education that permits them to make well-judged choices about their health and the avoidance of health hazards;

* a valued role in society that offers them self-respect and the respect of others;

* encouragement and support in selecting a healthy life-style;

* participate in the making and implementation of policies that affect their health.

Individuals are responsible for:

* valuing their own health and that of members of their family; seeking information to make responsible decisions to preserve and promote health; and adopting a healthy life-style wherever they have a choice to do so;

* recognizing that they have opportunities to shape their own lives and those of their families; and power to make choices as individuals, as consumers and as electors who determine their own future health and that of fellow citizens;

* seeking to maintain a purposeful attitude to life, giving respect, friendship, love and minimal hurt to others; and pursuing reconciliation in preference to conflict.

4. World Health Forum, 1984, Vol.5, No 2, pp 131

RIGHT TO LIFE OF HANDICAPPED - Alison Davis

I am 28 years old, and suffer from a severe physical disability which is irreversible. I was born with myelomeningocele spina bifida.

I have suffered considerable and prolonged pain from time to time, and have undergone over 20 operations thus far, some of them essential to save my life. Even now my health is at best uncertain. I am doubly incontinent and confined to a wheelchair and thus I should have "no worthwhile quality of life".

However, because I was fortunately born in rather more tolerant times, I was given the chance to defy the odds and live, which is now being denied to handicapped newborns. Even so, my parents were encouraged to leave me in the hospital and "go home and have another" and I owe my life to the fact that they refused to accept the advice of the experts.

Despite my disability I went to an ordinary school and then to university, where I gained an honours degree in sociology. I now work full-time defending the right to life of handicapped people. I have been married eight years to an able-bodied man, and over the years we have travelled widely in Europe, the Soviet Union and the United States. This year we plan to visit the Far East.

Who could say I have "no worthwhile quality of life"? I am sure though that no doctor could have predicted when I was 28 days old (and incidentally had received no operation at all) that despite my physical problems I would lead such a full and happy life. I do not doubt that they were "acting in good faith" when they advised my parents to abandon me, but that does not mean that their advice was correct.

I feel that the medical profession could go a lot further than it has to condemn the constant undermining of the rights of handicapped people at progressively later stages in their lives. There is nothing magical about the age of 28 days after all. It is simply the currently accepted boundary of "non-personhood" for babies with congenital defects.

Legislation could well lead to the *de facto* decriminalization of the act of killing a handicapped person of any age, just as it did in Hitler's Germany. And if it does, woe betide any handicapped people who are too ill to defend their right to life by protesting that they are in fact happy. And woe betide us all, when we get too old to be considered "useful" and all the friends who could have spoken in our defence have already been oh so lovingly "allowed to die".

5. **World Health Forum, Vol 14, 1993, pp 135**

RIGHT TO A HEALTHY ENVIRONMENT

Pecple need to have the means to acquire the resources on which health depends: safe food and water, fuel, and a secure shelter. They need to be protected not only from physical, chemical, and biological hazards, but also from crime and violence, which are encouraged by poverty and the use of drugs, and from injuries at their place of work. A healthy environment is not only a need, it is also a right; the right to live and work in an environment conducive to physical and mental health is enshrined in the Universal Declaration of Human Rights. Everyone shares the responsibility for ensuring that this right is duly acknowledged.

Everyone also shares responsibility for health and for passing on to the next generation a world whose resources are not depleted and whose natural systems are not degraded. There is a powerful synergy between health, environmental protection, and sustainable resource use. Individuals and societies who share the responsibility for achieving a healthy environment and managing their resources sustainably become partners in ensuring that global cycles and systems remain unimpaired.

6. WHO Chronicle, Vol 38, No 5, 1984

REPRODUCTIVE HEALTH, YOUTH, AND THE LAW

Health cae is the legitimate concern of any nation, with the right to health said to pertain to individuals and the duty to provide health care to the State. Legislation is used not only as a vehicle for expressing this concern but also as a method for treating the system of "rights" and "duties". Health codes are often extensions of constitutional statements and are central to any rational attempt to organize and regulate the various health care and promotion services.

7. The Indian Practitioner, Vol. XLII, No 12, December 1989

WORLD MEDICAL ASSOCIATION DECLARATION OF HONG KONG ON THE ABUSE OF THE ELDERLY

The elderly have the same rights to care, welfare and respect as other human beings.

Physicians whether consulted by an aged person directly, the nursing home, or the family will see that the patient receives the best possible care.

8. The Health Provider's Guide to Contraception. The Pathfinder Fund, 1983

Family planning is an essential component of any broad-based development strategy that seeks to improve the quality of Life for both individuals and communities, the lives of millions of mothers and children will be saved (through family planning). Family planning is the basic human right.

Choice is a Key Concept in family planning. There is no perfect contraceptive method, and some methods will be more suitable to a particular client's needs than others. Clients must be offered the full range of methods available in the community, and health providers must help explain how these methods vary in convenience, effectiveness, and appropriateness.

9. World Health Forum, Vol 17, No 1, 1996

THE SOCIAL ACTION DIMENSION OF HEALTH DEVELOPMENT

Health promotion and social action for health support the health-for-all goal in two ways; by promoting healthy lifestyles and community action for health, and by creating conditions that make it possible to live a healthy life. The first entails empowering people with the knowledge and skills needed for healthy living. The second calls for influencing policymakers so that they pursue health-supportive public policies and programmes. Strong social support for health action needs to be initiated, accelerated and maintained. A public that knows its rights and responsibilities, supported by political will and awareness at all levels of government, can make health for all a reality.

ISHA

One Day Symposium on
"Right to Health", 15th March, 1997
Jointly organized by National Law School of India University
and
Indian Society of Health Administrators

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1. Universal Declaration of Human Rights - Adopted by the U N on 10th December, 1948.

"Article 25 (1) Every one has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social serivices.....

(2) Motherhood and childhood are entitled to special care and assistance....."

2. International Covention on Economic, Social and Cultural Rights - Entry into force on 3rd January, 1976

"Article 12 (1) The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the still birth-rate of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical serivce and medical attention in the event of sickness".

3. The Convention on the Rights of the Child, 1989

"Article 24 (1) State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabillitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".

4. The Constitution of India, 1948

"Article 39. The State shall in paticular, direct its policy towards securing - (e) that the health and strength of workers and the tender age of women are not abused.... (f) that children are given opportunities and facilities to develop in a healthy manner....

"Article 41. The State shall, within the limits of its economic capacity and development, make effective provision for securing the right ....to public assistance in cases of .....old age, sickness and disablement....

"Article 47. The State shall regard the raising of the level of nutrition and the standard of living of people and the improvement of public health as among its primary duties and, in paraticular, the State shall endeavour to bring about prohibition of the consumption except for medicine purposes of intoxicating drinks and of drugs which are injurious to health."

While international treaties on Human Rights do recognize health as a basic right, the Indian Constitutional text accomodates this basic need as a Directive Principle of State Policy to be realized subject to the economic capacity and development of the State. In the last nearly five decades, the Governments at the Centre and in the States have enacted a number of laws and launched a variety of programmes directed towards the increasing realisation of health services to the people gnerally, and to women, handicapped, and children in particular. A national health policy is promulgated and hundred of thousands of crores of rupees spent in the delivery of health services.

The object of the symposium is to examine the evolution of health from a mere welfare programme to a right which every citizen can legitimately claim from the Government. Is it a legally enforceable right or is it only a policy to become a right sometime in future? What is the content of right to health? Is the "health for all by 2000 A D" a slogan or wishful thinking only? How far are we from that goal? What are the programmes now in place at the Central and State levels on the health front? Who gets what out of these programmes? How adequate are they and what are the prospects of making them more effective? What are the budgetary allocations for health at Centre and in States and what are the priorities? Where are we lacking - in infra-structure, personnel, funds, political will?

What is the view of the medical profession on right to health in the context of India. Should the courts take the concept as a fundamental right and start directing the government to enforce it as such? What will be the impact or consequence? How does the liberalisation/privatisation process affect health services?

In short, the Symposium expects to gather the considered views of the profession (doctors, nurses, hospital administrators, health policy planners) on the nature, content, scope and the present reality of the "Right to Health" with a view to develop a jurisprudence which hopefully will support health as a basic human right. Problems of health in Indian context have to be borne in mind rather than looking at it in an abstract or ideal perspective.

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INDIAN SOCIETY OF HEALTH ADMINISTRATORS, 9ISHAO, BANGALORE
in collaboration with
NATIONAL LAW SCHOOL OF INDIA UNIVERSITY, BANGALORE

One Day Meeting on RIGHT TO HEALTH - March 15, 1997
Venue: Committee Room: Director's Office Building, NIMHANS

TENTATIVE PROGRAMME

SESSION I-RIGHT TO HEALTH; MAJOR ISSUES
Chairman: Dr. S.M. Channabasavanna, Director, NIMHANS

A. Dr. N.R. Madhava Menon, Director, National Law School.
B. Dr Ashok Sahni, ISHA.

SESSION II - RIGHT TO HEALTH: SECTORAL ACHIEVEMENTS
Chairman: Dr R M Varma, Professor Emeritus, NIMHANS.

Short presentations

A. Dr V Parameshvara, Past President, IMA.
B. Dr Chikka Nanjappa, President, Karnataka Medical Council
C. Mr T V Antony, Former Chief Secretary, Tamil Nadu
D. Dr G V Nagaraj, Addl. Director, Directorate of Health and Family Welfare Services, Government of Karnataka
E. Prof N S Ramaswamy, Director, CARTMAN, Bangalore.
F. Dr P N Halagi, Addl. Director (Planning), India Population Centre.
G. Dr H R Basavaraj, Institute of Health Comparative Medicine.
H. Mrs Krishnakumari Menon, President, Karnataka Parents Association for Mentally Retarded Citizens

SESSION III - RIGHT TO HEALTH: PUBLIC HEALTH ISSUES
Chairman: Dr Madhava Menon, Director, National Law School of India University.

A. Dr K Basappa, Prof Preventive and Social Medicine
B. Dr M Narayanapp, Prof Preventive and Social Medicine
C. Dr (Mrs) M K Vasundhra, Prof Preventive and Social Medicine
D. Dr Om Prakash, Consulting Physician, St Martha's Hospital.
E. Dr Mohan K Issac, Addl. Professor of Psychiatry, NIMHANS.

SESSION IV - SUMMARY OF ISSUES
Chairman: Dr Madhava Menon, Director, National Law School of India University.

Report by Prof. Joga Rao, National Law School of India University.