1) Public Health Care system: Threats & options - C. Sathyamala.
2) Communication - as if PEOPLE mattered - David Werner
3) Medicalization of Health Care & Challenge of Health for All - David Sanders.
4) Health as a Human Right - from Charter.
5) Regional Consultation on Public Health & Human Rights - 10-11 Apr 2001, NHRC.
6) Rt. to Health Care - Moving from idea to reality - Abhay Shukla.
7) A Concept paper on Universal Access to Health & Health Care - Fr. S. Ouseppurampil
8) Universal Access to Health for all - "
9) " " " " " " - "
10) Community based Primary Health Care approach to reach the Unreached - Dr. Arole.
11) Universal Access to Health Care: A mission Possible - Dr. Mani Kalliath.
12) People's campaign for Decentralised Planning & the Health Sector in Kerala - Ekbal
13) The Rt. to Health Care is a Basic Human Right / Protocol to document cases - JSA
14) RAHA's Medical Insurance Scheme - RAHA
15) Women's access to health Care as a Fundamental Right - Sama.
16) Background to Campaign on Women's Access to Health - Women's Global Network for RR.
17) Rt. to Mental Health & Rehab - Centre for adv. in MH
~~18~~

P.T.O

18) Establishing 'Rt. to Health Care' – Is it a realistic app. ~~State Bank of Mysore~~ - CMA /

19) Report on 'Rt to Health Care' Seminar - ASF

20) Report on Hunger Watch Meet, Feb, Mumbai.

21) Rt. to Health Care - Campaign Strategy - presented at ASF - Dr. Ravi.

22) Schedule of National Consultation on Universal Access to Health - 4 Aug '03.

23) Presentation by Dr. Antony Joseph at the 4 Aug Consultn on Univ. Axs to Health

L-3A.1 (1)

Public Health Care System: Threats and Options
(Concept paper for the mfc annual meet, 2003, draft)
C Sathyamala

The theme for the next Annual Meet, "Public Health Care System: Threats and Options", is being proposed at a time when the health care system in India is undergoing a radical transformation. The massive expansion of the private medical sector, entry of private insurance in medical care, introduction of payment ("user fees"[1][1]) for medical services in the government sector are just three such changes we have witnessed in the last decade. The rapidity with which these changes are taking place leads one to view such developments with great trepidation. It could well be that in a matter of few years we will have installed the American model of high-cost, profit-driven, technology intensive, unjust, inequitable health care system in our country. This view may perhaps be dismissed as being unnecessarily alarmist, but there is certainly a general concern that soon health care is going to be out of the reach of ordinary people.

The growing sense of disquiet many of us are experiencing is beginning to be voiced in public fora with, surprisingly, the government and its agencies too joining in at the chorus. As a sign of good "governance"[2][2], a dual system (one for the rich and one for the poor) is being proposed to tackle the issue of equity in health care without in any way disturbing or altering the process of disinvestment that has been set into motion. A high-technology based medical service on par with what is available internationally elsewhere, is to be provided by the private sector for the small section of the population that can easily meet the costs (and for the purposes of earning foreign exchange) and a "minimum clinical package" courtesy World Bank (1993)[3][3] provided by the government to be availed of by the poor if and when they can mobilize sufficient resources to meet the direct service charges and the indirect costs (transport, loss of wages) such care entails.

Concern not withstanding, among the critics there appears to be a tacit acceptance of the nature of things to come and a tacit agreement as to the near impossibility of stopping or reversing the relentless march of market forces. Depending upon one's current world view and analysis, suggestions for 'improving' the government's national health policy aim at creating a space for the poor within the framework laid down by the state under the aegis of the World Bank and Transnational Capital, without challenging the very frame work itself. While at one level such a strategy may be taken to reflect a pragmatism of sorts, increasingly it is being upheld as the most, and often the only viable alternatives under the given circumstances. Could this be due to the near absence of a genuine pro-people movement in the country to articulate the needs and aspirations of the marginalized from their perspective? Is a different perspective possible? Are there other options which will place people's need centre-stage? How should mfc contribute to the development of such a perspective and help evolve strategies that can translate into concrete demands difficult to coopt and make health care a justiciable right for all? This should form the focus of the mfc annual meet.

---

[1][1] Why *user* fees? The word 'fee' means, a payment made to a professional person or to a professional or public body in exchange for advice or services (concise Oxford Dictionary, 10th ed). Is the addition of 'user' in order to camouflage the nature of privatisation of public services?

[2][2] There is an entire chapter in one of Susan George's book (will supply details later) which discusses when and why the archaic word 'governance' was brought back into general usage by the World Bank.

[3][3] "Investing in Health Care", World Bank, 1993

It is not sufficient to say that public health is under attack or that the public health care system is being dismantled. There is need to spell out what exactly is being attacked and what exactly is being dismantled. And most importantly, how exactly it is going to affect the health of the poor because, the poor view with indifference (and once-in–a-way, with anger), what currently exists in the name of public health services. When present, broken down and vandalized buildings of sub-centres/PHCs in the villages and taluk towns; every cadre of health personnel from the level of the inadequately trained village health worker to the doctor at the district head quarters out to exploit their ignorance and capitalize on their misery and helplessness; corruption from the top to the bottom of the ladder; anti-poor, casteist, sexist (and in the last decade, communal) attitude of the individual medical personnel especially the doctors, the 'leaders' of the medical team; non-availability of medicines/equipment and poor service in public hospitals, particularly at the district levels; anti-poor, anti-women aggressions carried out by the department of population control – the poor have borne mute testimony to what government health services mean at the ground level and are not going to be impressed very much if they are to be informed that such 'services' are going to be disbanded.

In any case today even from among the poorer sections of the population, the trend is to 'seek' medical care from the private sector when possible. It is only when there are no options as in times of serious illnesses when the cost of care is too great, that the compulsion to utilize government health services arise (which increasingly is turning to be no option at all with the introduction of service charges in the public sector). The irony is that the observation – people, poor people are spending money on medical care is being seen as a statement of their "willingness" to pay for treatment costs. While this may be more a reflection of an absence of other options than an exercise of real choice, studies on household expenditure on health have seldom asked two additional critical questions: how was the money for payment mobilized in the first place and what was the impact on the household economy as a consequence of this[4][4]. Thus, while studies abound on household expenditure on medical care, equal attention has not been paid to assess, for instance, rural indebtedness due to disease and treatment costs. How ever one explains the whys of this lacuna, this 'short-sightedness' has worked against the interests of the poor. Studies such as these have legitimized the notion of payment for 'services' and have cleared the way for introducing "user fees" in public health services. Even here, contrary to the proclaimed objectives, the introduction of fees is not to generate funds for the resource-poor public sector. The intention is to wean away from the public sector to the private, that section of the population that is currently using it but has any surplus at all to spend (if money has to be paid in either case, why settle for what appears to be 'second best'?[5][5]). The intractable truth is that with its one and only goal of 'maximizing profits' at any cost, the private sector (and monopoly capital) cannot tolerate any form of competition whatsoever.

We need to understand the move to phase out the state-owned secondary and tertiary referral services in this context as a logical step for removing a major hurdle in the path towards unfettered private monopoly in curative clinical services. Plans are also afoot to convert the role of the government from a provider of even basic health services into a mere financier who will, on behalf of the poor, 'purchase' the necessary services from the private sector. This with an avowed intention of improving quality of care by encouraging competition

---

[4][4] The other important questions are the proportion *and* rate of illnesses for which medical care is not sought; nature of such illnesses; gender, class, caste differentials etc.

[5][5] In many parts of the country, government hospitals are called dharm or charity hospitals because they did not charge money

among the private providers, apparently the most effective way of achieving the stated objective. In reality it could very well be yet another ruse to provide more government subsidy to the already state-subsidized private sector.

We are situated in a time in history when India has seen more than fifty years of Independence from direct colonial rule. We are also situated in a time in history when India has become a seemingly willing subject to the neo-colonial rule under the conditionalities of the Structural Adjustment Programme. In this period of fifty-five years, an entire generation of the poor has taken birth and died without having had even the 'luxury' of two full meals everyday for the entirety of their life time. In stark contrast to their lives, they have witnessed the fruits of development built on their labour being reserved for the comfort and enjoyment of a small section of the population – the upper class and the upper caste. Today, it is no accident that this very same small section is bartering away the country's sovereignty and future to buy a place for themselves amongst the global ruling class.

Fifty years is a long time to have laid open the true intentions of our country's ruling elite towards its people. It is not chance but choice that we have millions of people living a life of chronic starvation when there is food rotting in the godowns. It is not chance but choice that has created the necessary pre-conditions for the dictatorship of transnational capital.

To take an instance, it is not chance but choices made over fifty years that has created a burgeoning private medical sector over-running the health care system in the country. For, how else does one explain the fact that a private sector which accounted for only 20% of the health services in the early eighties, is now providing more than 80%? Where did the doctors currently stocking the private sector come from? Are they not the products of our educational system and policies and for most part subsidized by the labor of the poor (through indirect taxes)? Can a critique of medical education be unconnected to a critique of the educational policy in general? Why are we shocked when we observe the mandalisation and communalisation of the medical community in utter disregard to the Hippocratic oath? Is not the dual policy that is being proposed today regarding medical manpower been the norm rather than an exception since Independence? The training of licentiates in the period immediately following Independence may have been in keeping with the needs and resource availability in the country at that time. But choice was made to train a 'full fledged' doctor matching international standards. Today when we have a surplus of doctors trained to fit international norms, can we justify the renewed discussion on licentiate course to provide 'sub-standard' personnel to take care of the needs of the poor? When we have an optimum doctor-population ratio[6[6]] why are we opening more and more medical colleges? Why is the World Bank (1993) which has arrogated to itself the right to set the terms for our country's health care system silent regarding the presence of surplus doctors in the country or the fact that Indian doctors form a substantial portion of the medical community in several western countries? Why is the national policy (2001 draft) silent on this? Colonial legacy cannot be the only reason, we have had more than fifty years to over turn it.

The theme for the annual meet should therefore have a historical perspective running through it. We should re-examine the economic/political considerations and compulsions, that have shaped the national health policy since Independence and where necessary its links to the colonial past and 'heritage'. Only then will the analysis of the new health policy under Structural Adjustment Programme make sense.

[6[6]] incidentally, what *is* the rationale for deciding what is an optimum ratio.

The theme will be incomplete without a discussion on the contribution of non-governmental organizations (ngo). Historically, the ngo sector, previously called the voluntary sector, has contributed in critical ways to the shaping of the national health policy and programmes. Initially in the role of the service providers, the emphasis was on setting up hospitals, particularly in rural areas and in training manpower of all levels. Over the years, many such organizations enlarged their perspective of individual care to include 'communities' and experimented with alternate delivery systems by, for instance, training village health workers. Campaigning for policy changes, highlighting disparities and equity issues, generating critical data, more often than not from a pro-people (poor, women) perspective, are some of the other important contributions. However, the last decade has seen the emergence of questionable priorities largely determined by the agenda of the funders. There has also been a moving away from working directly with people to 'lobbying' and 'advocating' with policy makers as the most effective means of bringing about change. Over a period of time, the potential for supporting people's struggles is being slowly frittered away and the poor are beginning to view such organizations with cynicism and distrust.

The fact that the disparate ngo sector contains within it a section of the liberal vocal middle class with little social accountability and no explicit ideology or long-term commitment has made it a sitting duck for cooption. The dependence on external funding, be it domestic or foreign, has meant that it is possible to manipulate and pressurize at critical times and shift their attention from issues of people's livelihood to seeking means to protecting their own.

It is this vulnerability and the accompanying vacillation that makes the ngo sector attractive to the World Bank (itself an ngo!) and the state who wish to bring into their fold the dangerous potential for dissent and give it a shape in their own image. A calculated political act of blurring the lines by clubbing all organizations irrespective of their political leanings (right, centre or left)[7][7] under one umbrella term "non-governmental organizations" was the first step towards containing dissent, an act which went largely unprotested. However, that it is still possible to channelize the not inconsiderable energy of the sector into a coherent political force against oppressive policies has been amply demonstrated by, for instance, the campaign against hazardous contraceptives, SDSP tests. The move to form a people's Health Assembly being another such attempt.

MFC is uniquely placed to examine the contribution of the ngo sector to the shaping of national health policy. Many of its members have been in the forefront at critical junctures in reaching health care to the poor and the marginalized both in the literal and figurative sense. With the rich experience and wisdom gained over the past thirty years of intervention, experimentation and participating in the political process to influence health policies either at an individual level or as an organization, the discussion could be very rewarding if we bring to it our own personal experiences. The strengths of the mfc are its non-sectarian approach and a potential to critically examine an issue without taking anything as a given. Can we turn this ability of ours to examine dispassionately, our several attempts at creating an alternate world view in health care, the successes and failures of our 'projects' and question our own thinking with the luxury of hind sight?

This decade is going to bring about cataclysmic changes, particularly when the WTO treaty comes into effect in 2005. The "reforms"[8][8] that are being ushered in the name of globalization are already beginning to be experienced with rising unemployment, retrenchment of workers, and a shift towards insecure, casual labour and poor wages. Added to this is the impact of privatization of public health care services, rising drug prices and costs of treatment. These changes are going to have an adverse impact on the health of the poor and lead to a rise in morbidity and mortality rates in the vulnerable sections of the population.

5 communication as if PEOPLE mattered

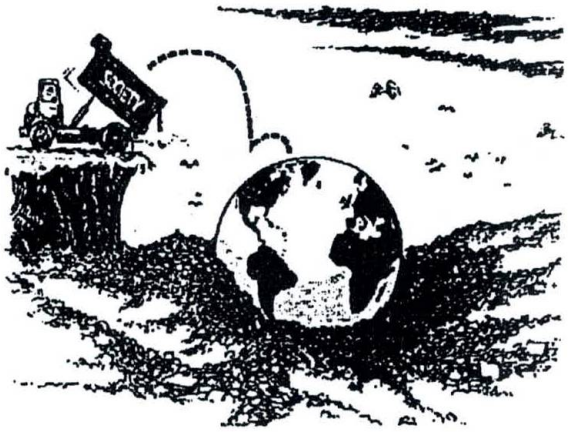
adapting health promotion and social action to the global imbalances of the 21st century

by David Werner

DEMOCRACY as a prerequisite for a HEALTHY SOCIETY

Why participation is essential – and how it is undermined

The well-being of an individual or community depends on many factors, local to global. Above all, it depends on **the opportunity of all people to participate as equals in the decisions that determine their well-being**. Unfortunately, history shows us that equality in collective decision-making—that is to say **participatory democracy**—is hard to achieve and sustain. Despite the spawning of so-called 'democratic governments' in recent decades, most people still have little voice in the policies and decisions that shape their lives. Increasingly, the rules governing the fate of the Earth and its inhabitants are made by a powerful minority who dictates the Global Economy. Thus **economic growth (for the wealthy) has become the yardstick of social progress, or 'development,' regardless of the human and environmental costs.**



And the costs are horrendous! The top-down 'globalisation' of policies and trade—through which the select few profit enormously at the expense of the many—is creating a widening gap in wealth, health and quality of life, both between countries and within them. A complex of worldwide crises—social, economic, ecological and ethical—is contributing to ill-health and early death for millions. Increasingly, giant banks and corporations rule the world, putting the future well-being and even survival of humanity at risk. Driven more by hunger for private profit than for public good—the massive production of consumer goods far exceeds the basic needs of a healthy and sustainable society. Indeed, its unregulated growth compromises ecological balances and imperils the capacity of the planet for renewal.

Yet in a world where unlimited production and resultant waste have become a major health hazard, there are more hungry children than ever before. According to Worldwatch's *The State of the World, 1999*, **the majority of humanity is now malnourished**, half from eating too little and half from eating too much!

Mahatma Gandhi wisely observed: 'There is enough for everyone's need but not for everyone's greed.' Sadly, **greed has replaced need as the driver of our global spaceship**. Despite all the spiritual guidelines, social philosophies, and declarations of human rights that *Homo sapiens* (the species that calls itself wise) has evolved through the ages, the profiteering ethos of the market system has side-tracked our ideals of compassion and social justice. Humanity is running a dangerous course of increasing imbalance. To further fill the coffers of the rich, our neoliberal social agenda systematically neglects the basic needs of the disadvantaged and is rapidly despoiling the planet's ecosystems, which sustain the intricate web of life.

The dangers—although played down by the mass media—are colossal and well documented. Forward-looking ecologists, biologist, and sociologists sound the warning that our current unjust, un-

healthy model of economic development is both humanly and environmentally unsustainable.

'Yes, we know that,' say many of us who believe in Health for All and a sustainable future. 'We are deeply worried.... But what can we do?'

There are no easy answers. The forces shaping global events are gigantic, and those who accept them as inevitable so impervious to rational dissent, that many of us hide our heads in the sand like ostriches. And so humanity thunders headlong down the path of systemic breakdown—more polarisation of society, more environmental deterioration, more neglect of human rights and needs, more social unrest and violence—as if our leaders were incapable of thought and our populations anaesthetised.

What action can we take, then—individually and collectively—to change things for the better, for the common good?

The purpose of this background paper

The interrelated crises of our times—the ways that globalisation, corporate rule, and top-down, 'development' policies undermine democratic process and endanger world health—are discussed in other background papers for the People's Health Assembly. The purposes of this paper are:

1. to examine the strategies used by the world's ruling class to keep the majority of humanity disempowered and complacent in the face of the crushing inequalities and hazards it engenders;
2. to explore the methods and resources whereby enough people can become sufficiently aware and empowered to collectively transform our current unfair social order into one that is more equitable, compassionate, health-promoting, and sustainable.

TOP-DOWN MEASURES of SOCIAL CONTROL

Disinformation

With all the technology and sophisticated means of communication now available, how is it that so many people appear so unaware that powerful interest groups are undermining democracy, concentrating power and wealth, and exploiting both people and the environment in ways that put the well-being and even survival of humanity at stake? How can a small elite minority so successfully manipulate global politics to its own advantage, and so callously ignore the enormous human and environmental costs? How can the engineers of the global economy so effectively dismiss the emerging risk of unprecedented social and ecological disaster?

In short, what are the weapons used by the ruling class to achieve compliance, submission, and social control of their captive population?

True, riot squads have been increased, prison populations expanded, and military troops deployed to quell civil disobedience. But far more than tear-gas and rubber bullets, **disinformation has become the modern means of social control**. Thanks to the systematic filtering of news by the mass media, many 'educated' people have little knowledge of the injustices done to disadvantaged people in the name of economic growth, or of the resultant perils facing humanity. They are unconscious of the fact that the overarching problems affecting their well-being—growing unemployment, reduced public services, environmental degradation, renewed diseases of poverty, bigger budgets for weapons than for health care or schools, more tax dollars spent to subsidize wealthy corporations than to assist hungry children, rising rates of crime, violence, substance abuse, homelessness, more suicides among teenagers—are rooted in the undemocratic concentration of wealth and power. Despite their personal hardships, unpaid bills, and falling wages, ordinary citizens are schooled to rejoice in the 'successful economy' (and spend more). They pledge allegiance to their masters' flag, praise God for living in a 'free world,' and fail to see (or to admit) the extent to which the world's oligarchy (ruling minority) is undermining democracy and endangering our common future. And our textbooks and TVs keep us strategically misinformed.

One dollar, one vote: private investment in public elections

One way 'government by the people' is undermined is through the purchase of public elections by the highest bidders. In many so-called democracies a growing number of citizens (in some countries, the majority) don't even bother to vote. They say it makes no difference. Politicians, once elected, pay little heed to the people's wishes. The reason is that wealthy interest groups have such a powerful political lobby. Their big campaign donations (bribes?) help politicians win votes—in exchange for political favours. The bigger the bribe, the more campaign propaganda on TV and mass media. Hence more votes.

This institution of legal bribery makes it hard for honest candidates (who put human need before corporate greed) to get elected. Democratic elections are based on one person, one vote. With the deep pockets of big business corrupting elections, results are based on one dollar, one vote. This makes a mockery of the democratic process.

The erosion of participatory democracy by the corporate lobby has far-reaching human and environmental costs. Hence the biggest problems facing humanity today—poverty, growing inequality, and the unsustainable plundering of the planet's ecosystems—continue unresolved.

Sufficient wisdom, scientific knowledge and resources exist to overcome poverty, inequity, hunger, global warming and the other crises facing our planet today. But those with the necessary wisdom and compassion seldom govern. They rarely get elected because they refuse to sell their souls to the company store. Winners of elections tend to be wheelers and dealers who place short-term gains before the long-term well-being of all.

To correct this unhealthy situation, laws need to be passed that stop lobbying by corporations and wealthy interest groups. In some countries, citizens' organisations are working hard to pass such campaign reforms. But it is hard to get them past legislators who pad their pockets with corporate donations. Only when enough citizens become fully aware of the issues at stake and demand a public vote to outlaw large campaign donations, will it be possible for them to elect officials who place the common good before the interests of powerful minorities.

But creating such public awareness is an uphill struggle—precisely because of the power of the corporate lobby and the deceptive messages of the mass media. To make headway with campaign reforms, institutionalised disinformation must be exposed for what it is. To accomplish this, more honest and empowering forms of education and information sharing are needed.

Schooling for conformity, not change

It has been said that **education is power**. That is why, in societies with a wide gap between the haves and have-nots, **too much education can be dangerous**. Therefore, in such societies, schooling provides less education than indoctrination, training in obedience, and cultivation of conformity. **In general, the more stratified the society, the more authoritarian the schools.**

Government schools tend to teach history and civics in ways that glorify the wars and tyrannies of those in power, whitewash institutionalised transgressions, justify unfair laws, and protect the property and possessions of the ruling class. Such history is taught as gospel. And woe be to the conscientious teacher who shares with students 'people's history' of their corner of the earth.

Conventional schooling is a vehicle of disinformation and social control. It dictates the same top-down interpretations of history and current events, as do the mass media. It whitewashes official crimes and aggression. Its purpose is to instill conformity and compliance, what Noam Chomsky calls 'manufacturing consent.'

For example, although the United States has a long history of land-grabbing, neocolonial aggression and covert warfare against governments committed to equity, most US citizens take pride in their 'benevolent, peace-loving nation'. Many believe they live in a democracy 'for the people and by the people, with liberty and justice for all'—even though millions of children in the US go hungry, countless poor folks lack health care, prison populations expand (mainly with destitute blacks), and welfare cut-backs leave multitudes jobless, homeless and destitute.

the NEED for BOTTOM-UP approaches to communication

To see through the institutionalised disinformation, and to mobilise people in the quest for a healthier, more equitable society, we need alternative methods of education and information-sharing that are honest, participatory, and empowering. This includes learning environments that bring people together as equals to critically analyse their reality, plan a strategy for change, and take effective united action.

Fostering empowering learning methods is urgent in today's shrinking world, where people's quality of life, even in remote communities, is increasingly dictated by global policies beyond their control.

Alternative media and other means of people-to-people communication

There have been a number of important initiatives in the field of alternative media, communication, and social action for change.

The alternative press. While struggling to stay alive in recent years, the alternative press (magazines, flyers, bulletins, newsletters, progressive comic books) has provided a more honest, people-centred perspective on local, national and global events. Some of the more widely-circulating alternative magazines in English (often with translations into several other languages) include:

The New Internationalist
Z Magazine
Resurgence
The Nation
Third World Resurgence
Covert Action Quarterly
Multinational Monitor

Also, there are many newsletters and periodicals published by different watchdog groups such as the International Forum on Globalization, IBFAN, BankWatch, the National Defense Monitor and Health Action International, among others. It is important that we subscribe to and read (and encourage others to read) these progressive alternative writings.

Alternative community radio and TV. The role and potential of these is similar to that of the alternative press. Stations that do not accept advertising are less likely to belong to or sell out to the controlling elite. But to survive they need listener support.

Internet. Electronic mail and websites have opened up a whole new sphere of rapid, direct communication across borders and frontiers. The Web is, of course, a two-edged sword. The Internet is currently available to less than 2% of the world's people, mostly the more privileged. And instant electronic communications facilitate the global transactions and control linkages of the ruling class. But at the same time, E-mail and the World-Wide-Web provide a powerful tool for popular organisations and activists around the globe to communicate directly, to rally for a common cause and to organise international solidarity for action.

The potential of such international action was first demonstrated by the monumental worldwide outcry, through which non-government organisations (NGOs) and grassroots organisations halted the passage of the Multilateral Agreement on Investment (MAI). (The MAI was to have been a secret treaty among industrialised countries, giving even more power and control over Third World Nations.) The primary vehicle of communication for the protest against MAI was through the Internet.

Mass gatherings for organised resistance against globalised abuse of power. The turn of the Century was also a turning point in terms of people's united resistance against global trade policies harmful to people and the planet. The huge, well-orchestrated protest of the World Trade Organization (WTO) summit meeting in Seattle, Washington (now celebrated worldwide as the 'Battle in Seattle') was indeed a breakthrough. It showed us that **when enough socially committed people from diverse fields unite around a common concern, they can have an impact on global policy making**.

The agenda of the WTO summit in Seattle was to further impose its pro-business, anti-people and anti-environment trade policies. That agenda was derailed by one of the largest, most diverse, international protests in human history. Hundreds of groups and tens of thousands of people representing NGOs, environmental organisations, human rights groups, labour unions, women's organisations, and many others joined to protest and barricade the WTO assembly. Activists arrived from at least 60 countries. The presence of so-many grassroots protesters gave courage to many of the representatives of Third World countries to oppose the WTO proposals which would further favor affluent countries and corporations at the expense of the less privileged. In the end, the assembly fell apart, in part from internal

disaccord. No additional policies were agreed upon.

Perhaps the most important outcome of the Battle in Seattle was that, despite efforts by the mass media to denigrate and dismiss the protest, key issues facing the world's people were for once given center stage. It was a watershed event in terms of grassroots mobilisation for change. But the activists present agreed that it was just a beginning.

The People s Health Assembly, with its proposed 'People's Charter for Health' and plans for follow-up action, holds promise of being another significant step forward in the struggle for a healthier, more equitable approach to trade, social development, and participatory democracy. For that promise to be realised, people and groups from a wide diversity of concerns and sectors must become actively involved around our common concern: the health and well-being of all people and of the planet we live on.

EDUCATION *for* PARTICIPATION, EMPOWERMENT, *and* ACTION *for* change

The term 'Popular Education,' or 'Learner-centered education,' refers to participatory learning that enables people to take collective action for change. Many community-based health initiatives have made use of these enabling methodologies, adapting them to the local circumstances and customs. Particularly in Latin America, methods of popular education have been strongly influenced by the writings and awareness-raising 'praxis' of Paulo Freire (whose best known book is *Pedagogy of the Oppressed.*)

Education of the oppressed—the methodology of Paulo Freire

In the mid-1960s the Brazilian educator, Paulo Freire developed what he called **education for liberation**, an approach to adult literacy training, (which proved so revolutionary that Freire was jailed and then exiled by the military junta.) With his methods, non-literate workers and peasants learned to read and write in record time—because their learning focused on what concerned them most: the problems, hopes and frustrations in their lives. Together they critically examined these concerns, which were expressed in key words and provocative pictures. The process involved identification and analysis of their most oppressive problems, reflection on the causes of these, and (when feasible) taking action to 'change their world'.

Learning as a two-way or many-way process

With Freire's methodology, problem-solving becomes an open-ended, collective process. Questions are asked to which no one, including the facilitator have ready answers. 'The teacher is learner and the learners, teachers.' Everyone is equal and all learn from each other. The contrast with the typical classroom learning is striking. **In typical schooling**, the teacher is a superior being who 'knows it all'. He is the owner and provider of knowledge. He passes down his knowledge into the heads of his unquestioning and receptive pupils, as if they were empty pots. (Freire calls this the 'banking' approach to learning because knowledge is simply deposited.)

In education for change, the facilitator is one of the learning group, an equal. She helps participants analyse and build on their own experiences and observations. She respects their lives and ideas, and encourages them to respect and value one another's. She helps them reflect on their shared problems and the causes of these, to gain confidence in their own abilities and achievements, and to discuss their common concerns critically and constructively, in a way that may lead to personal or collective action. Thus, according to Freire, the learners discover their ability to 'change their world'. (For this reason Freire calls this a 'liberating' approach to learning).

The key difference between 'typical schooling' and 'education for change' is that **the one pushes ideas into the student's heads, while the other draws ideas from them**. Typical schooling trains students to conform, comply, and accept the voice of authority without question. Its objective is to maintain and enforce the status quo. It is disempowering. By contrast, education-for-change is enabling. It helps learners gain 'critical awareness' by analysing their own observations, drawing their own conclusions and taking collective action to overcome problems. It frees the poor and oppressed from the idea that they are helpless and must suffer in silence. It empowers them to build a better world—hence it is 'education for transformation'.

examples of GRASSROOTS health programmes that have combatted ROOT CAUSES of POOR HEALTH

Community-based health programmes in various countries have brought people together to analyse the root causes of their health-related problems and to 'take health into their own hands' through organised action. In places where unjust government policies have worsened the health situation, community health programmes have joined with popular struggles for fairer and more representative governments. The following are a few examples of programmes where people's collective 'struggle for health' has led to organised action to correct inequalities, unfair practices and/or unjust social structures.

Gonoshasthaya Kendra (GK). GK is a community health and development programme in Bangladesh that began during the war for national independence. Village women, many of them single mothers (the most marginalised of all people), have become community health workers and agents of change. Villagers collectively analyse their needs and build on the knowledge and skills they already have. Repeatedly health workers have helped villagers take action to defend their rights.

One example of this is over water rights. In analysing their needs, families agreed that access to good water is central to good health. UNICEF had provided key villages with tubewells. But rich landholders took control of the wells and made people pay so much for water that the poor often went without. Health workers helped villagers organise to gain democratic, community control of the wells. This meant more water and better health for the poor. And it helped people gain confidence that through organised action they could indeed better their situation.

Another example concerns schooling. Villagers know education is important for health. But most poor children of school age must work to help their families survive. So the GK communities started a unique school, which stresses cooperation, not competition. Each day the children able to attend the school practise teaching each other. After school these same children teach those unable to attend school. This process of teaching one another and working together to meet their common needs, sews seeds for cooperative action for change.

Jamkhed, India. For over three decades two doctors, Mabel and Raj Arole, have worked with poor village women, including traditional midwives. These health facilitators have learned a wide variety of skills. They bring groups of women together to discuss and try to resolve problems. In this way, they have become informal community leaders and agents of change. They help people rediscover the value of traditional forms of healing, while at the same time demystifying Western medicine, which they learn to use carefully in a limited way.

In Jamkhed, women's place relative to men's has become stronger. Women have found courage to defend their own rights and health and those of their children. As a result of the empowerment and skills-training of women, child mortality has dropped and the overall health of the community has improved dramatically.

The Philippines. In this island nation, during the dictatorship of Fernando Marcus, a network of community-based health programmes (CBHPs) evolved to help people deal with extreme poverty and deplorable health conditions. Village health workers learned to involve people in what they called **situational analysis**. Neighbours would come together to prioritise the main problems affecting their health, identify root causes and work collectively towards solutions.

In these sessions it became clear that **inequality—and the power structures that perpetuate it—were at the root of ill health**. Contributing to the dismal health situation were: unequal distribution of farm land (with huge land-holdings by transnational fruit companies), cut-backs in public services, privatisation of the health system, and miserable wages paid to factory and farm workers. The network of community-based programs urged authorities to improve this unjust situation. When their requests fell on deaf ears, they organised a popular demand for healthier social structures. These included free health services, fairer wages, redistribution of the land to the peasantry, and above all else, greater accountability by the government to its people.

The fact that the CBHP network was awakening people to the socio-political causes of the poor so threatened the dictatorship that scores of health workers were jailed or killed. But as oppression grew, so did the movement. The CBHP network joined with other movements for social change. Finally, the long process of awareness-raising and cooperative action paid off. In the massive peaceful uprising of 1986, thousands of citizens confronted the soldiers, putting flowers into the muzzles of their guns. The soldiers (many of whom were peasants themselves, acquiesced. After years of organising and grassroots resistance, the dictatorship was overthrown. (Unfortunately, the overall situation has not changed greatly. With persistent domination by the US government and multinational corporations, gross inequities remain and the health of the majority is still dismal. The struggle for a healthier, more equitable society continues.)

Nicaragua. Similar to the CBHP in the Philippines under Marcus, in Nicaragua during the Somoza dictatorship a network of non-government community health programmes evolved to fill the absence of health and other public services. Grassroots health workers known as **Brigadistas de Salud** brought groups of people together to conduct **community diagnoses** of problems affecting their health, and to work together toward solutions. As in the Philippines, the ruling class considered such **community participation** subversive. Scores of health workers were 'disappeared' by the National Guard and paramilitary death squads. Many health workers went underground and eventually helped form the medical arm of the Frente Sandinista, the revolutionary force that toppled the dictatorship.

After the overthrow of Somoza, hundreds of Brigadistas joined the new health ministry. With their commitment to strong participation, they helped to organise and conduct national 'Jornadas de Salud' (Health Days). Their work included country-wide vaccination, malaria control, and tuberculosis control campaigns. At the same time, adult literacy programmes, taught mainly by school children, drastically increased the nation's level of literacy.

As a result of this participatory approach, health statistics greatly improved under the Sandinista government. Since the Sandinistas were ousted with the help of the US government, health services have deteriorated and poverty has increased. Many health indicators have suffered. But fortunately, communities still have the skills and self-determination necessary to meet basic health needs and assist one another in hard times.

Project Piaxtla, in rural Mexico. In the mountains of western Mexico in the mid-1960s a villager-run health programme began and gradually grew to cover a remote area unserved by the health system. Village health promoters, learning in part by trial and error, developed dynamic teaching methods to help people identify their health needs and work together to overcome them.

Over the years, Piaxtla evolved through three phases: 1) curative care, 2) preventive measures, and 3) socio-political action.
It was the third phase that led to the most impressive improvements in health. (In two decades, child mortality dropped by 80%.) Through Community Diagnosis, villagers recognised that a big

david werner

cause of hunger and poor health was the unconstitutional possession of huge tracts of farmland by a few powerful landholders, for whom landless peasants worked for slave wages. The health promoters helped the villagers organise, invade the illegally large holdings, and demand their constitutional rights. Confrontations resulted, with occasional violence or police intervention. But eventually the big landholders and their government goons gave in. In two decades, poor farmers reclaimed and distributed 55% of good riverside land to landless farmers. Local people agree that their struggle for fairer distribution of land was the most important factor in lowering child mortality. And as elsewhere, people's organised effort to improve their situation helped them gain the self-determination and skills to confront other obstacles to health.

The practical experience of Project Piaxtla and its sister programme, PROJIMO, gave birth to 'Where There Is No Doctor,' 'Helping Health Workers Learn,' 'Disabled Village Children' and the other books by David Werner that have contributed to community-based health and rehabilitation initiatives worldwide.

networking and COMMUNICATIONS among GRASSROOTS programmes and movements

From isolation to united struggle

In different but parallel ways, each of the com munity initiatives briefly described above developed enabling participatory methods to help local people learn about their needs, gain self-confidence, and work together to improve their well-being. Each forged its own approaches to what we referred to earlier as **education for change**.

At first community health initiatives in different countries tended to work in isolation, often unaware of each other's existence. There was little communication and sometimes antagonism between them. But in time this changed, partly due to growing obstacles to health imposed by the ruling class. (Nothing solidifies friendship like a common oppressor.) Programmes in the same country or region began to form networks or associations to assist and learn from each other. By joining forces, they were able to form a stronger, more united movement, especially when confronting causes of poor health rooted in institutionalised injustice and inequity.

National networks in Central America and the Philippines provided **strength in numbers** that gave community health programmes mutual protection and a stronger hand to overcome obstacles.

In the 1970s, community-based health programmes in several Central American countries formed **nationwide associations**. Then in 1982 an important step forward took place. Village health workers from CBHPs in the various Central American countries and Mexico met in Guatemala to form what became the **Regional Committee of Community Health Promotion**.

This Regional Committee has helped to build solidarity for the health and rights of people throughout Central America. Solidarity was particularly important during the wars of liberation waged in Central America (and later in Mexico), when villages were subjected to brutal and indiscriminate attacks by repressive governments and death squads.

Learning from and helping each other

One of the most positive aspects of networking among grassroots programmes and movements has been the cross-fertilisation of experiences, methods and ideas.

Central America. For example, in the 1970s, the Regional Committee and Project Piaxtla organised a series of **'intercambios educativos'** or **educational interchanges**. Community health workers from different programmes and countries came together to learn about each other's methods of confidence-building, community diagnosis, and organisation for community action.

At one of these Intercambios, representatives from Guatemala, in a highly participatory manner, introduced methods of 'conscientización' (awareness-raising) developed by Paulo Freire, as they had adapted them to mobilise people around health-related needs in Guatemala.

Likewise the village health promoters of Piaxtla, in Mexico, introduced to participants a variety of methods of discovery-based learning, which they had developed over the years (see below).

Reaching across the Pacific. An early step towards more global networking took place in 1??, when an educational interchange was arranged between community health workers from **Central America** and the **Philippines**. A team of health workers from Nicaragua, Honduras and Mexico visited a wide range of community-based health programmess, rural and urban, in the Philippines. In spite of language barriers, the sharing of perspectives and sense of solidarity that resulted were profound. Social and political causes of ill health in the two regions were similar. Both the Philippines and Latin America have a history of invasion and subjugation, first by Spain and then by the United States. Transnational corporations and the International Financial Institutions have contributed to polarising the rich and poor. And in both regions, the US has backed tyrannical puppet governments that obey the wishes of the global marketeers in exchange for loans and weapons to keep their impoverished populations under control.

Participants in the Latin American-Philippine interchange came away with a new understanding of the global forces behind poor health. They became acutely aware of the need for a worldwide coalition of grassroots groups and movements to gain the collective strength needed to construct a healthier, more equitable, more sustainable global environment.

the life and death of PRIMARY HEALTH CARE

Health for All? The United Nations established the World Health Organization (WHO) in 1945 to co-ordinate international policies and actions for health. WHO defined health as 'complete physical, mental, and social well-being, and not merely the absence of disease.'

But in spite of WHO and the United Nations' declaration of Health as a Human Right, the poorer half of humanity continued to suffer the diseases of poverty, with little access to basic health services. In 1987, WHO and UNICEF organised a watershed global conference in Alma Ata, USSR. It was officially recognised that the Western Medical Model, with its costly doctors in giant 'disease palaces,' had failed to reach impoverished populations. So the world's nations endorsed the **Alma Ata Declaration,** which outlined a revolutionary strategy called **Primary Health Care (PHC)**, to reach the goal of **Health for All by the Year 2000**. The vision of PHC was modeled after the successful grassroots community-based health programmes in various countries, as well as the work of 'barefoot doctors' in China. It called for **strong community participation in all phases**, *from planning and implementation to evaluation.*

Health for No One? We have entered the 21st century and are still a long way away from 'Health for All.' If our current global pattern of short-sighted exploitation of people and environment continue, we will soon be well on the road to 'Health for No One.' The current paradigm of economic development, rather than eliminating poverty, has so polarised society that combined social and ecological deterioration endangers the well-being of all. But sustainable well-being is of secondary concern to the dictators of the global economy, whose all-consuming objective is GROWTH AT ALL COST!

It has been said that Primary Health Care failed. But in truth, it has never been seriously tried. Because it called for and the full participation of the underprivileged along with an equitable economic order, the ruling class considered it subversive. Even UNICEF—buckling under to accusations by its biggest founder (the US government) that it was becoming 'too political'—endorsed a disembowelled version of PHA called **Selective Primary Health Care**. Selective PHC has less to do with a healthier, more equitable social order than with preserving the *status quo* of existing wealth and power.

The World Bank's take-over of health planning. The kiss of death to comprehensive PHC came in 1993 when the World Bank published its World Development Report, titled 'Investing in Health.' The Bank advocates a restructuring of health systems in line with its neo-liberal free-market ideology. It recommends a combination of privatisation, cost-recovery schemes and other measures that tend to place health care out of reach of the

poor. To push its new policies down the throat of poor indebted countries, it requires acceptance of unhealthy policies as a pre-condition to the granting of bail-out loans.

In the last decade of the 20th century, the World Bank took over WHO's role as world leader in health policy planning. The take-over was powered by money. The World Bank's budget for 'Health' is now triple that of WHO's total budget. With the World Bank's invasion of health care, comprehensive PHC has effectively been shelved. **Health care is no longer a human right. You pay for what you get.** If you are too poor, hungry and sick to pay, forget it. The bottom line is business as usual. Survival of the greediest!

COALITIONS for the health and well-being of HUMANITY

Primary Heath Care as envisioned at Alma Ata was never given a fair chance,—and globalisation is creating an increasingly polarised, unhealthy and unsustainable world. — In response, a number of international networks and coalitions have been formed. Their goal is to revitalise comprehensive PHC and to work towards a healthier, more equitable, more sustainable approach to development. Two of these coalitions, which have both participated in organising the People's Heath Assembly, are the following.

The Third World Health Network (TWHN), based in Malaysia, was started by the Third World Network, which has links to the International Consumers Union. The TWHN consists of progressive health care movements and organisations, mainly in Asia. One important contribution of the Network has been the collection of a substantial library of relevant materials, their lobby for North-South equity and the promotion of networking between Third World organisations.

The International People s Health Council (IPHC) is a coalition of grassroots heath programmes, movements and networks. Many of its members are actively involved in community work. Like the TWHN, the IPHC is committed to working for the health and rights of disadvantaged people—and ultimately, of all people. Its vision is to advance towards a healthy global community founded on fairer, more equitable social structures. It strives towards a model of people-centred development, which is participatory, sustainable, and makes sure that all people's basic needs are met.

The IPHC is not just a South-South network for underdeveloped countries, but also includes grassroots struggles for health and rights among the growing numbers of poor and disadvantaged people in the Northern 'overdeveloped' countries.

For the last two years the Third World Network and the IPHC have worked closely together in the preparations for the People's Health Assembly.

METHODOLOGIES of EDUCATION for CHANGE

One of the most rewarding activities of the IPHC was a post-conference workshop held in Cape Town, South Africa, on Methodologies of Education for Change. Health educators from Africa, Central America, Mexico, North America, the Philippines and Japan—most with many years of experience— facilitated group activities. Each demonstrated some of the innovative learning and awareness raising methods they use in their different countries. The challenge of the workshop was **to design or adapt methods of education for action to meet the new challenges of today's globalised and polarised world.**

From micro to macro, local to global: ways of making and understanding the links

The Cape Town Workshop participants agreed that a global grassroots movement needs to be mobilised to help rein in the unhealthy and unsustainable aspects of globalisation.

To do this, learning tools, methods, and teaching aids must be developed to help ordinary people see the links between their local problems and

L-3A.3 (3)

(Second section of)
The Medicalization of Health Care and
The Challenge of Health for All — David Sanders.

This emphasis on medically-driven programmes is reflected in the internal organisational structure of many ministries of health and WHO itself: such arrangements reinforce the tendency towards vertical technical approaches and militate against implementation of comprehensive PHC.

Health care continues to be an instrument of social control.

Overtly unethical behaviour and human rights violations by health personnel are, unfortunately, not only a disgraceful part of health history, but persist, particularly in situations of war and political oppression. However, health care as an instrument of social control is much more subtle and widespread. Central to this is the mystification by the health professions of the real causes of illness, which is often attributed to ill-considered individual behaviour and natural misfortune, rather than to social injustice, economic inequality and oppressive political systems. Examples of such individualised and conservative approaches range from the promotion of family planning, in isolation from social development, as a means of population control, to oppressive forms of health education that neglect the social determinants of certain 'lifestyle' factors linked to ill-health.

david werner

Guiding values and suggested action

The vision of the Peoples' Health Assembly is of an accessible, affordable, equitably distributed, appropriate and sustainable health system, based on the principles of comprehensive PHC and responsive to its users. Mechanisms for popular participation in the health system should ensure its accountability and also contribute to the movement for participatory democracy in society at large.

In order to achieve such a vision the following broad types of action are suggested:

Advocate at national and international levels for prioritisation of and investment in health.

There is accumulating evidence that investment in the social sectors has not only contributed to social development but has also often led to economic development. The 'Good Health at Low Cost' examples of Cuba, Sri Lanka, China, Costa Rica and Kerala State in India demonstrate that a commitment to broad-based, equitable development, with investment in women's education, health and welfare, has a significant and sustainable impact on the health and social indicators of the whole population. To realise the equity essential for a healthy society, evidence suggests that a strong, organised demand for government responsiveness and accountability to social needs is crucial. Recognition of this important challenge informed the Alma Ata call for stronger community participation. To achieve and sustain the political will to meet all people's basic needs, and to regulate the activities of the private sector, a process of participatory democracy—or at least a well-informed movement of civil society—is essential: analysts have noted that such political commitment was achieved in Costa Rica through a long history of egalitarian principles and democracy, in Kerala through agitation by disadvantaged political groups, and in Cuba and China through social revolution. 'Strong' community participation is important not only in securing greater government responsiveness to social needs, but also to mobilize an active, conscious and organised population critical to the design, implementation and sustainability of comprehensive health systems.

Good Health at Low Cost

Despite the dismal living conditions and health situation in many poor countries, a few poor states have succeeded in making impressive strides in improving their people's health. In 1985, the Rockefeller Foundation sponsored the 'Good Health at Low Cost' study to explore why certain poor countries with low national incomes managed to achieve acceptable health statistics. More specifically, they asked how China, the state of Kerala in India, Sri Lanka, and Costa Rica attained life expectancies of 65–70 years with GNPs per capita of only US$300–1,300.

Upon completing the study, the authors determined that the increased life expectancies were due to a reduction in child and infant mortality rates (IMR) in the four states and were accompanied by declines in malnutrition and, in some cases, in the incidence of disease. These remarkable improvements in health were attributed to four key factors:

- political and social commitment to equity (i.e. to meeting all people's basic needs);
- education for all, with an emphasis on the primary level;
- equitable distribution throughout the urban and rural populations of public health measures and primary health care;
- an assurance of adequate caloric intake at all levels of society in a manner that does not replace indigenous agricultural activity.

The importance of factor one, a strong political and social commitment to equity, cannot be overemphasised. While the course of action may vary, equitable access to health services necessitates breaking down the social and economic barriers that exist between disadvantaged subgroups and medical services.

Of the four regions investigated, China was the most exceptional in terms of equality. Whereas in the other three states, the decline in IMR was largely due to better social services (improved health care coverage, immunisation, water and sanitation, food subsidies and education), China's improvements were rooted in fairer distribution of land use and food production. The population was encouraged to become more self-sufficient, rather than to become dependent on government assistance.

While all four regions developed cooperative, community-oriented approaches to resolving problems and meeting basic needs, in the 15 years since the Rockefeller study, China has had the most success in maintaining its advances towards 'good health at low cost'.

Source: Werner, D. and Sanders, D. (1997) Questioning the Solution: The Politics of Primary Heath Care and Child Survival. Palo Alto: HealthWrights, p.115.

Concerted action should be taken to persuade individual governments to invest in health. WHO needs to be lobbied to assume a stronger advocacy role. It should take the lead in analysing and publicising the negative impact that globalisation and neoliberal policies are having on vulnerable groups. It should spearhead moves to limit health hazards aggravated by globalisation, including trade in dangerous substances such as tobacco and narcotics. It needs to strongly assert health as a Human Right and publicise and promote the benefits of equitable development and investment in health. The extent to which WHO and governments play such roles will depend on the extent to which popular mobilisation around health occurs. Communities have to be active and organised in demanding these changes.

Demystify the causes of ill-health and promote an understanding of its social determinants.

Since 'health' and 'medicine' have become virtually synonymous in the popular consciousness, it is important to communicate the evidence for the fact that ill-health results from unhealthy living and working conditions, from the failure of governments to provide health-promoting conditions through policies that ensure greater equity. It then becomes obvious that health problems are the result of structural factors and political choices and that their solution cannot lie in health care alone, but requires substantial economic reform as well as comprehensive and intersectoral health action. Mechanisms to disseminate this message, including the use of the mass media, must be identified and exploited.

Advocate and promote policies and projects that emphasise intersectoral action for health.

Government health ministries and international health agencies need to be pressed to engage as partners with the sectors, agencies and social groups critical to the achievement of better health. Policy development must be transparent and inclusive to secure broader understanding and wider ownership of health policies. Structures involving the different partners need to be created at different levels from local to national, or within such settings as schools and workplaces. The priority should be to focus on geographical areas with the greatest health needs and involve communities and their representatives at local level. Subgroups with responsibility for health, within local, provincial or national government (e.g. health committees of local government councils) should be promoted and should have links to the above structures. This has occurred in some of the Healthy Cities projects in both industrialised and developing countries. Currently the Brazilian law requires different groups to discuss the health policies to be promoted, and includes community and consumer participation.'

Intersectoral action to reduce traffic accidents

In the early 1970s, Denmark had the highest rate of child mortality from traffic accidents in Western Europe. A pilot study was started in Odense. Forty-five schools participated in an exercise carried out with accident specialists, planning officials, the police, hospitals and road authorities, to identify the specific road dangers that needed to be addressed. A network of traffic-free foot and cycle paths were created as well as a parallel policy of traffic speed reduction, road narrowing and traffic islands. Following the success of the pilot study, the Danish Safe Routes to Schools Programme has been implemented in 65 out of 185 proposed localities and the number of accidents has fallen by 85%. Accidents can, and must, be avoided. It is the responsibility of each one of us, but many initiatives can and should come from local authorities.

Source: Walking and Cycling in the City. WHO, 1998E. p. 64

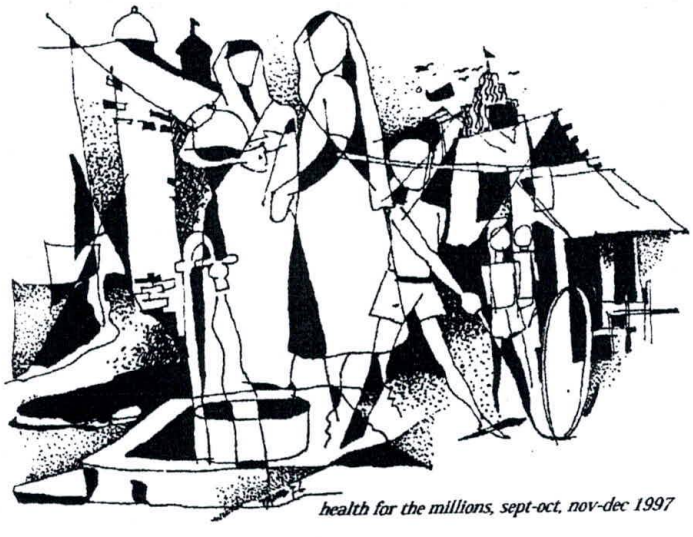
A process of engaging the public in a dialogue about public health problems and in setting goals for their control can both popularise health issues and become a rallying-point around which civil society can mobilise and demand accountability. It can also create the basis for popular involvement in implementation of health initiatives.

Actively develop comprehensive, community-based programmes.

Most programmes addressing priority health problems start from a health care or services perspective. While curative, personal preventive and caring actions are very important and still constitute the core of medical care, comprehensive PHC demands that they be accompanied by rehabilitative and promotive actions. In addressing priority health problems comprehensively, by defining and implementing promotive, preventive, curative and rehabilitative actions, a set of activities common to a number of health programmes will be developed as well as a horizontal infrastructure.

The principles of programme development apply equally to all types of health problems, from diarrhoea to heart attacks to domestic violence. After the priority health problems in a community have been identified, the first step in programme development is the conducting of a situation analysis. This should identify the prevalence and distribution of the problem, its causes, the potential resources to address them,, including community capacities and strengths that can be mobilised and actions that can be undertaken to address the problems. The more effective programmes have taken the above approach, involving health workers, other sectors' workers and the community in the three phases of programme development, namely, assessment of the nature and extent of the problems, analysis of their multi-level causation and priority actions to address the identified causes. Here, partnerships with NGOs with expertise in various aspects of community development are crucial.

Clearly, the specific combination of actions making up a comprehensive programme will vary from situation to situation. However, there are certain principles that should inform programme design, one of which is the deliberate linking of actions that address determinants operating at different levels. So, for example, in a nutrition programme any intervention around dietary inadequacy (immediate cause) should also address household food insecurity (underlying cause). Clearly the principle of linking curative or rehabilitative (feeding), preventive (nutrition education) and promotive actions (improved household food security) should be applied to health programmes other than nutrition, together with addressing basic causes in the political and economic realm.



health for the millions, sept-oct, nov-dec 1997

A Comprehensive Approach to Under Nutrition in Zimbabwe: The Children's Supplementary Feeding Programme (CSFP)

The existing community-based popular infrastructure that had developed during the war permitted a more rapid and better-organised implementation of the nutrition programme than would otherwise have been possible. Mothers evaluated the children's nutritional status by measuring and recording their upper arm circumferences. Those with mid-upper-arm circumferences less than 13 cms were included in the programme. The reasons for this cut-off point were explained to all parents, both those of children admitted to the programme, as well as those considered not at risk. They then established locations for supplementary feeding (which the mothers preferred to be located close to their homes and fields), and themselves cooked the food and fed the underweight children.

The design of the programme was informed, on the one hand, by an understanding of the most important factors underlying rural child undernutrition in Zimbabwe and, on the other, by knowledge of rational dietary measures and identification of locally used and cultivable food sources (analysis). By deliberately selecting for use in the programme foods that were highly nutritious, traditionally used in weaning and commonly cultivated, and by reinforcing their value with a very specific message in the form of a widely distributed poster asserting the importance of groundnuts and beans in addition to the staple, it was possible to shift the focus of the intervention from supplementary feeding towards small-scale agricultural production programme. This was aimed at reinstating the cultivation of groundnuts— culturally a 'women's crop'— which had been largely displaced as a food crop in Zimbabwe by the commercialisation of maize. The provision by the local and the national government of communal land, agricultural inputs and extension assistance, together with the policy of collective production on these groundnut plots, contributed to improving poor households' food security. The joint involvement of ministries of health and agriculture in this project led to the development of intersectoral Food and Nutrition Committees at sub-district, district and provincial levels.

The programme design therefore allowed the linking of a rehabilitative measure (supplementary feeding) to preventive and promotive interventions (nutrition education and food production), thereby displaying the features of a comprehensive primary health care programme. This comprehensive approach to child undernutritiongreatly influenced the management of this problem within the health sector. It resulted in a changed approach of health staffto the dietary management of the sick child and to nutritional rehabilitation. It also created a community-level infrastructure of feeding points and food production plots/child care centres to which recuperating undernourished children could be sent. Thus the sequenced addressing of immediate (dietary) and underlying causes (household food insecurity, inadequate young child care and inaccessible health services) by the feeding,the communal plots and pre-school centres respectively, was made possible by both careful design based on a prior analysis and by the presence of a well-organised and motivated population. Intersectoral action and structures for nutrition and food security developed around the project, from the bottom-up, and were supported at higher levels of government.

health for the millions, sept-oct. nov-dec 1997

Source: Sanders in Werner, D & Sanders, D. (1997). Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto: HealthWrights.

In other health programmes - such as the Safe Motherhood Initiative, the programme for Integrated Management of Childhood Illness and Tuberculosis management (DOTS) - as also in technical guidelines for the management of common non-communicable diseases, similar minimum or core service components can be identified. Standardising and replicating these core activities in health facilities is helpful in reinforcing their practice throughout the health system, but does not guarantee the implementation of a comprehensive PHC programme, which must involve other sectors as well as communities in promotive actions.

Promote the use and dissemination of appropriate health technologies

The use of appropriate health technologies can have a number of positive effects, which include spreading health care more widely and increasing its cost-effectiveness. One of the less obvious, but

very important effects of appropriate technology is in demystifying health care by giving lower-level health workers and, through them, community members better understanding, skills and effective technologies forhealth care. Thus the medical professions' monopoly of knowledge and expertise can be challenged. A good example is the use of homemade cereal gruels, which have been shown to be very effective in rehydration during diarrhoea.

Similarly, if certain appropriate health technologies become widely incorporated into standard health practice, their use can stimulate a critical approach to the expanding range of inappropriate, sophisticated and expensive technologies. A good example is that of pharmaceuticals. Encouragement of the use of a standardised, short list of inexpensive drugs (essential drugs lists) known by their own name (generics), not a trade name, can reduce bad prescribing practices and begin to undermine the operations of the pharmaceutical industry. Evidence that such an initiative has succeeded in challenging the forces that historically have dominated health care has been the extent of the opposition by the pharmaceutical industry to WHO's essential drugs programme.

Increasing the visibility and role of community-based health workers.

In the early years of the PHC movement an important and effective role was played by community health workers (CHWs) in the implementation of PHC. One of the strongest features of CHWs is that they are predominantly women who can often identify and gain access to those households and individuals with the greatest health needs. Indeed, many of the 'model' PHC initiatives relied extensively on CHWs for their successful operation. Further, the role of CHWs was seen not merely as a technical one of extending basic health care to peripheral communities and households: it was also, importantly, frequently an advocacy and social mobilising role, enlisting the conscious involvement of communities and other sectors in health development.

The conservative economic and political environment of the late 1980s and 1990s has contributed to the demise of many CHWs programmes: policy-makers seldom advocate the retention of this cadre, and communities are economically unable to support them.

Given the very positive past experiences of CHW programmes in diverse situations, and the increasing need for community-based workers given the international health crisis, aggravated in many countries by the HIV pandemic, it is urgent that the progressive health movement advocate and campaign for the reintroduction of this cadre and look for innovative ways to care for their communities.

Advocate for equity in health and health care.

Equity is core to the policy of Health for All. Socio-economic inequalities are growing everywhere, at a more rapid rate than ever before. Together with reductions in public health and social services in many countries, this is leading to growing inequities in health. To advocate equity in health and health care more successfully amongst international organisations, governments, donors and professional organisations, we have to demonstrate the social differentials in access to health resources and in health outcomes. The progressive health movement needs to press for the monitoring of equity in health through advocacy and information dissemination.

Promote more appropriate health personnel education and better management.

The primary health care approach needs much more strongly to inform the content of health sciences curricula as well as the learning process and choice of venues for learning. The aim is to equip learners with competencies spanning a broader range than has traditionally been the case. There is accumulating evidence that problem-oriented and practice-based approaches result in more relevant learning, and in the acquisition of problem-solving skills, both necessary attributes for the successful development of the PHC approach. If health workers are to contribute to a health system that enables people to assume more responsibility for their own health through an emphasis on preventive and promotive measures

Table: Key indicators for monitoring equity in health and health care

Indicator categories	Indicators measuring differences between population groups
Health determinants indicators	Prevalence and level of poverty Income distrivution Educational levels Adequate sanitation and safe water coverage
Health status indicators	Under 5-year child mortality rate Prevalence of child stunting [Recommended additional indicators: maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1–4 year old mortality rate expressed separately]
Health care resource allocation indicators	Per capita distribution of *qualified* personnel in selected categories Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels Per capita distribution of total health expenditures on personnel and supplies, as well as facilities
Health care utilisation indicators	Immunisation coverage Antenatal care coverage % of births attended by a qualified attendant Current use of contraception, percentage

Source: World Health Organization (1998). Final report of meeting on policy-orientated monitoring of equity in health and health care. 29 September–3 October 1997. Geneva: WHO. page ii.

integrated with curative and rehabilitative measures, then their training must expose them to good practice at district level and to the social issues at community level. There is also an urgent need for teaching staff in the health sciences to upgrade their skills to carry out such a reorientation of the curricula.

The above suggestions for education reform apply equally to all categories of health personnel, as well as to undergraduate and post-graduate training. It has long been acknowledged that nurses play a pivotal role in the PHC team; in addition, they constitute the largest category of health personnel in many countries. Endorsement of such educational reforms and their fuller implementation and promotion by the nursing leadership within individual countries is critically important for progress towards Health for All.

In most countries, health education institutions have not carried out curriculum reform along the lines described above. Although there are indications that some have embarked or will embark on such a course, there will probably still be a significant delay before sufficient 'new' graduates are available to work in and transform the health system. Clearly, if the implementation of comprehensive PHC is to be achieved during the next decades, the process of curriculum reform in the educational institutions needs to be accelerated and accompanied by a massive programme of capacity development of personnel already working in the health system. In short, the current Health for All imperative demands the rapid expansion of continuing education activities in most countries. Some of this in-service learning should take place in multi-disciplinary teams to promote better teamwork.

Similarly, education in PHC needs to involve personnel from other health-related sectors as well as community members: capacity development for these constituencies has generally been neglected and has weakened the growth of both community participation and intersectoral involvement in health development.

Health personnel management also needs to be greatly strengthened through the development of incentives, appropriate regulations and improved support and supervision. The technocratisation of health care that has been a feature of the past decade has resulted in increasing inequities in service provision and reduced accountability of service providers. The progressive health movement needs to lobby strongly for greater investment in human resources for health, since people are the key to more appropriate and accountable health services.

CONCLUSIONS

- It is clear that progress towards Health for All has been uneven and is increasingly compromised. Gains already achieved are under threat from a complex and accelerating process of globalisation and neoliberal economic policies, which are negatively impacting on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes, which have reduced substantially the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilising roles - which are the keys to its sustainability - have been neglected, not only in the discourse but also in implementation.
- Government health ministries need to be pressed to enter into partnerships with other sectors, agencies and communities to develop intersectoral policies that address the determinants of inequities and ill-health. The policy-development process needs to be inclusive, dynamic, transparent and supported by legislation and financial commitments.
- The time is long overdue for more forcefully translating policies into actions. The main actions should centre around the development of well-managed and comprehensive programmes involving communities, the health sector and other sectors. The process needs to be structured in well-managed district systems, which need to be considerably strengthened, particularly to effectively reach the household, community and primary levels. Here, PCH centres and their personnel have to focus onthe reinstatement of community health worker schemes.
- The successful implementation of decentralised health systems will require targeted investment in infrastructure, personnel, management and information systems. A key primary step is a new capacity development of district personnel through training on the job practice and health systems research. Such human resources development must be practice-based, problem and community oriented and come after we reorient, educational institutions and professional bodies.
- Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here partnerships with NGOs and their expertise in various aspects of community development is crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. The identification of well-functioning organs of people's organisations , whether or not they are presently active in the health sector, needs to be urgently pursued to make the necessary alliances that can multiply our efforts.
- In promoting the above move from policy to action, WHO needs to be pressed to play a much bolder role in: advocating equity and legislation needed for its achievement; pointing out the dangers of globalisation poses to health; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive PHC programmes are developed; entering into partnerships with and influencing other multilateral and bilateral agencies and donors, as well as NGOs and professional bodies, towards a common Alma Ata rooted vision of PHC; and advocating for major needed investments in health, especially in human resource development, without which Health for All will remain a mere statement of intent.

Suggested reading list

Sanders, D. (1985). The Struggle for Health. Hampshire, UK: Macmilliian Education.

Sanders, D. (2000) 'Primary Health Care 21 - Everybody's Business' in Primary Health Care 21 - Everybody's Business: An international meeting to celebrate 20 years after Alma Ata. Geneva: WHO.

Werner, D. and Sanders, D. (1997) Questioning the Solution: The Politics of Primary Heath Care and Child Survival. Palo Alto: HealthWrights, p.115.

World Bank (1994) Better Health in Africa: Experience and Lessons Learned. Washington DC: World Bank.

David Sanders has more than 20 years experience working in the health sector in Southern Africa particularly in Zimbabwe and South Africa and has been actively involved in the development of health policy and services with both the Southern African liberation movements and with the newly independent governments of Zimbabwe and South Africa. David Sanders has since April 1993 been Director and Professor of a new Public Health Programme at the University of the Western Cape, South Africa, which provides practice-oriented education and undertakes research in public health and primary health care. David Sanders is author of "The Struggle for Health: Medicine and the Politics of Underdevelopment" and co-author of "Questioning the Solution: the Politics of Primary Health Care and Child Survival" and has researched and written in the areas of political economy of health, structural adjustment, child nutrition and health personnel education.

HEALTH AS A HUMAN RIGHT

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand the cancellation of Third World debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.

- Demand the control and taxation of speculative international capital flows.
- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion,

nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
- Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.
- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.

- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

☐

A PEOPLE-CENTERED HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drugs policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried

out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD
Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:
- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

Amendment
- After the endorsement of the PCH on December 8, 2000, it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.

- The section of War, Violence and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read *to end all kinds of sanctions*. An additional action point number 11 was added concerning natural disasters.

Regional Consultation on PUBLIC HEALTH & HUMAN RIGHTS

REGIONAL CONSULTATION
on
PUBLIC HEALTH
& HUMAN RIGHTS

10-11 April, 2001, New Delhi

REPORT & RECOMMENDATIONS

Organised by

National Human Rights Commission

In collaboration with

Ministry of Health & Family Welfare
Government of India

World Health Organization
South East Asia
Regional Office

Justice J.S. Verma
Chairperson
(Former Chief Justice of India)

Foreword

The World Health Organization, in its Constitution declares that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being' and it also says that 'health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity'. The Nobel Peace Laureate, Elie Wiesel has observed that 'one cannot, one must not, approach public health today without looking into the human rights component'. The International Covenant on Economic, Social and Cultural Rights also recognizes 'the enjoyment of the highest attainable standard of health' as the right of every human being. Thus, right to health of the highest attainable standards, is a basic human right with universal recognition. It must, therefore, be treated as a State responsibility with the obligation to ensure its due respect.

In India, the national Constitution recognizes the State obligation in clear terms in Article 47 which provides that the raising of the level of nutrition and the improvement of public health are among the primary duties of the State. This is a Directive Principle of State Policy contained in Part IV of the Constitution which lays down the principles fundamental in the governance of the country and obligates the State to apply them in making laws. Another directive principle in Article 48A imposes the duty to protect and improve the environment and to safeguard the forests and wild life in the country, which too is related to improvement

of public health. Both these articles in Part IV of the Constitution have been judicially interpreted to expand the meaning and scope of 'right to life' guaranteed as a fundamental right in Article 21 of the Indian Constitution. Thus, in India the national Constitution elevates the 'right to health of the highest attainable standards' to a guaranteed fundamental right which is enforceable by virtue of the constitutional remedy under Article 32 of the Constitution.

The National Human Rights Commission, therefore, naturally considers it of prime importance that the needed emphasis on improvement of public health is given by all agencies to fulfill the promise held out in the directive principles in keeping with the State obligation in a republican democracy.

In April 2000, the Commission constituted a Core Advisory Group on Health, comprising of experts in the field, with the object of preparing a plan of action for systemic improvements in the health delivery systems in the country. The first Chairperson of the Core Group was the late Prof. V. Ramalingaswamy, who is now succeeded by Prof. N.H. Antia. The Convenor of the Core Group is Prof. K. Srinath Reddy. The Commission is grateful to all the members of the Core Group for their invaluable contribution to the Commission's efforts in this direction.

Pursuant to this programme, and in keeping with its broad objective to give greater practical meaning to the right to health care, the Commission organized two major Consultations on "Maternal Anaemia' in April 2000, and on 'Human Rights and HIV/AIDS' in November 2000. Continuing in this direction, the Commission organized a Regional Consultation on 'Public Health and Human Rights' in April 2001 with a view to bringing the policy makers, public health experts, legal professionals, human rights activists and others together to deliberate on issues like Nutritional Deficiencies, Access to Health Care and Tobacco Control. The rationale behind the exercise was to evolve practical recommendations for improving the current facilities.

These exercises were performed by the Commission in collaboration with the Ministry of Health and Family Welfare, Department of Women and Child Development (Ministry of Human Resource Development), UNICEF, UNAIDS, WHO, Lawyers Collective and NACO for whose contribution the Commission is grateful.

The linkage between human rights and human development is recognized and so is the significance of public health. The primary targets for the year 2015 of the World Bank also include public health issues such as improvement of reproductive health of women, reduction in infant and maternal mortality rates etc. There is a felt need for genuine partnerships between the government, community, NGOs, medical and legal professions with points of entry at policy making, norm setting, professional associations, service delivery area, research and education. The goal of linking health and human rights is to contribute to advancing human well being beyond what could be achieved through an isolated health or human rights based approach.

It is my fervent hope that the recommendations of the Regional Consultation on Public Health and Human Rights would be given serious consideration and acted upon by the policy makers, planners and others to make 'health for all', a reality.

J. S. Verma

(J.S. Verma)

Dated: 21 June 2002
Place: New Delhi

EXECUTIVE SUMMARY

1. Human rights and public health are powerful and modern approaches with intrinsic connections, which share the common objective of protecting the health and the well being of all individuals. The Calcutta Declaration adopted at the Regional Public Health Conference in 1999 had, in its agenda for action, recommended using a rights approach to health. Upholding human rights and the dignity of all human beings and adoption of an intergenerational approach are important prerequisites for improving public health and ensuring sustainable development.

2. The National Human Rights Commission of India, in collaboration with India's Ministry of Health and the World Health Organization, organised the **Regional Consultation on Public Health and Human Rights** in New Delhi on 10-11 April 2001. The objective was to advocate the importance of adopting a synergistic approach to public health and human rights. The Consultation also sought to identify avenues of action conforming to human rights principles to advance public health objective in three priority areas, viz., access to health care, nutrition and tobacco control.

3. The initiative brought together experts in public health, nutrition, law and human rights, and representatives of NGOs and international organisations. Keynote presentations by experts were followed by intense deliberations in working groups to identify key strategies and initiatives. Two panels of experts discussed the regional perspective and partnerships.

4. Governments have the obligation to respect, protect and fulfil human rights. They have a responsibility for their people's health, which could be fulfilled only through providing adequate health and social measures. Public health officials have dual responsibilities of protecting and promoting public health, and respecting, protecting and fulfilling human rights.

5. For developing countries, realisation of human rights, as they apply to health, is a matter of '**progressive realisation**' of making steady progress towards a goal. The services should be scientifically sound and conform to public health "best practice". The implications of the **right to enjoy the benefits of scientific progress** for health issues have been at the core of recent concerns on access to drugs for the developing world, and vaccine development.

6. The 1978 Alma-Ata Declaration called on nations to ensure essential primary health care availability. The World Health Assembly, in 1998, stressed the will to promote health by addressing its basic determinants and prerequisites. Arbitrary restrictive measures that fail to consider other valid alternatives are abusive of human rights principles and in contradiction with public health 'best practice'. Discrimination in health systems, and unsound human development policies and programmes exacerbate disparities in health. Equal treatment within societies and within health care settings should be the norm.

7. The major determinants of health lie outside the health system. Human rights provide a useful tool for advancing public health goals, and a framework for analysis and research into complex health problems. A systematic human rights analysis using an analytical and action-oriented framework, with indicators reflecting compliance with health promotion and human rights principles, could guide **evidence-based health policy** and programme development.

8. Health and development in various parts of India have progressed unevenly. **Health care** expenditure is the second most common cause of rural indebtedness. The health infrastructure needs to be reviewed, recast and revitalised to ensure its convergence with existing primary health care priorities. Multi-faceted development efforts can improve the health situation.

9. **Nutrition** is a cornerstone that influences and defines people's

health. In the South East Asian (SEA) Region, 40% of under-five children were underweight and out of this 43% stunted, 30% had a low birth-weight, 23% of the population had Iodine Deficiency Disorders. 1.3 million persons had clinical Vitamin A deficiency, and two-thirds of pregnant women had iron-deficiency anaemia. Among the priority areas for action are growth monitoring/promotion, nutrition surveillance, promotion/ support of breast-feeding, food security and safety net, and anaemia prevention and control strategy.

10. Governments have a responsibility to create enabling conditions to help individuals make informed choice and to change the vulnerability pattern by enacting legislation and putting in place appropriate enforcement and redressal mechanisms. An **Anti-tobacco Bill** has been introduced in the Indian Parliament in March 2001 that seeks to protect the rights to information. Child health would be protected by the prohibition on sale to minors.

11. The Royal Thai Government's comprehensive anti-tobacco package focuses on provision of health education and public information. The media had helped shape several key health policies. A civil group had petitioned for a National Health Insurance Act. Sri Lanka effected a reduction of child mortality to 0.9% in 1999. Its government is working on appropriate solutions to the new challenges of tobacco control, environmental issues, drug abuse and Sexually Transmitted Diseases. Nepal has 747 health posts besides 197 Public Health Centres (PHCs) and health centres. Female smokers form a third of its hospital out-patients.

12. Application of the **new synergy** of Public Health and Human rights requires additional efforts to create consultative mechanisms, as well as education, training and research in health and human rights. Capacity should be enhanced for inter-disciplinary learning and research on linkages between public health and human rights at national and regional levels. Purposeful public health action calls for capacity building

and development of partnerships among legal and public health institutions/ professionals, relevant government agencies, health NGOs, other sectors of civil society and representatives of the people. Such networks in SEA countries will serve national and regional public health needs.

13. State **Public Health Regulatory Authorities** and a National Public Health Advisory Body should be established in India to regulate public health practices and monitor the implementation of public health programmes. For dependable delivery of essential health care, the primary, secondary and tertiary systems should be effectively linked. People's empowerment makes all the difference in health outcomes. To promote participation of the people in the development of health care systems, decentralization of authority in health care systems and structural adjustment should be facilitated through Panchayati Raj and other local institutions.

14. Measures suggested for **health personnel** include standardization and quality-assurance in their training, restructuring of their undergraduate education to make it more public health oriented, and a continuing medical education programme with emphasis on public health, and rational use of drugs and diagnostics. To ensure availability of quality **essential drugs,** good manufacturing practices must be enforced and a price control policy evolved with the prices linked to purchasing capacity of the population.

15. For effective implementation of the National **Nutrition Policy,** the National Policies of Action on Nutrition and Child and the Infant Milk Substitutes Act should be monitored. Steps should be taken to minimise loss of procured or stored food-grains.

16. A comprehensive national **Tobacco Policy** should be evolved, and a multi-sectoral national level nodal agency established for tobacco control. All states should take steps for passing resolutions for adopting provisions relating to control of all other tobacco products (other than cigarettes). Information Education Communication (IEC) programmes

should disseminate correct information related to the effects of tobacco consumption. Assistance for smoking cessation should be integrated into health care services.

17. Health and human rights experts have a **collective responsibility** to conceptualise and carry forward these agenda for a better and healthier society. The Human Rights Commissions in South East Asian countries are uniquely placed to make a significant difference to the quality of health and health care in the region.

BACKGROUND AND RATIONALE

The goal of extending the benefits of sustainable health over an expanding life span, to all members of the human family, is the cardinal tenet of public health. The Declaration of Human Rights eloquently upholds the right to life as an inalienable entitlement of all human beings. As the mutually nurturing relationship between health and development becomes increasingly clear, protection of health (as an essential requirement for enabling human beings to develop to their full potential) becomes integral to the mandate of human rights. Such a shared vision and shared mission pave the way for a natural alliance between the advocates of public health and the defenders of human rights. Purposeful partnership between the two groups, catalysed by a conjoint consultation, would be very productive for public health.

The National Human Rights Commission (NHRC) of India, under the Chairmanship of Justice J.S. Verma, has accorded a pivotal position to the promotion of public health in its plan of action. It has constituted a Core Group on Public Health to assist the Commission with technical advice on matters related to health. Prof. V. Ramalingaswami (National Professor of Medicine) chairs this group, of which Prof. K. Srinath Reddy (All India Institute of Medical Sciences) is the Convenor. The NHRC has, in Collaboration with other organisations (including UN agencies), organised two national workshops on anemia and HIV-AIDS, to consider issues related to their control in the context of human rights.

In order to extend the discussion to a broad range of issues relating health to human rights, NHRC proposes to convene a consultation, in April 2001, on 'Public Health and Human Rights'. The consultation would involve interaction between health scientists, health activists, jurists, policy makers and representatives from other sections of the civil society. The envisaged end products of the consultation are recommendations

for prioritised action in each of the major areas of concern. These recommendations would be then considered by the NHRC for directing the relevant national agencies to initiate the desired action and implement the proposed strategies for advancing public health towards the desired goals.

The NHRC is organizing this consultation, in partnership with the Ministry of Health and Family Welfare (Govt. of India) and World Health Organization (SEARO). By aligning interests and pooling resources, such a partnership will provide synchrony of effort and synergy of effect in promoting public health in India and the South East Asia Region.

For the purpose of this Consultation, National Human Rights Commission, Ministry of Health and Family Welfare and World Health Organization have identified three areas of public health concern: (1) Nutritional Deficiencies, (2) Access to health care (including emergency medical care) and (3) Tobacco Control. Recommendations, generated at the Consultation, would help provide the NHRC with a framework for advocacy and action to advance public health goals in these areas, through relevant administrative, legislative and executive measures.

For these reasons, a partnership between the NHRC (India), Ministry of Health and Family Welfare (Government of India) and WHO (SEARO) would provide a confluence of common interests and cumulatively contribute in the advancement of essential public health goals in India (and other SEAR countries). The consultation, in turn, will provide a platform for establishing partnerships between various stakeholder groups for follow-up action and advocacy.

In this context, one of the follow-up measures proposed, to consolidate and continue the efforts initiated at the consultation, would be to establish partnerships between public health institutions/groups and the national law institutes in India (located at Bangalore, Bhopal, Hyderabad and Kolkata). Through collaborative arrangements between each national

law institute and one or more public health group, focused work would be carried out on selected areas of health evaluated in the context of human rights. For example, one of the law institutes may take up continued work on nutrition and human rights, in partnership with one or more public health groups who have expertise and interest in that area. Others would take up the prime responsibility for providing legal leadership in other specific areas of health. Such collaborative work, linking multiple legal and public health institutions, would provide a filip to the growth of Public Health Law as an academic discipline apart from facilitating informed advocacy on public health as a human rights concern.

OBJECTIVES OF THE CONSULTATION

1. To identify avenues of action which can advance short, medium and long-term objectives of public health in three prioritised areas of concern for further advocacy, by the NHRC, for implementation by the various agencies concerned. The areas to be covered by this Consultation will be (1) Nutritional Deficiencies, (2) Access to health care (including emergency medical care) and (3) Tobacco Control.
2. To establish partnership between public health experts, jurists and community representatives (including health NGOs) to pursue informed advocacy for pubic health action in the context of human rights.
3 To create mechanisms for future collaboration between academic institutions/departments of law and public health experts to periodically produce well researched position papers on major public health issues from the perspective of law and human rights, thereby promoting the growth of Public Health Law both as an academic discipline and as a pathway for public health action.

PARTICIPANTS PROFILE

The Participants would include:

(a) Public Health experts and health scientists.
(b) Legal experts (drawn from national law institutes as well as from the Judiciary and the Bar)
(c) Representatives of health NGOs.
(d) Representatives of the community (drawn from various sections of the civil society, including consumer groups).
(e) Policymakers (drawn from the legislative and executive branches, from the national and provisional levels)
(f) Representatives of NHRC, MOHFW and WHO (SEARO).
(g) Observers from other UN Agencies (UNDP, UNICEF, UNAIDS, FAO, ILO, UNESCO, UNIFEM).

WHO (SEARO) will consider the feasibility of supporting the participation of neighbouring countries who are members of WHO (South East Asian Region).

Main Content Areas

(1) Nutritional Deficiencies,
(2) Access to health care (including emergency medical care) and
(3) Tobacco Control.

In each of these areas, the Consultation would focus on identifying specific activities w0hich are desirable but are currently lacking or deficient. Priority would be accorded to activities where substantial health benefits are expected to accrue in a relatively short time frame, through specific legislative/executive measures. The recommendations would have to be framed in a manner that would enable NHRC to seek their implementation through clearly indicated actions to be undertaken by the concerned agencies. The consultation does not aim to produce state of the art public health reviews but instead will focus on producing a clearly stated agenda of action which the NHRC can catalyse through its intervention.

Process

The above objectives can only be achieved, if adequate preparatory work is performed to generate a preliminary consensus, among stakeholder groups, on prioritized areas for action in each of the content areas listed above. The main multi-disciplinary consultation would provide an opportunity for critical appraisal of these suggestions and convergence on key recommendations to be forwarded to the NHRC (to accomplish objective 1). The consultation would also provide an opportunity to partnerships, which will advance advocacy and follow-up action (to accomplish objectives 2 and 3).

The preparatory work would be performed by Planning Group comprising of Ms S Jalaja (Joint Secretary, NHRC), Dr. Srinivas Tata (Deputy Secretary, Ministry of Health and Family Welfare) Dr. Tej Walia (World Health Organization) and Prof. K S Reddy (Convenor, NHRC's Core Group on Public Health and Human Rights). The Planning Group would identify key resource persons in each of the main content areas listed above. They would be requested to provide suggestions of specific legislative/executive actions, which will advance public health objectives in that area. A structured formal would be provided by the secretariat so that the nature of the action, its rationale and expected benefits as well as relevance to human rights are succinctly described and the implementing agencies are clearly identified. Each suggestion by the resource persons would be provided utilizing such a proforma, which does not exceed one page.

The Planning Group would screen the suggestions received from various resource persons, in each in the areas, and shortlist them for further discussion in the main consultation. Three working groups for the conference would be established, prior to the conference.

The Consultation would consist of an initial plenary addressing the broad theme, working group discussions to evolve recommendations in their assigned areas and a final plenary to consider the working group reports. There would also be small group meetings to identify the opportunities for partnership and mechanisms for follow-up action.

PROCEEDINGS

INAUGURAL SESSION

The Regional Consultation commenced with the ceremonial lighting of the lamp by **Nitin Singh,** a Class IV student of Kendriya Vidyalaya, Delhi.

Mr. N. Gopalaswamy, Secretary General of the National Human Rights Commission (NHRC) of India welcomed the delegates. The logo of the NHRC features the famous words of an ancient Indian seer, *sarve bhavantu sukhinah*' (let everybody be happy). He said that the subsequent words, '*sarve santu niramayah*' (let everybody be free of disease) were also important and needed to be followed. He mentioned about the efforts taken by the NHRC in this regard by bringing together experts in the areas of health and human rights to review the status and suggest strategic direction and agenda for future action. Two Consultations had been held earlier which had come forth with meaningful measures on 'maternal anaemia' and 'HIV/AIDS'.

Dr. Palitha Abeykoon, Director, Health Technology and Phamaceuticals at the South East Asia Regional Office of the World Health Organization (WHO) conveyed the appreciation of his Regional Director for the initiative taken by the NHRC in organising the series of consultations relating to health and human rights and addressing some of the most pressing health issues. The Human Rights Commissons in South East Asia, he said, were uniquely placed to make a significant difference to the quality of health and health care in the countries of the Region.

The Calcutta Declaration adopted by the Regional Public Health Conference organised by the WHO in Calcutta in November 1999 had identified some key areas in its agenda for action. One of these was

ACCESS TO HEALTH CARE

1. **Recommendation**: Since lack of opportunities for participation of the people in the development of health care systems is a human rights violation – the consultation recommends that NHRC facilitate decentralization of authority in health care systems of the country, through Panchayati Raj and other local institutions, by devolution of appropriate financial, administrative and supervisory powers.

   Action to be taken: In all national health related programmes such as those under the Ministries, Department of Health & Family Welfare, Women and Child Development and Social Justice and Empowerment, emphasis should be on primary health care with community participation. Enlisted NGOs, with proven involvement and commitment in this area, may be appropriately involved in facilitating this process.

   Implementation Steps: Each of the concerned Ministries/departments to develop and report indicators for progressive decentralization (from a minimum level to the most desirable level).

2. **Recommendation:** Since the absence of an adequate quantity of reasonable-quality health care personnel at the primary and secondary level health care facilities, resulting in lack of access to basic health care, is a human rights violation the consultation recommends that NHRC facilitate standardization and quality-assurance in the training of the various cadres of health care personnel.

   (a) Action to be taken: Restructure undergraduate education for medical, dental, nursing and rehabilitation professionals to make the training more public health oriented with regard to knowledge, motivation and skills.

   Implementation Steps: The Ministry of Health (GOI), through the relevant Councils – Medical Council of India, Dental Council

of India, Indian Nursing Council and Rehabilitation Council of India– to develop plans of action (with curricular content), within one year.

(b) Action to be taken: Develop a programme for continuing medical education of health care providers with special focus on primary health centre personnel. This should particularly place emphasis on the knowledge and skills relevant to public health, and rational use of drugs and diagnostics.

Implementation Steps: The Ministry of Health (GOI), through the relevant Councils, develop a plan of action within one year.

3. **Recommendation**: Since any lack/inadequacy of access to health care at the various levels for the lower and middle socio-economic strata of the country would be a human rights violation - the Consultation recommends that NHRC facilitate strengthening and effective linkages of the primary, secondary and tertiary levels of the health care delivery system for dependable and assured delivery of essential health care services (acute as well as chronic).

   Action to be taken: The Ministries of health and Family Welfare at the Centre and States should develop state-specific plans for strengthening the health care delivery systems at all three levels with effective linkages and referral systems.

   Implementation Steps: The Planning Commission should coordinate the development of these plans with the Central and State Governments and seek their submission within one year.

4. **Recommendation:** Since the provision of emergency medical care for trauma related emergencies as well as medical, surgical and obstetric emergencies is a minimum requirement of a Welfare state, the Consultation recommends that NHRC should constitute an Expert Group/Task Force to identify the requirements of Essential Emergency Health Care and recommend appropriate models and guidelines; these can then be, forwarded to the Central and State governments

for their review and implementation.

Action to be taken: NHRC to constitute the Expert Group and then forward the recommendations to the Central and State governments for necessary action.

Implementation Steps: NHRC to constitute an Expert Group and facilitate its meetings to enable submission of report in 6 months.

5. **Recommendation:** Since irrational or unethical medical practice, leading to exploitation of or injury to the citizen, is a human rights violation- the Consultation recommends that NHRC facilitate the regulation of irrational or unethical medical practice in the public and private health care sectors of the country, through the development of guidelines for use of drugs, diagnostics and therapeutic procedures, with a regulatory framework for monitoring and enforcement.

   Action to be taken: Clinical practice guidelines are to be developed for common diseases/disorders and clinical procedures. The Ministry of Health & Family Welfare, Govt. of India should coordinate their development and widespread dissemination among the health professionals to the country with the help of premier medical institutions and professional associations and relevant professional Councils (such as Medical and Dental Councils).

   Implementation Steps: The Ministry of Health and Family Welfare, Government of India should complete this process within one year, with a provision for review of the guidelines every three years (or earlier if needed).

6. **Recommendation:** The Government of India should put in place an updated National Drug Policy to ensure "an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of India and the rational use of drugs by prescribers, dispensers and consumers.

   (a) Action to be taken: NHRC should call upon the Government

of India to:

i) Expand equitable access to essential medicines and ensure mechanisms to make available vital HIV–related and other essential drugs to all persons who need them, on a non-discriminatory basis.

ii) Refrain from taking measures which would deny or limit equal access to all persons to preventive, curative or palliative pharmaceuticals or medical technologies used to treat diseases of public health importance (such as HIV/AIDS or the most common opportunistic infections that accompany them).

iii) Adopt legislation or other measures to safeguard access to such preventive, curative or palliative pharmaceuticals or medical technologies free from any limitations by third parties; adopt all appropriate positive measures to the maximum of the resources allocated for this purpose, so as to promote effective access to such preventive, curative or palliative pharmaceuticals or medical technologies; increase access to medicines, in accordance with the health needs of the people (especially those who can least afford the costs); act constructively to strengthen pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order to further promote innovation and the development of domestic industries consistent with national law.

The government needs to take measures such as compulsory licensing or parallel importation to increase access to life saving drugs at affordable prices to overcome hazards to public health and nutrition caused by HIV/AIDS and other diseases. The availability of low-cost generic drugs needs to be expanded with guarantees of their quality.

iv) To ensure availability of essential drugs at affordable prices for HIV/AIDS and other diseases of public health importance, the NHRC should issue a notice to the Government of India calling upon it to identify the various areas of government action and the measures taken / proposed especially in relation to TRIPS.

Implementation Steps: The Ministry of Health & Family Welfare and D/O Chemicals, Government of India to report on action taken within 3 months.

(b) Action to be taken: Ensure quality of drugs produced and marketed for use by the people, by defining minimum standards of quality and enforcing good manufacturing practices (GMP), with strong mechanisms for monitoring and regulation through national and state drug control authorities.

Implementation Steps: The Ministry of Health and Family Welfare, through Drug Controller General of India and State Drug Control Authorities to develop protocols for testing and monitoring, on an ongoing basis.

NUTRITIONAL DEFICIENCIES

1. **Recommendation:** The Consultation considered that it is essential to provide access to iodised salt, for all sections of population, on a sustained and affordable basis. Therefore, there is an urgent need to monitor the distribution and quality of iodised salt throughout the country.

   Action to be taken: i) The Consultation recommends that NHRC should direct the Central government to clearly spell out its policy summarizing the current public health evidence as well as its present administrative position. The government should come up with a status paper on this.

   ii) Surveys should be conducted on the availability of iodised salt, quality of iodisation and the prevalence of iodine Deficiency Disorders. The results should be obtained within one year and remedial actions be taken to plug the gaps.

   Implementing Agencies: NHRC to take up the matter with the Government of India (Department of Health and Salt Commissioner's Office).

2. **Recommendation:** The Infant Milk Substitutes Act had been enacted to promote breast feeding and to stop unethical practices of selling infant milk substitutes. The Consultation felt that despite the enactment of the Act, some infant food manufacturers are still resorting to promotion of infant milk substitutes in illegal ways through sponsoring of events, etc.

   Action to be taken: The Consultation recommends that a review be undertaken of the implementation of the IMS Act, with specific reference to violations and a report be submitted, within 6 months, of the remedial action taken.

   Implementing Agencies: The Government of India, through the

Department of Women and Child Development.

3. **Recommendation:** Right to food availability for all sections of the community, particularly those who are socially/economically underprivileged, should be ensured especially in a situation of adequate food reserves. Loss of food grains/cereals due to faulty storage or other reasons is unacceptable.

   Action to be taken: The Ministry of Agriculture, government of India to take measures to ensure food availability in coordination with other concerned Ministries such as Rural Development & Employment. It should also detail the plan of action for Food Corporation of India to monitor and reduce wastages in storage or transport.

   Implementing Agencies: The Government of India, through the Ministry of Agriculture

4. **Recommendation:** The Consultation recommends that media guidelines should incorporate the following:
   - The Practice of breast-feeding should be protected and promoted
   - Adverse effects of child marriage and adolescent pregnancy should be publicized.
   - Citizens should be provided information related to the right to nutrition and provision of relevant services

   Action to be taken: Guidelines to be declared by the relevant Ministries within 6 months.

   Implementing Agencies: Government of India through the Ministries/ Departments of Health and Family Welfare, Women and Child Development and Information & Broadcasting.

5. **Recommendation:** The Implementation of the recommendations of the NHRC sponsored workshop on Maternal Anaemia (April 2000) should be reviewed to evaluate the progress made and identify the barriers in effective implementation.

   Implementing Agencies: The Department of Women & Child Development should report to NHRC on this, within two months.

6. **Recommendation:** The proposed Public Health Regulatory Authorities should monitor the effective Implementation of the National Nutrition Policy and the National Policies of Action on Nutrition and Child.

   Implementing Agencies: Till such a time that the proposed Authorities are established, the Department of Women and Child Development should annually report to the NHRC about the implementation, utilizing criteria developed by experts.

7. **Recommendation:** The Consultation suggested that NHRC initiate an overview, by the Ministry of Law and Justice, of the level of compliance with the following international covenants to which India is a signatory:
   - Convention on the Rights of the Child (CRC)
   - Conventions on the Elimination of All Forms of Discrimination Against Women (CEDAW)
   - SAARC Declaration on the Girl Child

The Right to Health Care

Moving from idea to reality

- *Abhay Shukla, CEHAT*

"Should medicine ever fulfil its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life cycle and remove them. Should it ever come to pass, Medicine, whatever it may then be, will become the common good of all." - *Rudolf Virchow, c.1850*

Background: Inequity in health and access to health care

India is known to have poor health indicators in the global context, even in comparison with many other developing countries. However, we also bear the dubious distinction of being among the more inequitous countries of the world, as far as health status of the poor compared to the rich is concerned. This underscores the fact that there is a tremendous burden of unnecessary morbidity and mortality, which is borne almost entirely by the poor. Some striking facts in this regard are -

- Infant mortality among the economically lowest 20% of the population is 109, which is ***2.5 times*** the IMR among the top 20% population of the country.
- Under-five mortality among the economic bottom 20% of the population (bottom quintile) is 155, which is not only unacceptably high but is also ***2.8 times*** the U5MR of the top 20% (top quintile).
- Child mortality (1-5yrs age) among children from the 'Low standard of living index' group is ***3.9 times*** that for those from the 'High standard of living index' group according to recent NFHS data (IIPS, 2002). Every year, 2 million children under the age of five years die in India, of largely preventable causes and mostly among the poor. If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala, then 16 lakh deaths of under-five children would be avoided every year. This amounts to ***4380 avoidable deaths every day,*** which translates into ***three avoidable child deaths every minute***.
- Tribals, who account for only 8% of India's population, bear the burden of ***60% of malarial deaths*** in the country.

Such gross inequalities are of course morally unacceptable and are a serious social and economic issue. In addition, such a situation may also be considered a *gross violation of the rights of the deprived sections of society*. This becomes even more serious when viewed in the context of ***gross disparities in access to health care*** -

- The richest quintile of the population, despite overall better health status, is *six times more likely* to access hospitalisation than the poorest quintile. This actually means that the poor are unable to afford and access hospitalisation in a large proportion of illness episodes, even when it is required
- The richest quintile have *three times higher level* of coverage for measles immunization compared to the poorest quintile. Similarly, a mother from the richest 20% of the population is *3.6 times more likely* to receive antenatal care from a medically trained person, compared to a mother from the poorest 20%. The delivery of the richer mother is *over six times more likely* to be attended by a medically trained person than the delivery of the poor mother.
- As high of 82% of outpatient care is accessed from the private sector, met almost entirely by out-of-pocket expenses, which is again often unaffordable for the poor.

- About three-fourths of spending on health is made by households and only one-fourth by the government. This often pushes the already vulnerable poor into indebtedness, and in over 40% of hospitalisation episodes, the costs are met by either sale of assets or taking loans.
- The per capita public health expenditure in India is abysmally low, below $5 annually. India has one of the most privatized health systems in the world (only five countries on the globe are worse off in this respect), effectively denying the poor access to even basic health care.

The gist of these sample facts is that the existing system of 'leave it to the market' effectively means ***'leave health care for the rich and leave the poor to fend for themselves'***.

One implication that emerges from the above discussion is that the problem of large-scale ill health in India should not be seen as primarily a technical-medical issue. The key requirement is not newer medical technologies, more sophisticated vaccines or diagnostic techniques. The fact that the prosperous sections of the population enjoy a reasonably good health status implies that *the technical means to achieve good health do broadly exist in our country today* (though there is definitely a need to better adapt these to our country's conditions and traditions, and certain improved techniques might help in specific contexts).

In fact, for the vast majority, the key barriers to good health are not the lack of technology but poverty and health system inequity. Poverty, a manifestation of social inequity, leads to large sections of the population being denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy local environment, which are all prerequisites for health. At the same time, we have a ***highly inequitable health system*** which denies quality health care to all those who cannot afford it (the fact that even those who **can** afford it do not always get rational care is another important, but somewhat separate issue!). In this paper, which is primarily addressed to those working in the health sector, we will focus on the critical *health system* issues, with a rights-based approach. Let us see how we can view this entire situation from a rights based perspective.

The Right to Health Care as a component of the Right to Health

Looking at the issue of health under the equity lens, it becomes obvious that the massive burden of morbidity and mortality suffered by the deprived majority is not just an unfortunate accident. It constitutes *the daily denial of a healthy life, to crores of people, because of deep structural injustice, within and beyond the health sector.* This denial needs to be addressed in a rights based framework, by systematically establishing the right of every citizen of this country, to a healthy life. More specifically, health care can no longer be viewed as just a technical issue to be left to the experts and bureaucrats, an issue of charity to be dealt with by benevolent service delivering institutions, or a commodity to be sold by private doctors and hospitals. The role of all these actors needs to be redefined and recast in a framework where every person, including the most marginalized, is assured of basic health care and *can demand and access this as a right.*

It is clear that achieving a decent standard of health for all requires a range of far reaching social, economic, environmental and health system changes. There is a need to bring about broad transformations both within and beyond the health care sector, which would ensure an adequate standard of health for all. In other words, to promote the **Right to Health** requires action on two related fronts (WHO, 2002):

Promoting the Right to underlying determinants of health

This involves working for the right to 'the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health' (WHO, 2002). Agencies engaged in the health sector cannot deal with most of these issues on their own, though they need to highlight the need for better services and conditions, and can advocate for improvements in these areas in a rights based framework. Organisations working in the health sector should support and ally with other agencies working directly in these areas, to help bring about relevant improvements.

Promoting the Right to Health Care

Given the gross inequities in access to health care and inadequate state of health services today, one important component of promoting the Right to Health would be to ensure access to appropriate and good quality ***health care*** for all. This would involve reorganisation, reorientation and redistribution of health care resources on a societal scale. The *responsibility of taking forward this issue seems to lie primarily with agencies working in the health sector*, though efforts in this direction would surely be supported by a broad spectrum of society.

In the remaining portion of this paper, we will focus on the process of establishing ***the Right to health care*** as a imminent task, to be taken up by organisations in the health sector within the broader context of Right to Health outlined above.

The justification for establishing the Right to Health Care

We may view the justification for this right at three levels - constitutional-legal, social-economic and as a human right issue.

The constitutional and legal justification

The right to life is recognised as a fundamental right in the constitution (Article 21) and this right has been quoted in various judgements as a basis for preventing avoidable disease producing conditions and to protect health and life. The ***directive principles of the Indian constitution*** include article 47, which specifies the duty of the state in this regard:

> **47.** Duty of the state to raise the level of nutrition and the standard of living and to improve health:- The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties ...

In an important judgement (*Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996)*, the Supreme Court of India ruled that -

> In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. ... Article 21 imposes an obligation on the State to safeguard the right to life of every person. ... The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. *Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21.* (emphasis added)

Similarly in the cases *Bandhua Mukti Morcha v. Union of India and others, 1982* concerning bonded workers, the Supreme Court gave orders interpreting Article 21 as mandating the right to medical facilities for the workers.

Basic social services are now being recognised as fundamental rights with the 93rd amendment in the constitution accepting Education as a fundamental right. Despite the controversy and problems regarding the actual provisions of the Bill, it is now being accepted that essential social services like education can be enshrined in the fundamental rights of the Constitution. This forms an appropriate context to establish the right to health care as a constitutionally recognised fundamental right.

The social and economic justification

It is now widely recognised that besides being a basic human right, provision of adequate health care to a population is one of the essential preconditions for sustained and equitable economic growth. The proponents of 'economic growth above all' may do well to heed the words of the Nobel Laureate economist Amartya Sen:

> 'Among the different forms of intervention that can contribute to the provision of social security, the role of health care deserves forceful emphasis ... A well developed system of public health is an essential contribution to the fulfilment of social security objectives.
> ...we have every reason to pay full attention to the importance of human capabilities *also as instruments* for economic and social performance. ... Basic education, good health and other human attainments are not only directly valuable ... these capabilities can also help in generating economic success of a more standard kind ... *(from India: Economic Development and Social Opportunity by Jean Dreze and Amartya Sen)*

The human rights justification

The right to basic health care is recognised internationally as a human right and India is a signatory to the International Covenant on Economic, Social and Cultural Rights which states in its Article 12 -

> The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health... The steps to be taken...shall include those necessary for ...The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Reference can be made to other similar international conventions, wherein the Government of India has committed itself to providing various services and conditions related to the right to health, e.g. the Alma Ata declaration of 'Health for all by 2000'. The National Human Rights Commission has also concerned itself with the issue of 'Public health and human rights' with one of the areas of discussion being 'Access to health care'. The time has come to begin asking as to how these human rights related commitments and concerns will be translated into action in a realistic, time-bound and accountable framework.

Health Rights – people's response to Globalisation-Liberalisation-Privatisation

The negative impact of Globalisation-Liberalisation-Privatisation policies on various social sector services, especially since the early 1990s has been widely experienced. With the growing withdrawal of the state from the social sector and encouragement to the private medical sector, raising the issue of health rights has become extremely relevant today. The ongoing abdication of basic obligations by the Public Health system needs to be countered by a strong movement to establish Health rights. Only a determined effort to establish these

rights can roll back the trend of weakening the Public health system, and can provide a framework for rejuvenation of this system with increased accountability.

The core content of the Right to Health Care in the first phase

Moving towards establishing the Right to Health Care is likely to be a process with various phases. First let us see what could be the *core content* of this right in the first phase, which could be achieved in the short to medium term.

Right to a set of basic public health services

In the context of the goal of 'Health for All' and various Health Policy documents, an entire range of health care services are supposed to be provided to all from village level to tertiary hospital level. As of today these services are hardly being provided adequately, regularly or of the required quality. Components of the public health system to be ensured in a rights based framework include:

1. Adequate *physical infrastructure* at various levels
2. Adequate skilled *humanpower* in all health care facilities
3. Availability of the complete range of specific *services* appropriate to the level
4. Availability of all basic *medications* and supplies (also see below)

The expected infrastructure and services need to be clearly identified and displayed at various levels and converted into an enforceable right, with appropriate mechanisms to functionalise this. For example, in a justiciable framework, basic medical services especially at Primary and Secondary levels cannot be refused to anyone – for example a PHC cannot express inability to perform a normal delivery or a Rural hospital cannot refuse to perform an emergency caesarean section. In case the requisite service such as a normal delivery is not provided by the public health facility when required, one approach could be to allow the patient to take recourse to a private hospital and receive free care, for which the hospital would receive time-bound reimbursement of costs incurred, at standard rates. This would firstly constitute a strong pressure on the public health system to perform better and deliver all services, and secondly, would ensure that the patient receives the requisite care when required, without incurring personal expenses. This could form one of the steps towards accessing the right to health care.

Similarly the state has an explicit obligation to maintain public health through a set of preventive and promotive services and measures. These of course include coverage by immunisation, antenatal care, and prevention, detection and treatment of various communicable diseases. However, it should also encompass the operation of epidemiological stations for each defined population unit (say a block), organizing multi-level surveillance and providing a set of integrated preventive services to all communities and individuals.

In summary, the movement to establish the Right to Health Care aims to *substantially strengthen, reorient and make accountable the Public Health System*. The 'public' has to come back centre-stage in the Public Health System!

Right to emergency medical care and care based on minimum standards from private medical services

Although the right to health care is not a fundamental right in India today, the right to life is. In keeping with this 'Emergency Medical Care' in situations where it is lifesaving, is the right of every citizen. No doctor or hospital, *including those in the private sector*, can refuse minimum essential first aid and medical care to a citizen in times of emergency, irrespective of the person's ability to pay for it. The Supreme Court judgement quoted above (*Paschim*

Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996), directly relates to this right and clear norms for emergency care need to be laid down if this right is to be effectively implemented. As a parallel, we can look at the constitutional amendments enacted in South Africa, wherein the Right to Emergency Medical care has been made a fundamental right.

At the same time there is an urgent need for a comprehensive legislation to regulate qualification of doctors, required infrastructure, investigation and treatment procedures especially in the private medical sector. Standard guidelines for investigations, therapy and surgical decision making need to be adopted and followed, combined with legal restrictions on common medical malpractices. Maintaining complete patient records, notification of specific diseases and observing a ceiling on fees also needs to be observed by the private medical sector. The Govt. of Maharashtra is in the process of enacting a modified act to address many of these issues, and the National Health Policy 2002 stipulates the enactment of suitable regulations for regulation of minimum standards in the private medical sector in the entire country by the year 2003. This would include statutory guidelines for the conduct of clinical practice and delivery of medical services. There is a need to shape such social regulation of this large medical sector within the larger, integrated framework of Right to health care.

Right to essential drugs at affordable cost

Attaining this right would consist of two components:

1. Availability of certain basic medications free of cost through the public health system (see above)
2. A National Essential Drug Policy ensuring the production and availability of an entire range of essential drugs at affordable prices

The Union as well as state Governments need to publish comprehensive lists of essential drugs for their areas. A ceiling on the prices of these drugs must be decided and scrupulously adhered to, with production quotas and a strict ban on irrational combinations and unnecessary additives to these drugs.

Right to patient information and redressal

The entire range of treatment and diagnosis related information should be made available to every patient in either private or public medical facility. Every patient has a right to information regarding staff qualifications, fees and facilities for any medical centre even before they decide to take treatment from the centre. Information about the likely risks and side effects of all major procedures can be made available in a standard format to patients. Information regarding various public health services which people have a right to demand at all levels should be displayed and disseminated. This should include information about complaint mechanisms and for redressal of illegal charging by public health personnel.

Superseding the CPA, a much more patient-friendly grievance redressal mechanism needs to be made functional, with technical guidance and legal support being made available to all those who approach this system. This would provide an effective check on various forms of malpractice. In case the services mandated under this right are not given by a particular facility, the complainant need not take recourse to lengthy legal procedures. Rather, the grievance redressal mechanism with participation of consumer and community representatives should be empowered to take prompt, effective and exemplary action.

Right to monitoring and accountability mechanisms

Keeping in mind the devolution of powers to the Panchayati Raj system, we need to propose an effective system of people's monitoring of public health services which would be

organised at the village, block and district levels. Community monitoring of health services would significantly increase the accountability of these services and will lead to greater people's involvement in the process of implementing them. The Union Ministry of Health and Family Welfare, with support from WHO, has implemented an innovative pilot project for 'Empowering the rural poor for better health' in six talukas of the country. Taking this and various other experiments into account, a basic framework for such monitoring needs to be developed.

Health rights related to various vulnerable sections of the population and in special situations

It is obvious that the establishment of any system of rights is relevant only if it benefits the most vulnerable or deprived sections of the population, and addresses the needs of people facing situations where their basic rights are likely to be denied. All the above types of provisions need to be implemented keeping in view some of the following key rights (an illustrative, not exhaustive list):

- Women's Right to Health Care, including provision of services related to both reproductive and non-reproductive health problems specific to women, and appropriate general health services for women;
- Children's Right to Health Care, with a focus on nutritional supplementation, control of infectious diseases in childhood and reduction in infant and child mortality;
- Health Rights of HIV-AIDS affected persons, including facilities for detection, counselling, non-discriminatory treatment and access to anti-retroviral drugs;
- Right to Mental health care, with a focus on strengthening primary mental health care, non-discriminatory quality treatment and community based rehabilitation systems;
- Right to Health Care for unorganised workers, who lack effective health care coverage and face a range of occupational hazards, with a clear liability on employers;
- Right to Health Care for urban deprived communities, including putting in place Urban primary health care systems and effective referral mechanisms;
- Health rights in conflict situations, where due to communal or other forms of violence persons from particular communities may be denied access to basic health services or may be discriminated against;
- Health rights of communities facing displacement or involuntary resettlement, depriving them of their customary environment and livelihood, and placing them in often hostile new surroundings which may include threats to health and poorer access to health care

This list may be further expanded to include the elderly, disabled persons, migrants and other categories of vulnerable people. Any system of health rights would need to explicitly address the special health needs of such groups, which would require provision of special services and forms of protection against discrimination.

Ways ahead – building a campaign on the Right to health care

Some of the possible areas of activity of a broad coalition like Jan Swasthya Abhiyan, which could develop a campaign on the issue of Right to Health Care, are suggested below.

Involving diverse social sectors in a dialogue on the Right to Health Care

While some health activists and groups have mooted the concept of the Right to Health Care, it is an idea, which is yet to be widely discussed and accepted in our country. One of the key tasks in the immediate future is to generate discussion at the broadest possible level about this right. Groups to be involved in such a debate include health policy makers, medical and

public health academics, private medical professionals, people's organisations, women's groups, organisations representing or working with various vulnerable groups, various segments of the NGO sector including both health related and non-health NGOs and trade unions of health care personnel. It is obvious that the viewpoints of various social groups and actors may be greatly divergent on this issue. However, the very process of discussing and debating the issue gives it a primary legitimacy, which then needs to be built upon. This becomes a basis for generating a continuously widening consensus about the basic justification, content and implementation model for the Right to Health Care.

Analysing international experience on the Right to Health Care

There is valuable international experience available about mandating the Right to Health or Health Care. These experiences need to be collated, and analysed with the Indian context in mind. Especially legislation and provisions made in developing countries are of value in this respect.

Cuba with a socialist constitution accords the right to health to its citizens, according it a status equivalent to civil and political rights.

South Africa, after the overthrow of apartheid, in Article 27 of its constitution has specified certain provisions relevant to this right. This includes mandating the right to access to health care services, specifying that the state must take reasonable legislative measures to achieve realisation of this right, and declaring that no one may be refused emergency medical treatment. From another end, we have a new system of Universal health care access in Thailand whose features need to be studied and discussed as relevant to the Indian context.

Similarly, there has been an entire process of developing the concept of right to health and health care in the international human rights discourse. Various United Nations health rights instruments refer to health related rights. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR), UN Convention on Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) are some such significant conventions, in which India is a signatory.

Given this background, one of the critical tasks ahead of us is to make an in-depth study of these experiences and utilise this for developing the judicial form and implementation-related content of the Right to Health Care in the Indian situation.

Organizing regional public hearings on the Right to Health Care

One way of developing such a consensus and mobilising various social organisations is to organise regional public hearings, on the issue of Right to Health Care. The NHRC could be a partner or 'mediator' for such public hearings, which could involve presentation of cases of Denial of health care. With the involvement of State Public health officials and policy makers in such hearings, the stage could be set for addressing the core issues, demanding accountability and putting in place monitoring mechanisms to ensure basic health rights.

Discussing detailed proposals to implement the Right to Health Care

One of the crucial issues in furthering this campaign is the development of a model for implementing this Right. This needs to be done, keeping in mind the specificities of the Indian health care system, judicial framework (including the fact that Health is a state subject), socio-economic situation including major class, caste and gender disparities and recent processes such as the positive and negative lessons of the impending 93rd Constitutional amendment. Considerable groundwork and consultation is required to develop a model, which would take into account legal, operational and human rights considerations and form the basis for practical implementation of this right.

Legal actions towards implementation of the Right to Health Care

Next, there is a need to take appropriate legal action to establish this basic right. Submitting a National petition on Right to Health Care to the National Human Rights Commission, with extensively documented cases of denial of health care could be a logical first step. Filing of specific PILs, focussed on key health rights may also be necessary to exert legal pressure and to provide leverage to the campaign. Political lobbying for passage of state level legislations, such as Public Health Acts, may be essential to actually establish legal entitlements, which can be activated by any ordinary citizen.

Making the Right to Health Care a Fundamental Constitutional Right

Finally, we need to move towards the medium-term objective of establishing Health Care as a Fundamental Right in the Indian Constitution. This would be a prolonged and challenging process, and would involve political mobilisation and influencing public and political opinion on a large scale, besides formulating an appropriate bill based on legal inputs. This would need to be complemented by State level legislations and effective strengthening of the Public health system. Putting in place effective monitoring mechanisms, and widespread public awareness about the entitlements would be essential for this right to become operational in any meaningful form. One conception of the minimum content of the fundamental right to health care is outlined in the accompanying box.

Proposed minimum content of the fundamental right to health care

1. *Making the right to health care a legally enforceable entitlement by legal enactment*
2. *A national health policy with a detailed plan and timetable for realization of the core right to health care*
3. *Developing essential public health infrastructure required for health care; investing sufficient resources in health and allocating these funds in a cost-effective and fair manner*
4. *Providing basic health services to all communities and persons; focusing on equity so as to improve the health status of poor and neglected communities and regions*
5. *Adopting a comprehensive strategy based on a gender perspective so as to overcome inequalities in women's access to health facilities*
6. *Adopting measures to identify, monitor, control and prevent the transmission of major epidemic and endemic diseases*
7. *Making reproductive health and family planning information and services available to all persons and couples without any form of coercion*
8. *Implementing an essential drug policy*

(Adapted from Audrey R. Chapman, The Minimum Core Content of the Right to Health)

While the course and outcome of all our efforts would depend on the much larger political environment, the slogans of 'Right to Health' and 'Right to Health Care' should continue to be the rallying-cry on our banner. Whether we are confronting the State or are trying to envisage models for the future and shape people's counter-hegemony, the vision of the Right to Health and Health Care should form one of the components of our dream for a more just and humane society.

(This article is an updated version of a note prepared by Dr. Abhay Shukla of CEHAT, for the Seminar on 'Right to Health Care' organised on 3-4 January 2003 during the Asian Social Forum at Hyderabad. Several sections of this article are adapted from Abhay's article 'Right to health care' published in Health Action, May 2001)

Annexure

Suggesting a system for Universal access to health care

While trying to achieve these specific rights in the first phase, our overall goal should be to move towards a system where every citizen has assured access to basic health care, irrespective of capacity to pay. A number of countries in the world have made provisions in this direction, ranging from the Canadian system of Universal health care and NHS in Britain to the Cuban system of health care for every citizen. In the Indian context, while the right to health care needs to be enshrined in the Constitution as a fundamental right, there is a need to develop a complementary system of Universal access to health care.

The existing massive private medical sector in India, which commands over three fourths of the doctors and provides a similar proportion of outpatient care, needs to be addressed and tackled in any system to provide Universal health care coverage. One possible scenario to make this right functional could be a system of Universal social health insurance. The services could be given by a combination of a significantly strengthened and community-monitored public health system, along with some publicly regulated and financed private providers, under a single umbrella. The entire system would be based on public financing and cross-subsidy, with free services to the majority population of rural and urban working people including vulnerable sections, and affordable premium amounts (which could be integrated with the taxation system) for higher income groups.

One key aspect would be that this should be a ***Universal system (not targeted)***, which would ensure coverage of the entire population and also retain a strong internal demand for good quality services. (Of course, certain very affluent sections may choose to pay their share of taxation / premium and yet opt out and access private providers.) Another issue is that there should be ***no fees*** *or nominal fees at the time of actual giving of services*. Finally, the patient should be assured of a range of services with minimum standards, whether given from the public health system or publicly financed and regulated private providers. The entire system could be managed in a decentralised manner, with consumer's monitoring of quality and accessibility of services.

This entire model would of course imply a *significantly higher public expenditure on health services*. However, with decentralised management and a focus on rational therapy, it has been estimated that it should be possible to organise the most basic elements of such a system by devoting about 3% of the GNP towards public health care to start with. This should then be progressively raised to the level of *5% of GNP spent on Public health to give a full range of services to all*. This level of funds could be partly raised by appropriate taxation of unhealthy industries, reallocations within the health sector (including reorganising existing schemes like ESI) and ending all subsidisation of the private medical sector. This of course needs to be combined with changed budgetary priorities and higher overall allocation for the health sector. Incidentally, the new National Health Policy claims on paper the intention to more than double the financial allocation for the public health system and bring it to the level of 2% of the GDP, and to increase utilisation of public health facilities to above 75% by the end of this decade. This admirable yet vague intention needs to be converted into concrete action by means of strong and sustained pressure from various sections of civil society, coupled with concrete proposals to functionalise universal access to health care.

In this context, ensuring the Right to Health Care for all is not an unrealistic scenario, but has become an imperative for a nation, which as the 'world's largest democracy' claims to accord certain basic rights to its citizens, including the right to life in its broadest sense.

L-3A.7 (7)

A concept paper on universal access to health and health care.

Fr.S.Ousepparampil

The fifties and the sixties really witnessed a considerable shift towards "Health for all" especially in the developing countries. In India the Bhore Committee recommended a decentralized Primary Health Care approach to make health accessible to marginalized and the underprivileged. At the dawn of independence this was adopted as the basis for India's health care policy. But the actual implementation of this policy was beset with major problems and in the process it became over medicalzed, over westernized, over centralized, and over professionalized and beaurocratized. The focus of peoples health in peoples hand was over looked and peoples health ended up in specialists hands. The strength and resilience of Indian systems of medicine and the social, cultural and economic factors too were ignored. It goes with out saying that today the public health system is in disarray characterized by inadequate capacity in the field, organizational fragmentation and disjointed decision making. Thus we failed to mobilize people to play a vital role in their own health and health care set up. After 55 years of independence access to health still remains a cutting edge issue in India. Health is a function not only of medical care, but of the over all integrated development of the society – cultural, economic, spiritual, educational, genetic endowment, environmental exposure, lifestyles, social and political influence, income and available medical care. And thus health is a multifaceted phenomena.

The setting up of Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research in the seventies again kick-started the thinking process to bring people oriented health care to the fore friend. The report of this panel is unique in that, it represents the joint deliberations of national experts from both medical as well as social sciences.

The report clearly demonstrated that health as a component of overall social and economic development, which in turn is influenced by our own health culture and practice based on the influence of mind and body interactions. The report emphasized the need to have an integrated approach to health and medical care and insisted that the best of the Western and the indigenous systems be integrated. And this process can provide an accessible, affordable and sustainable health care systems to this country which is people oriented and decentralized.

The report clearly defines the role that people can play in this set up. The 73rd and 74th amendments of the constitution has really made it possible to have such a viable, alternative model today. And health is one of the subjects under the Panchayat Raj system under section 11 of the schedule and it provides ample opportunity to inaugurate a nation wide move for universal access to health in the third millennium.

Today we need to make health and medical care a peoples movement. The report clearly indicates that appropriate health care can be provided to the entire population at about half the existing expenditure in the combined public and private sector. We need to harness the locally available human resource and empower especially the women by demystifying health which has been highly mystified subject in the hands of the professionals. Today all of us know that what our country need is a "bottom up, people oriented system, which can provide health care to the marginalized and the underprivileged people living below the poverty line.

The committee looked at various options of alternative models of health set up.

1) The village level
2) Sub-center level.
3) Community health center with a population of 100,000.
4) District level
5) Specialist center.

It is true that in a large subcontinent like ours we certainly need modifications to meet the varying needs and there should be no hesitation to do this. In all these effort we do need a well informed health care sector which presupposes education of the masses and it is here that we envisage a special role for voluntary secotor.

In the ultimate analysis we need to realize and recognize that we need to move away from counter productive, consumerist, western model and replace it with people based, participatory model of health and health care facilities as unprecedented opportunities and challenges face the nation and the world we seek to improve human health through participation and collaboration.

L-3A.8 (8)

Universal Access to Health for all

UN and its WHO have done a lot to make the health accessible to all through different documents and institutions. On the other hand WTO and many of the pharmaceutical companies are trying to do the opposite to make profit and exploit the whole world for profit. Poverty and illness are in a vicious circle. Because of poverty illness come and because of illness poverty increases. Illness is prevented not mainly by medicine but by nutrition and sanitation.

Global ethics demands availability of health care for all. It is premised on universally accepted values and norms. There is a common ground apparent in the process of development of medical systems. That ground is the universal values and norms shared by all- values of sanctity of humanness, human rights, and preservation of environment. It is the individual and collective ethics of responsibility. The global ethics is an ongoing and never-ending process. The civilized world is held together by the global ethics. From this universal ethics emerges the rights and duties recognized and operationalised by the internationally accepted charter like the UN. Declaration. Now all the nations in the world must individually legitimate, empower, protect and implement these values and norms with structures and strictures in every aspect of human medical needs. The final norm is interact, integrate and progress and become accessible to all by avoiding isolation in the name of specialization. All the medical systems are good for humanity but not all those who deal with them. They, many of them, do not respect ethical values and moral norms. What is needed is metanoia against the prevailing paranoia. The present paranoia must go. The global ethics demands availability of health care for all.

Medical Science, and also any science, is the process of knowing the bits and pieces of the phenomenal world. It deals with attaining the manipulative power of the material world. Atoms are bonded; different kinds of things are bonded. The Universe is a bond. Some call it 'field", electric field, magnetic field, gravitational field, etc. The bonds bind and build. All these bonds and fields postulates are fragmentary explanations of the observed phenomena. When we put them together with logic behind it a particular science is born. When legal bit s are bound together we have legal system. When medical bits are put together we have medical science.

Integration is a synthesis of the valid elements of the different systems of medicine into a modern scientific health science, which the people need. All the systems have valid and invalid elements in them. Therefore, the attempt required is to put the valid elements together and without adhering to the ego-reinforcing antiquities. The development of a scientific world-view, sharing of the experiences of private practitioners with scientists and researchers, development of scientific data for the existing practices, and eradication of quackery in the non-developed areas are included in integration

There are three groups of Medical systems. 1) Allopathic medical system with a philosophy of man, 2) Chinese, î yurveda, etc., meeting the medical needs of man with an equal footing as that of Allopathic medicine with their own explanations of man. Therefore, these systems are to be called parallel systems of medicine – parallel to that of allopathic medicine. Hence, we have allopathic medicine, parallel medicine and alternative medicine. Alternative practices are interventions for one or the other ailment without a proper philosophy supporting it. It can get integrated to into allopathic or parallel medicines. These three groups of medicines can be further integrated into each other. Cross-reference

groups of medicines can be further integrated into each other. Cross-reference of patients to different practitioners is easily possible if the integration of medical systems is a reality. . Integrative medicine is a term loosely used to describe biomedicine, parallel medicine and alternative medicines used in combination.

Systems of medicine grew up with integration like any other science. This we have seen already. Now what we need is simple integration and inter-system integration of medical systems. This is a natural out come based on the very nature of the development of science. Divisions and analyses are for better understanding. True learning is in integration. Unless the integration of medical systems is an on going process universal access to health care is a mirage. Health care needs coalition and integration of the knowledge of a man with a single medicine and of the trained medical practitioner. It is a holistic and interactive approach, not isolative and solipsistic.

Dr. J. Dasgupta

Universal Access to Health for all

DR. J. OUSEPARMPIL,
Senior Fellow, University Grants Commission,
Dept. of philosophy, University of Poona
drouse@pn2.vsnl.net.in
020- 7171803, 9822256275

In the following two pages I put forward only two points: 1) Medical science grew up with a process of integration. This is true in the case with any science, physical or social. 2) The world is moving fast towards a global ethics. Human rights demands universal access to health for all. All the systems of medicine are good but not all that handle them. A metanoia is the need of the day. Avoid isolation by specialization, integrate medical systems and follow human rights, which is part of global ethics.

UN and its WHO have done a lot to make the health accessible to all through different documents and institutions. On the other hand WTO and many of the pharmaceutical companies are trying to do the opposite to make profit and exploit the whole world for profit. Poverty and illness are in a vicious circle. Because of poverty illness comes and because of illness poverty increases. Illness is prevented not mainly by medicine but by nutrition and sanitation. Unethical exploitation of resources is the main cause of denying universal access to health for all.

Global ethics demands availability of health care for all. It is premised on universally accepted values and norms. There is a common ground apparent in the process of development of medical systems. That ground is the universal values and norms shared by all- values of sanctity of humanness, human rights, and preservation of environment. It is the individual and collective ethics of responsibility. The global ethics is an ongoing and never-ending process. The civilized world is held together by the global ethics. From this universal ethics emerges the rights and duties recognized and operationalised by the internationally accepted charter like the UN. Declaration. Now all the nations in the world must individually legitimate, empower, protect and implement these values and norms with structures and strictures in every aspect of human medical needs. The final norm is interact, integrate and progress and become accessible to all by avoiding isolation in the name of specialization. All the medical systems are good for humanity but not all those who deal with them. They, many of them, do not respect ethical values and moral norms. What is needed is *metanoia* against the prevailing *paranoia*. The present *paranoia* must go. The global ethics demands availability of health care for all.

Medical Science, and also any science, is the process of knowing the bits and pieces of the phenomenal world. It deals with attaining the manipulative power of the material world. Atoms are bonded; different kinds of things are bonded. The Universe is a bond. Some call it 'field", electric field, magnetic field, gravitational field, etc. The bonds bind and build. All these bonds and fields postulates are fragmentary explanations of the

observed phenomena. When we put them together with the logic behind it a particular science is born. When legal bits are bound together we have legal system. When medical bits are put together we have medical science. Medical science is grouped with different logic and we have different systems of medicine. This process is never complete unless we integrate all the different systems of medicine with the same logic.

Integration is a synthesis of the valid elements of the different systems of medicine into a modern scientific health science, which the people need. All the systems have valid and invalid elements in them. Therefore, the attempt required is to put the valid elements together and without adhering to the ego-reinforcing antiquities. The development of a scientific world-view, sharing of the experiences of private practitioners with scientists and researchers, development of scientific data for the existing practices, and eradication of quackery in the non-developed areas are included in integration

There are three groups of medical systems. 1) Allopathic medical system with a philosophy of man, 2) Chinese, Āyurveda, etc., meeting the medical needs of man with an equal footing as that of allopathic medicine with their own explanations of man. Therefore, these systems are to be called parallel systems of medicine – parallel to that of allopathic medicine. Hence, we have allopathic medicine, parallel medicine and alternative medicine. Alternative practices are interventions for one or the other ailment without a proper philosophy supporting it. It can get integrated to into allopathic or parallel medicines. These three groups of medicines can be further integrated into each other. Cross-reference of patients to different practitioners is easily possible if the integration of medical systems is a reality. . Integrative medicine is a term loosely used to describe biomedicine, parallel medicine and alternative medicines used in combination.

Systems of medicine grew up with integration like any other science. This we have seen already. Now what we need is simple integration and inter-system integration of medical systems. This is a natural out come based on the very nature of the development of science. Divisions and analyses are for better understanding. True learning is in integration. Unless the integration of medical systems is an on going process universal access to health care is a mirage. Health care needs coalition and integration of the knowledge of a man with a single medicine and of the trained medical practitioner. It is a holistic and interactive approach, not isolative and solipsistic.

Community Based Primary Health Care Primary Health Care approach to reach the unreach

55 years after independence health conditions of majority of Indians are steadily deteriorating. Widespread malnutrition among children and women is a major health problem. Lack of clean portable water primitive sanitary conditions and environmental degradation contribute to nearly 60% illnesses in rural areas. There is growing disparity between women - men, urban-rural, rich-poor, landowner – landless labors and high caste – low caste. Unchecked population is detrimental to physical, mental and social health of people, specially women and children.

There is a need to accept and promote broader definition of health, which is physical, mental, social and spiritual well being. Health and medical care are different. The government has wrongly promoted medical care in the name of health. Highly commercialized and greedy private medical sector is promoting curative care and medicalizing the society. It is promoting unnecessary and expensive technology. This commercialization is resulting in erosion of ethics and moral values.

Health and development go together. They are two sides of the same coin. World Health Assembly promoted Primary Health Care approach to meet universal health needs of all in the world. The Alma Ata Conference highlights following principles:

- Health is fundamental right and therefore it should be accessible, available, affordable and culturally acceptable to all
- People have right and responsibility to plan and maintain their own health.
- Health and development are intimately related. Integration with sectors such as environment, agriculture, education and women's income generation needs to be promoted.
- There is a need to integrate curative services and with promotion, prevention and rehabilitation.
- The present curative oriented and technical care needs to be replaced by wholistic health.
- No one system is perfect and it has limitations, therefore the best in all system should be available to the community.
- Health care personnel should replace hierarchal approach by team approach.

In the early 80s ICSSR and ICMR appointed a committee to suggest alternate strategy to achieve 'Health For All'. This committee provided, some far reaching solutions. Empowering local communities through knowledge, skill and budget.

Decentralization up to block level and provision of integrated graded health services. Unfortunately, there was no infrastructure or mechanism to bring these ideas in practice. With the promotion of Panchayati Raaj System (PRS) it may be possible to decentralize health services and meet the health needs of all. However, PRI has some problems.

- Feudal Indian villages with widespread politicization.
- Low status of women with unbelievable discrimination and violence against women.
- Unjust treatment of tribal and low caste people.
- Rural poverty and lack of basic infrastructure.

The civil society therefore has the challenges of:

- Bringing health, especially to women and children.
- The rural masses and marginalized groups like adivasis and city slum dwellers.
- To bring awareness to these groups about their own health, their rights and responsibilities.
- To increase the capacity of local communities to plan and promote their own health programs.
- To train and empower the grassroot workers.
- To monitor the activities of doctors, paramedical workers and others who are supposed to serve the communities.
- Integrate different development activities which result in better health.
- To promote people's organizations for self-reliant health care.

Many non-government organizations like Comprehensive Rural Health Project (CRHP) have promoted primary health care approach to improve health of the people with varying degrees of success.

Grassroots worker

Variously called as VHW, VHG, CHV,or Animator. The grassroots worker is kingpin for the Primary Health Care (PHC) approach. She should be a middle aged woman with standing in the community and who has enough time and social consciousness to serve the people. As the vulnerable population in the village consists of young women and children, woman volunteer is essential. She should be chosen by community, especially community from target group. Illiteracy need not be a hindrance. She should not be directly paid salary by the organization. Many alternate avenues should be explored to support her. It is important that she should have adequate financial support, which not only gives her security but provides her good status in the community.

Training:

Initial training of grassroots worker should be of 1-2 weeks, followed by continuous monthly or fortnightly training for couple of days at a time. Training should be problem based, participatory and opportunities for group work should be given. The training should be more in community than in the classroom. Doctors may not be good trainers therefore preferably a nurse / social worker should be trained as a trainer. Training should include:

A. Technical

Technical knowledge about child nutrition, immunization, common illnesses, pregnancy, delivery, common illnesses of women should be included. Similarly they should know about common drugs and herbal medicine. In addition to technical medical knowledge she should be provided other skills.

B. Leadership

The grassroots worker is a bridge between health professionals and the people. She is a spokesperson on behalf of the community. As a leader of community she has different roles as advocacy, reconciliation and control of health workers. She should be able to mobilize people for health and development activities. She should be promoting moral values. Identify malpractices and report to appropriate authorities.

C. Health Worker as a Development Worker

She should identify and promote linkage between development and health e.g. agriculture and nutrition, women's education and family health, environment and health. She should be a good communicator. She should be able to coordinate activities of other functionaries such as Anganwadi worker, TBA, etc.

D. Community organizer

The health worker needs support of the community when dealing with many community health issues e.g.

(i) Remove stigma about leprosy, TB and AIDS.
(ii) To eliminate harmful practices which are detrimental to health.
(iii) To sensitize community regarding discrimination against women and girl child.
(iv) Dealing with sensitive issues like family planning, dowry etc.

Increasing capacity of the communities

Elected women members of Panchayat and the Village Sarpanch / Pradhan together with other functionaries take responsibility for health. In addition to information on health, they will be trained to manage their health programs including financial management. Under PRI they should receive financial support, thus making Primary Health Care sustainable.

Networking

Health and development are inseparable. The NGOs should be looking for involving development agencies in health program. There should be interaction between staff members and community with various agencies, NGOs and Governmental. One should be on the lookout to identify development agencies who can also incorporate health program. This kind of an integrated health program has a better chance of success than one started in isolation. On the other hand it is extremely difficult for hospital management to start Community Based Primary Health Care (CBPHC) programs. Often they end up in transferring hospital culture to village communities. It is better for motivated hospital staff to disassociate from hospital and start a new program, than be saddled with the institution.

It has been a pleasure to interact and train the members of CHAI in CBPHC all over India. Many of them have participated in Jamkhed training and have had tremendous success in promoting primary health care in remote parts of the country. Civil Society like CHAI have tremendous challenged in bringing equity and justice to meet health needs of the masses. Due to limitations of time I have confined my remarks to Community Based Health Care at grassroots level.

Thank you for giving me this opportunity to share my thoughts.

Dr. R. S. Arole
Director
Comprehensive Rural Health Project
Jamkhed

Community Based Primary Health Care Primary Health Care approach to reach the unreach

55 years after independence health conditions of majority of Indians are steadily deteriorating. Widespread malnutrition among children and women is a major health problem. Lack of clean portable water primitive sanitary conditions and environmental degradation contribute to nearly 60% illnesses in rural areas. There is growing disparity between women - men, urban-rural, rich-poor, landowner – landless labors and high caste – low caste. Unchecked population is detrimental to physical, mental and social health of people, specially women and children.

There is a need to accept and promote broader definition of health, which is physical, mental, social and spiritual well being. Health and medical care are different. The government has wrongly promoted medical care in the name of health. Highly commercialized and greedy private medical sector is promoting curative care and medicalizing the society. It is promoting unnecessary and expensive technology. This commercialization is resulting in erosion of ethics and moral values.

Health and development go together. They are two sides of the same coin. World Health Assembly promoted Primary Health Care approach to meet universal health needs of all in the world. The Alma Ata Conference highlights following principles:

- Health is fundamental right and therefore it should be accessible, available, affordable and culturally acceptable to all
- People have right and responsibility to plan and maintain their own health.
- Health and development are intimately related. Integration with sectors such as environment, agriculture, education and women's income generation needs to be promoted.
- There is a need to integrate curative services and with promotion, prevention and rehabilitation.
- The present curative oriented and technical care needs to be replaced by wholistic health.
- No one system is perfect and it has limitations, therefore the best in all system should be available to the community.
- Health care personnel should replace hierarchal approach by team approach.

In the early 80s ICSSR and ICMR appointed a committee to suggest alternate strategy to achieve 'Health For All'. This committee provided, some far reaching solutions. Empowering local communities through knowledge, skill and budget.

Decentralization up to block level and provision of integrated graded health services. Unfortunately, there was no infrastructure or mechanism to bring these ideas in practice. With the promotion of Panchayati Raaj System (PRS) it may be possible to decentralize health services and meet the health needs of all. However, PRI has some problems.

- Feudal Indian villages with widespread politicization.
- Low status of women with unbelievable discrimination and violence against women.
- Unjust treatment of tribal and low caste people.
- Rural poverty and lack of basic infrastructure.

The civil society therefore has the challenges of:

- Bringing health, especially to women and children.
- The rural masses and marginalized groups like adivasis and city slum dwellers.
- To bring awareness to these groups about their own health, their rights and responsibilities.
- To increase the capacity of local communities to plan and promote their own health programs.
- To train and empower the grassroot workers.
- To monitor the activities of doctors, paramedical workers and others who are supposed to serve the communities.
- Integrate different development activities which result in better health.
- To promote people's organizations for self-reliant health care.

Many non-government organizations like Comprehensive Rural Health Project (CRHP) have promoted primary health care approach to improve health of the people with varying degrees of success.

Grassroots worker

Variously called as VHW, VHG, CHV,or Animator. The grassroots worker is kingpin for the Primary Health Care (PHC) approach. She should be a middle aged woman with standing in the community and who has enough time and social consciousness to serve the people. As the vulnerable population in the village consists of young women and children, woman volunteer is essential. She should be chosen by community, especially community from target group. Illiteracy need not be a hindrance. She should not be directly paid salary by the organization. Many alternate avenues should be explored to support her. It is important that she should have adequate financial support, which not only gives her security but provides her good status in the community.

Training:

Initial training of grassroots worker should be of 1-2 weeks, followed by continuous monthly or fortnightly training for couple of days at a time. Training should be problem based, participatory and opportunities for group work should be given. The training should be more in community than in the classroom. Doctors may not be good trainers therefore preferably a nurse / social worker should be trained as a trainer. Training should include:

A. Technical

Technical knowledge about child nutrition, immunization, common illnesses, pregnancy, delivery, common illnesses of women should be included. Similarly they should know about common drugs and herbal medicine. In addition to technical medical knowledge she should be provided other skills.

B. Leadership

The grassroots worker is a bridge between health professionals and the people. She is a spokesperson on behalf of the community. As a leader of community she has different roles as advocacy, reconciliation and control of health workers. She should be able to mobilize people for health and development activities. She should be promoting moral values. Identify malpractices and report to appropriate authorities.

C. Health Worker as a Development Worker

She should identify and promote linkage between development and health e.g. agriculture and nutrition, women's education and family health, environment and health. She should be a good communicator. She should be able to coordinate activities of other functionaries such as Anganwadi worker, TBA, etc.

D. Community organizer

The health worker needs support of the community when dealing with many community health issues e.g.

(i) Remove stigma about leprosy, TB and AIDS.
(ii) To eliminate harmful practices which are detrimental to health.
(iii) To sensitize community regarding discrimination against women and girl child.
(iv) Dealing with sensitive issues like family planning, dowry etc.

Increasing capacity of the communities

Elected women members of Panchayat and the Village Sarpanch / Pradhan together with other functionaries take responsibility for health. In addition to information on health, they will be trained to manage their health programs including financial management. Under PRI they should receive financial support, thus making Primary Health Care sustainable.

Networking

Health and development are inseparable. The NGOs should be looking for involving development agencies in health program. There should be interaction between staff members and community with various agencies, NGOs and Governmental. One should be on the lookout to identify development agencies who can also incorporate health program. This kind of an integrated health program has a better chance of success than one started in isolation. On the other hand it is extremely difficult for hospital management to start Community Based Primary Health Care (CBPHC) programs. Often they end up in transferring hospital culture to village communities. It is better for motivated hospital staff to disassociate from hospital and start a new program, than be saddled with the institution.

It has been a pleasure to interact and train the members of CHAI in CBPHC all over India. Many of them have participated in Jamkhed training and have had tremendous success in promoting primary health care in remote parts of the country. Civil Society like CHAI have tremendous challenged in bringing equity and justice to meet health needs of the masses. Due to limitations of time I have confined my remarks to Community Based Health Care at grassroots level.

Thank you for giving me this opportunity to share my thoughts.

Dr. R. S. Arole
Director
Comprehensive Rural Health Project
Jamkhed

Universal Access to Health Care: A Mission Possible.

(Dr.Mani Kalliath, Community Health CHAI)

I a) **Beginning of the Country's Dream for Health:**

At the time of Independence 55 years ago Bhore Committee identified the major determinants of country's ill health namely poor nutrition, lack of access to amenities of water and sanitation, low health awareness and inaccessible health care. Accordingly independent India proudly launched the country -wide structure of Primary Health Centres and sub-centres and programs for nutrition and sanitation. By the seventies it was clear that the developmental efforts were not bearing fruit to the expectations generated by the Freedom Movement. Frustrated by the slow pace of development of the country and its poor, educated young men and women including professionals started initiatives in various sectors, moved by a spirit of idealism. These NGOs (as they came to be called) realized through trial and error that there needed to be an alternative, community-based approach to development. In the health sector many notable community based programs developed, most notable among them being the Jamkhed Project.

b) **Primary Health Care Can Deliver:**

Programs like Jamkhed demonstrated in the micro situation (up to a hundred villages) that they were operating in, that low cost quality health care is practical and possible within the country's resources. In combination with efforts at tackling the determinants of diseases namely poverty, lack of basic amenities and unhealthy life style, they could demonstrate remarkable improvement in the health status of people in the micro situation.

The proof of effectiveness of comprehensive of Primary Health Care was established as early as the Seventies. In this process other important lessons were also highlighted.

- Illiterate village women could be empowered and trained to deliver complicated and quality health care (A village level health care provider is a critical lack in the country, as majority of village level ailments can be responded to such a provider).

- Though health care is important control over other determinants contributed more in impacting on health status.

- A low cost and quality health care system is practical and possible within the country is resources.

- People need to be organized to effectively demand their rights for health care and other facilities as the Public Health System was geared to respond only upwards to the higher levels of the hierarchy.

c) **The Assault on Primary Health Care:**

However these working models and the lessons they brought out could not be replicated across the country. Over the next two and a half decades the opposite efforts became stronger namely to debunk and prove that Comprehensive Primary Health Care is impractical, is a failure and need to be scrapped. The assault on Comprehensive Primary Health Care was initiated as early as the 80's internationally when multilateral agencies started promoting

'Selective Primary Health Care.' Within less than a decade of proclaiming 'Health for All' and simultaneously with the adoption of India's first Health Policy (which is supportive of Primary Health Care), The conditions were being set for its failure and eventual scrapping. The national and state health beaurocracy steadily allowed the PHC to deteriorate, through changed priorities, inadequate funding, beaurocratic neglect and lack of competence. The way it was being implemented, the Primary Health Care was doomed to fail for the following reasons.

- It is a verticalised system, where the decisions related to Planning and Implementation is done at the capitals, far away from the locations where the problem exist.
- The system is controlled by techno – beurocrats whose thinking are in the curative mode and who have scant respect for the potentials of the common people for creating health.
- It is compartmentalized, and inefficient and does not have synergistic effect.
- It is designed not to elicit community participation, but only passive acceptance by an unquestioning public.
- It has very little service solutions to offer to the multitude of problems affecting the poor.

In the renewed assaults on Primary Health Care, under the Globalization Forces it is being scrapped without offering alternatives to the country's poor. The middle class and upper class have disowned it(Government Primary Health Care) and now the Government is disowning it and transferring the responsibility to non accountable 'Societies' What is offered instead is the 'Mantra of Privatization' as is happening in other sectors in the country. The poor are not being taken into confidence, nor is there a national consensus on these policy shifts.

d) **The Health Conditions of the Poor have deteriorated**

A brief look at the current Health Indices (NFHS 2) show that:
IMR at 68, Child Mortality Rate at 29 are high. However the same Indices are higher by 22% and 45% among SCs and STs. Maternal Mortality Rate estimated to be between 437- 570 remain unacceptably high, with 42% of rural women not getting any Ante-natal Care. Community Studies in tribal areas show half the women dying of maternity related causes die at home and another 15% die on the way to hospital. 53% of Under 5 children are malnourished and in low income categories is much higher as also 36% of women are undernourished, which is higher among disadvantaged groups. 50% of infant deaths and 35% of under 5 deaths are attributed to Diarrheas and Acute Respiratory Infections. Among adults TB Malaria and HIV/AIDS have come to occupy epidemic proportions with 15 million TB, 20- 30 million Malaria and 4 million HIV/AIDS positive cases.

Yet only 29% of the population use public medical sector for treatment and even among the poor households only 34% use the public medical sector. The rest are forced to seek care from the private providers at exorbitant prices with the result that medical expenses have become the second most important cause for rural indebtedness.

- Are the poor aware their Health Rights are being snatched away? (In spite of the Constitutional guarantees)

- How can the country's majority poor pay for the costly privatized curative care?

- Who is responsible for responding to the epidemics of old and new communicable disease raging among the poor and the burden of wasted lives?

These are a few of the mute questions the poor are asking, but unheard by the centres of power in health decision making.

II a) **The time has come to challenge the myth that Universal Access to Health Care is not Feasible**.

The time has come to challenge this myth that Primary Health Care approach is a failure and also Universal Access to Health Care is beyond the means of a developing country such as India. The successful micro experiments of community health need to be translated across the country not by creating Jamkhed's across the country, but by spreading the Jamkhed perspective across the country. What is required is to mobilize people large scale for health, to create a demand for delivery of public health and related services. It is also necessary for people to regain competency for tackling health problems they can at their own level.

The beginnings of the process have started in the country. There is a joining of forces of health and development activists, people oriented resource centres and health care providers, NGO's with interest in health and people's networks fighting for their Health Rights. We shall see later in the paper the emerging coalition for Health.

II b) **A theoretical model for replicating Primary Health Care at a larger level.**

A three tier theoretical model is presented for promoting primary health care, starting from the village and going up to the district level.

At the village level:

The village health committee is to be promoted consisting of the Panchayat member or village leader (heading the committee) the presidents of the women's groups and youth groups and the dai's and traditional healers. The ICDS worker would also need to be a member.
The committee would have the functions of.

1. Monitoring the health of the village community – especially the various priority segments

2. Ensuring availability of village level health care (for common ailments) through a trained health volunteer. The health volunteers who could be the Dai or any person with aptitude who has been trained to deliver simple care and to identify serious health problems or potential health problems. The ICDS worker is also responsible for health of the children and mothers.

3. Monitoring the services of the public health functionaries, that is the ICDS worker the sub – centre ANM's village duties and any other service provider, Male Health Worker, where the post exist and private health sector where it exists.

4. Develop a health plan for the village and ensuring all health related information's available to all village members.

5. The committee would need resources allocated from the village fund to meet minimum requirement and for emergencies. The community would purchase health care from the health providers at agreed upon charges and get stripulated public health care services from the public health functionaries free of cost. The committee would receive appropriate training's for these functions where-in the health providers will get more intensive training to be competent for treating common ailments and monitoring for serous ailments. (it is posssible for the same committee to be responsible for other service areas such as Animal Husbandry given appropriate training.

Some of the priorities for Training would include the following: –

- Treatment of common ailment
- Monitoring for potentially serious diseases.
- Village level perspective on health
- Duties and functions of sub centre and other government facilities / services at the village level

At the Mandal Level

The mandal level health committee need to be promoted under the leadership of the mandal president. It would have representatives of the village health Committees, apex representatives of people's organizations such as federated SHGS, farmers Clubs, Youth and Children's Clubs (if existing). Other possible members would be the NGO health facilitator, representative of special needs groups (if existing, such as People living with HIV/AIDS(PLHA's) , Differently abled persons etc.. The Primary Health Centre doctor or representative. The Public Distribution System (PDS) representative and other mandal level welfare related government bodies would also be represented.

The functions of the mandal level committees would be similar to the village health committee mentiond but at a higher levels of details and complexity. At this level the health care provider would be primarily the PHC. One of the key functions of the Committee would be to ensure full service from the Primary Health Centre, Sub – Centres and other government bodies and as well as support health related campaigns and awareness programs of the public bodies with the community.

The Mandal Committee would be allocated a health fund from the Mandal Panchayat Fund, augmented from local resources, which would be used for implementing Mandal level health plan. The Mandal level Health Plan priority would emerge from the village plans and that which cannot be implemented by the village committees. Technical facilitation would be required to ensure that the plan address determinants of health and is not biomedical focussed(as is the PHC plan).

The Mandal Health Committee requires capacity building for various competencies to play effective roles among which immediate priorities would include - a broad perspective on health, skills in developing implementing and monitoring mini-plans, the responsibilities of the public health systems at the mandal level.

At the level of the District / Taluk.

(As the district appear to be too large a unit Taluk level Committee may be appropriate) The District/Taluk Health Committee or Health Watch Committee would need to be lead by the Zilla Parishad President or such appropriate authority and would have representatives from NGO health networks, reputed public-spirited citizens. The district level officers of Health, Women and Child Welfare. Government Societies (Such as District Society for HIV, TB etc...) with a bearing on health would also need to be part of it, as well as private sector in health care represented by Indian Medical Association, Nursing Home's Association representative etc.

The Taluk/District Health Watch Committees would have the functions of

1. Monitoring the Health Status of the people.

2. Monitoring the quality and implementation of health care services both by the public sector and the private sector.

3. Implementing need based plans emerging from the village plans, which require district level implementations.

Appropriate capacity building would be required for the district level committee, among which the priority would be on District level Health Perspective based on determinants of health, Skills for Planning, Implementation and Monitoring of District/Taluk Health Plans, Responsibilities of the Public Systems in Health and allied areas at the district level.

III) **Experiences adding credence to such a Democratic Health Structure**:

a) Is the theoretical model presented purely a visionary one, out of touch with ground realities? There are macro level experiences lending credence to the effectiveness of decentralized planning and monitoring of health. The two experiences quoted below demonstrate the effectiveness of People's Watch Groups over Health Functionaries, when the community has been made aware and mobilized for health. Refer footnotes for a brief sketch of two programs. Arogya Iyyakkam from Tamil Nadu and Arogya Sathi program functioning in Maharashtra and Madhya Pradesh.

b) The Peoples Plan Process or Democratic Decentralization process in Kerala, where the state government supported building up the structure and process for decentralized planning is another wonderful example. The three layers of Local Self Government structures were empowered through capacity building, technical and financial support to develop need based plans relating to social services, infrastructure development and income generation. The committees at each level were empowered to develop plans and implement them, within the grant allocated, with the help of a technical advisory body. This process resulted in addressing key priorities of the community that determined their health status – such as environmental sanitation, provisioning of safe water, toilet facilities. These structures also

helped to motivate the public health system to function more efficiently and to co-ordinate better with the non-medical interventions. Where necessary the Local Body had sufficient financial powers to hire a doctor or supplement the PHC infrastructure or intervene with bio-medical interventions in response to a local epidemic. The People's Plan Process also resulted in demystification of health, - as a Lady Panchayat President of Dalit background explained. ' Health is not just doctors hospitals and medicines. More importantly it has to do with safe water, sanitation and sufficient food? (CHAI Network Representatives visit to People's Plan Process at Vaikom ? Aug 2000)

c) Experiences of CHAI Network

What are CHAI network's experiences in promoting access to Health Care by the Communities?

Almost seven years ago the CHAI leadership set in motion a bold and visionary process, which was also very timely. This process had three thrusts, which was summarized as ' Decentralization, Government – NGO Collaboration and Planning from Below'. CHAI had been promoting for over one and half decades prior to that the process of Community Health. Its member institutions were encouraged and supported to facilitate in the communities around them, health promotional activities, complementing the curative work of the institutions. Some of these institutions even began to work on ' Right to Health' aspects. However there was no structure existing in the net work to sustain this process as it was a direct partnership between CHAI Centre and the institutions and these become isolated examples not having larger impact. Hence Decentralization of Structures, Roles and Capacities of the CHAI Network was an immediate priority, on which was to be built up the other two processes of Government- NGO Collaboration and Planning from Below (Decentralization Thrust of CHAI– Mani Kalliath, 1998).

Decentralization

Though it was to be a long and laborious process, CHAI network has moved steadily in the Decentralization path. Decentralisation process has resulted in the formation of:

- 11 Regional Units (a Regional Unit or RU may be confined to one state or may cover several states especially in North India) have been strengthened and 5- 6 RUs are functioning effectively, some even as recognised state level Resource Agencies.
- 100 Diocesan Units (a Diocesan unit or DU usually extends over 2- 3 districts) with atleast 50% of them being active and 11 'Model Diocesan Units with intensive developments.

Government –NGO Collaboration:

The Government – NGO collaboration was facilitated through the newly developed program of ' Promotion of District Health Action Forums'. CHAI network like other Church Bodies has had an inward looking, approach in networking, wherein networking within Church Institutions was comfortable, where as there is reluctance to network with NGO's or other groups. Underlying this reluctance are historical, perspective related, skill related as well as structure and systems related reasons. Hence developing a structure of DHAF for relating with Government and NGOs is a very important starting point. CHAI network has now over three years experience of formal networking and by and large it has been positive.

Planning from Below

CHAI networks initiative in promoting 'Planning from Below' at a macro level got encouragement through its involvement in the Jan Swasthya Abhiyan Networking at the national level as well as its experiences through DHAF. The more advanced Regional Units incorporated this strategy in their Regional Plans. As an example the Tamil Nadu Unit strategized Planning from Below into its three year Diocesan Unit Strengthening Program presently being implemented. The planning is based on participatory identification and prioritization of village level health needs, which gets consolidated into a Diocesan Unit level plan. A drawback in CHAI networks activities has been the poor emphasis on documentation. As no professionally developed baseline data is available quantifying impact of these efforts at people's health, is difficult. In its future thrust CHAI Network hopes to build a coordinated national plan of activities, building on the Needs identified at the village level, with built in Management Information System (MIS).

(Refer for a detailed discussion on the CHAI experiences, the supplementary note on 'Universal Access to Health Care- Potential and Possibilities for CHAI Network')

d) **Jan Swasthiya Abhiyan- the beginning of National Coalition Building.**

The Jan Swathya Abhiyan is the first time several types of actors who could contribute to health have come together in the country. As mentioned earlier it includes health care provider networks (including CHAI), networks focussed on related issues, health activists and socially concerned resource groups and a large number of interested NGO's. Its potential strenghts have been a loose democratic organization, with a representative National Co-ordination Committee and State level Co-ordination Committees, and a transparent system for sharing information. There is a countrywide or regional focus on a few priorities, in which a campaign for Health as a Right is one of the priorities. Each participating network contributes by strengthening their efforts towards the common campaign issues within their areas of operation. Support can be sought and given to other groups based on each group's strength and specialization. JSA had decided to draw public attention to health related issues during the celebration of National Days this year.

In some states the JSA has been more active, Maharashtra being one example. Recently JSA related groups have been influential in making the State Health Department to recognize the need of a 'Health Worker for every Village', though the modalities of ensuring this is yet to be known. Going beyond the state level in many districts JSA bodies are active providing a platform for raising health issues.

At the International level JSA is active through the People's Health Assembly Committee representing all the regions of the World. JSA has been actively raising issues related to transparency and accountability of WHO in relation to World's Poor, the hijacking of Health Agenda by the Multinational Corporations through their financial contributions to WHO and through other private bodies created such as the Global Fund for Health.

As a coalition of various types of networks and groups working with different approaches and background skills, JSA is yet to establish sufficient confidence and acceptance among the different constituents. This requires ongoing efforts, sensitivity and mutual respect and a willingness organizationally to share resources. To some extend testing out relationships require time and evaluating of how the relationship has strengthened each groups genuine agendas.

IV Summary :

Universal Access to Health Care is not is not just a possible dream, it is a need whose hour has long been delayed. With the impact of Globalization forces on the lives and health of the poor, there is an urgency to make it a reality. The technical elements for its strategy has been demonstrated by hundreds of 'models' micro as well as macro level, that were created by pioneering groups across the country in the last two and a half decades. They have demonstrated the health creating abilities of ordinary and illiterate individuals, families, village communities and even macro groupings. The missing thread running through these efforts has been the creation of an effective structure/ network for releasing this potential countrywide as well as for channeling and focussing people's demand for Health Rights. The beginnings of the Health Coalition emerging in the country is a welcome signal.

CHAI Network with its countrywide presence, organisational structure and variety of health promotional experiences and skills is a major actor in this respect and looking to play an effective role. Recognising the complementary strenghts of various national level health actors, CHAI Network is continuing in its effort towards concerted action for 'Universal Access to Health Care'.

(The author of this paper and its supplementary note 'Universal Access to Health Care – Potential and Possibilities for CHAI Network' is beholden to the following persons: Fr.Sebastian Ousepparambil, Director CHAI for the inspiration and philosophical frame work of this paper, Sr.Fatima Associate Director CHAI and former Secretary CHAT as well as Dr.Sam Roy Liaison Officer for the insight into Diocesan Strengthening program in Tamil Nadu, Shri Shaju Joseph DHAF Co-ordinator for the insight into CHAI's DHAF experiences).

---

1. 'Arogya Iyyakkam' T.N.

This was an evolution from the people's literacy movement and women's movement, at the point when government support was withdrawn. This comprehensive health programme with people's participation is being implemented roughly in one thousand (1000) villages spread over twenty one (21)blocks of Tamil Nadu. The Programme had the following objectives.

- *Focus on improving children's nutrition (using weight measurement as an index of change).*
- *Making government health services responsive to people's needs and demands.*
- *Improving the cultural health practices*
- *Putting health on the agenda of Panchayati Raj Institutions (PRIs)*

The key intervention strategies included:

- *Intervening through the 'Village Health Worker' who is a community representative and whose orientation on health included a socio-political perspective of the family's health (world view)*
- *Maintaining a register of every child, which records vital events, six monthly records of weight and which, is 'understood and owned by the family'.*
- *Maintaining a village level register of services provided by the public health services (Primary Health Centers) which is placed in the 'Gram Sabha' meetings for monitoring and follow-up.*
- *Promoting and mobilizing a broad-based organizational structure at the village level (which includes the Panchayat member) for taking responsibility for health.*

During this short period of implementation 'Arogya Iyyakam' has advocated on issues such as

- *Resumption of 'Dai Training' by the PHCs*
- *Public hearing on the abusive style of functioning of the public health functionaries.*

*2. **'Arogya Sathi'***

'Arogya Sathi' project functions in four different locations in Maharasthra and Madhya Pradesh.

The objectives that guides these efforts included:

- *Developing strategies to make public health care an 'entitlement' for the people (as opposed to the present notion that it is a set of services provided by this welfare state)*

- *Ensuring sustainability of community health process.*
- *Developing innovative approaches to training of Arogya Sathis (illiterate Health Workers)*

The Strategies for implementing included:

- *Engaging mass organizations to take up health agendas (as NGO based health programmes were not sustainable in the long run)*
- *Promoting people based structures (village health committes and Jan Swasthya Samithis, which includes NGOs) for taking responsibility for health.*
- *Developing pictorial training materials including for assessment of the trainees (even if illiterate) and campaign materials that demystified health.*

The Programme aimed to address issues relating to public sector in health, the private sector in health, the health/ill health determinants as well as towards promoting people's alternative strategies for health. The public health sector was challenged to be accountable by monitoring their services (village health calendar) and through specific issue based campaign. The private sector was challenged to be rational and transparent in their services through promoting awareness of the people on their exploitation and through signature campaign with the private professionals. The `determinants' affecting health taken up for campaigning included `Anti Alcohol Campaign' and `Right to Food Campaign'.

Within a short period the programme has yielded results in the form of Arogya Sathis being able to handle 60% health contingencies of the community and considerable savings of the health expenditures of the people.

(These extracts are taken from the presentations at the Asian Social Forum 2003, Hyderabad)

C-3A.12 (12)

People's Health Assembly

People's Campaign for Decentralised Planning and the Health Sector in Kerala

by *B. Ekbal*

ISSUE PAPER

Nadine Gassman, Coordinator, Analytical Process, Fuente de Emprador 28, Tecamachalco, Estado de Mexico CP 53950, Mexico.
tel: 525-251 0283; fax: 525-251 2518; email: gasmanna@netmex.com

PHA Secretariat, 250A Jalan Air Itam, 10460 Penang, Malaysia.
tel: 604-229 1396; fax: 604-228 6506; email: phasec@pha2000.org; website: www.pha2000.org or www-sph.health.latrobe.edu.au/pha

In spite of the economic backwardness, Kerala has made remarkable achievements in health almost comparable to that of even developed countries. The widely accepted health indicators like crude death rate, infant mortality rate, and life expectancy evidence this. (Table 1)

Most analysts have seen Kerala's achievements in health as something of an enigma. Kerala achieved the health status as par with that of USA spending roughly 10 US $ per capita per year while US spends about 3500 $ per capita per year on health care. The GDP of Kerala is even less than that of the National average. Kerala's achievement in health in spite of its economic backwardness and very low health spending has prompted many analysts to talk about a unique "Kerala Model of Health," worth emulating by other developing parts of the world

Kerala Model of Health

There are many socio-economic conditions unique to Kerala, which have been postulated to make this health model possible. Kerala has a highly literate population compared to other Indian states. This especially the high female literacy, has to be given due credit when we look for explanatory factors. All over, the world indices such as infant mortality have shown an inverse relationship with female literacy.

It is also to be noted that Kerala has nurtured a political climate wherein the rights of the poor and the under privileged have been upheld and fought for. This was the result of a fairly long period of struggle for social reforms exphasising dignity of people who were considered socially 'inferior' which later found expression in secular-democratic movements culminating in nationalist and socialist movements. One common thrust of all such movements was on education and organisation of the downtrodden people. Hence, as has been pointed by many social scientists there is a remarkable reduction in the rate of exploitation of the underprivileged in Kerala compared to other Indian states.

The agrarian reforms that were implemented in the late 1950s ended the feudal relationship in agriculture and giving land to the tillers. This improved the social living conditions of the landless poor in the rural areas. This might have contributed to the alleviation of poverty among the agricultural laborers leading to the improvement of their health status.

The public distribution system of food through fair-priced rations shops distributed throughout Kerala assures minimum food materials at relatively cheap cost to the people. This has assured certain amount of nutritional status to the poor, warding of poverty related diseases.

Apart from the socio-economic factors outlined above the universally available public health, system in Kerala has also contributed to the high health status of the people. Kerala has a three-tier system of health care, the Primary Health Centres (PHC) and the Community Health Centres (CHC), Taluk and District Hospitals and the Medical Colleges evenly distributed both in the urban and the rural areas. Apart from Modern Medicine, Ayurveda, Homeopathy, and other alternative systems are also very popular in Kerala.

However, the widely acclaimed Kerala Model of Health has started showing a number of disturbing trends recently.

Kerala Health from Success to Crisis

Although the mortality is low, the morbidity (those suffering from diseases) is high in Kerala compared to other Indian states. Though there is a data gap in this regard the NSS (1974) and KSSP (1987) studies confirmed these observations (Table 2). Hence the Kerala situation was described as 'Low Mortality High Morbidity Syndrome" (Panicker and Soman 1985). It can be argued that when the expectancy of life increases there can be a corresponding increase in morbidity in terms of the high incidence of diseases like Cancer, Heart diseases etc. that affect old age people more. However, here also the Kerala situation is peculiar in that the infectious diseases like diarrhoea, hepatitis, tuberculosis etc are still prevalent in Kerala. Moreover, many epidemics that were supposed to have been eliminated from Kerala like Malaria are definitely staging a come back. In addition, diseases like Japanese Encephalitis that was sporadic in Kerala has appeared in many parts of the state as epidemic apart from the appearance of the modern scourge like AIDS.

Another disturbing trend is that the Public Health System is getting alienated from the people and only 30% of the people even from the lower income group seek medical help from the Government hospitals (Table 3). This is because of the fall in the quality of services at the Government hospitals. Lack of political commitment, bureaucratic inefficiency, corruption at various levels, lack of proper planning etc has contributed to this sorry state of affairs.

This environment of the perceived inefficiency of the Government medical facilities is one of the factors that provided the impetus for the growth of the private medical care set up in the state. The social milieu of the state is changing and features of a consumer society are visible in all occupations. This has led to the commercialisation and the commodification of health care. Health is no more seen as a right but as a commodity to be purchased by money. The huge remittance of foreign exchange from gulf countries even to the low and middle-income group houses further reinforced this attitude. All these tendencies are leading to a virtual uncontrolled growth of the private medical care facilities in the state.

A comparison of the infrastructure and health manpower development in the private and public sectors confirms the supremacy of the private sector in the state. The number of beds in the government institutions grew from around 36000 to 38000 in the 10-year period from 1986 to 1996, whereas in the same period, beds in private institutions grew from 49000 to 675000. This amounts to nearly 40% growth in the private sector beds in a period of 10 years as against nearly 5.5% in the Government sector. In the case of doctors about 5000 doctors work in the government sector whereas double the number work in the private sector (Table 4). More significantly, private sector has far outpaced the government facilities in the provision of sophisticated modalities of diagnosis and therapy, such as CT Scans, MRI Scans, Endoscopy Units etc. Simultaneously, public sector itself is being subjected to internal privatization. Because of the irregular supply of medicines and other materials patients seeking medical care from the government hospitals are forced to buy them from outside. Also the laboratory facilities are quite inadequate in the government hospitals and patients have to depend upon the private labs for getting investigations done in time.

The privatisation of medical care is leading to over medicalisation and escalation of the health care cost. The net result is the marginalisation of the poor and it is roughly estimated that at least 30% of the people in the state are denied health care or find it extremely difficult to meet the growing health expenditure.

The changing health scenario in Kerala has provoked analysts like the present author to comment that the Kerala Model of Health Care is slowly drifting towards an *American Model of Health Care.* The hallmarks of Kerala Model were low cost of health care and its universal accessibility and availability even to the poorer sections of society. This may be changing to the American Model where in spite of the technological supremacy 40 million people are denied health care because of privatisation and the escalation of the health care cost.

In short the important aspects of the present health scenario in Kerala are:

1. The simultaneous presence of the diseases of poverty and the diseases of affluence or life style diseases.
2. The decay of the public health system.
3. The uncontrolled growth of the private sector.
4. Escalation of health care cost.
5. Marginalisation of poor.

Towards a People's Health Policy

Toning up of the health care system in the state and making it capable of taking on the burden of provision of equitable, efficient and good quality health care needs concerted actions from the political parties, social movements and the professional organisations. Taking into consideration the specific problems of the Kerala health scenario a **People's Health Policy for Kerala** should be formulated. Reinstating the primacy of the government health services, with its emphasis on primary health care should form the basis of the health policy for Kerala. There should be some amount of social control and auditing of the private sector.

Decentralisation and Community Involvement in Health

These objectives can be realised only through an administrative and financial decentralisation of the health services department, while ensuring community involvement in formulating and implementing health care programs and reforms. The Panchath Raj now provides the possibility for the people to demand the resources to operate a health service in which the people themselves will play the dominant role and of which they will be the chief beneficiaries. All infrastructure, health manpower development, training, distribution, and production of drugs and equipment must conform to achieve this, and not in reverse as is at present. Only thus can a cost effective, human and accountable health service be provided that is funded and operated by the local bodies with the technical assistance of the health professionals. This system involves the entire community and especially the women in identifying their health problems. The people can be mobilised to improve not only the curative care but even more so in health education as well as in the prevention and control of the diseases that originate in their environment. The people have the greatest interest in improving the conditions that affect them and their children. This would also be an impetus to the overall improvement of the community of which they are a part.

The **World Health Organisation** was advocating Community Involvement in Health(CIH) as a pre-requisite for solving the health problems of the developing countries *(Community Involvement in Health Development: Challenging Health Services-Report of a WHO Study Group WHO Geneva – 1991).* WHO study group reports says that **"A critical step will be the decentralisation of health services and the corresponding strengthening of the local health services that will serve as the basis for CIH" and further "Structural changes in health systems will be necessary to support the CIH process. These changes include: decentralisation of planning, management, and budgeting ."**

The administration of the Primary Health Centres, Community Health Centres and the Taluk and District Hosptials are already handed over to the local bodies. Moreover, thanks to the on going Peoples' Campaign for Decentralised Planning, there is a tremendous scope for solving the health crisis through which Kerala is passing. And CIH as advocated by WHO has become an achievable objective in our state.

Panchayath Raj and the Health Sector

The possibilities that are opened up with the financial and administrative decentralisation of the health sector and the People's Campaign for Decentralised Planning are the following:

1. The control of infectious diseases and even the prevention, early detection, and management of the life style diseases can be achieved only by strengthening the primary and secondary level health care facilities. With the local bodies in control, this can be achieved with better community involvement.
2. Once the primary and secondary health care facilities are improved through the local bodies , the tertiary care centers like the medical colleges can entirely concentrate on medical education, research, and tertiary health care.
3. The problem of resource constraint in health sector can be solved with a more need-based reallocation of resources and generating local resources through community participation.
4. A better relationship between the health workers, people's representatives, and the people at large can be accomplished.
5. Once the public health system is reinforced the poor people who cannot afford the private health services will be benefited social equity in health care will be re- established.
6. There are provisions in the Panchayath Raj Act which can be invoked for the social control of the private sector.

An analysis of the experiences of the campaign so far shows that the we are definitely moving in the correct direction in solving the rural health problems of the state.

Decentralised Planning: Achievements

The concrete achievements realised so far can be summarised as follows:

1. As evidenced by the participation in the Gramasabhas, Development Seminars, Task Forces, Voluntary Technical Corps, and voluntary contributions both in terms of money and labor power, community participation in local development has become a reality in Kerala. More than anything else the sense of optimism

generated among the people by the campaign is the greatest achievement of the decentralisation process.

2. It was feared by many that, the health related projects would be confined to building more and more curative centres. It is true that there is a contradiction in health between the felt and real needs of the people. While only through a preventive and promotive approach the basic health problems can be solved, there is a growing demand for more sophisticated curative health facilities from the community. However, the preliminary examination of the health projects show that majority of them are for sanitation, health education and for improving the primary health care infrastructure in the villages. Of course, there are instances of unrealistic and inappropriate demands for hospitals. However, the thrust is on prevention and improvement of the existing health care facilities.

3. With the reallocation of plan funds within the health sector, the problem of financial constraints of the health sector appears to be solved. Of the 6000, Crores of rupees allotted to the local bodies for the Ninth Five Year 30% can be spent on social services sectors like health, education, water supply, sanitation etc. Of this at least 500 crores are available for heath sector. In the first year, the projects were mainly on water supply and sanitation. Nevertheless, the estimates from the first year projects shows that the local bodies are likely to spend at least 340 crores exclusively on health and health related projects. It may be interesting to note that the departmental allocation for Ninth Plan amounts to 310 crores. Thus, the primary and secondary health care institutions have been given adequate funding for improvement of the services rendered by these institutions. Once these facilities are better organised, the department can spend the fund allotted to them exclusively for improving the tertiary care facilities. Over all compared to the Eighth Plan, health funding has increased from 2.37 to 4.03 percentage of the total plan allocation.

4. A better working partnership is developing between the doctors, the health workers, the Panchayath functionaries, and the people in the rural areas. The health workers now feel that with out bureaucratic red-tapism and the involvement of the higher authorities improvements can be made at the Panchayath level itself. For the first time in the history of the medical profession, the doctors working at the rural areas have a role in the planning of the health care set up where they are working. This has given them a sense of participation and professional satisfaction.

5. The autonomy with in the decentralised set up has offered the local bodies to formulate and implement a number of imaginative community based health programmes. From organising blood donation camps to issuing health cards to the people of the Panchayats and conducting health surveys to study the health problems of the local community a number of innovative programmes are being accomplished by the local bodies.

It was pointed out that the widely acclaimed Kerala Model of Health that can be described as 'good health at low cost' and based on social justice is passing through a period of crisis and if unchecked this may lead to an American Model of Health based on privatisation and the marginalisation of the disadvantaged. The Panchayath Raj system rooted in community involvement is poised to change the health scenario in our state and is likely to conceive a new **Decentralised and Participatory Model of Health Care** in our state. In case this becomes a reality then Kerala will bestow another unique model of health care worth emulating not only by the other Indian states but also by other developing parts of the world.

TABLE ONE
KERALAM HEALTH STATUS
1996

Indicators	Keralam	India	USA
Crude Death Rate	6.3	10	7
Infant Mortality Rate	11	79	8
Crude Birth Rate	17.7	29	17
		Life Expectancy	
Male	66.8	57.7	73
Female	72.3	58.1	79

(Sources: 1. Health Services Data Government of Kerala 1996; 2. World Health Report WHO Geneva 1996)

TABLE TWO
KERALAM MORBIDITY

	Keralam NSS 1974	India	Keralam KSSP 1987
Acute Diseases	71	22	206
Chronic Diseases	83	21	136

TABLE THREE
UTILISATION OF HEALTH SECTORS
1987

Group	Public	Private
	%	
One	33	43
Two	25	50
Three	16	60
Four	8	66

(Group One - Poorest, Group Four – Richest)
(Source Table 2 to 3 Health and Development in Rural Kerala KP Kannan etal KSSP1991)

TABLE FOUR
GOVERNMENT AND PRIVATE SECTOR
1995

	Private	Government
No of Institutions	4288	1249
No of Beds	67517	42432
No of Doctors	10388	4907

(Source: Report on the Survey of Private Medical Institutions in Kerala 1995 Department of Economics and Statistics Government of Kerala 1996)

TABLE FIVE
PLAN ALLOCATION - HEALTH SECTOR
(in Indian Rupees-Crores-10 Million Rupees)

EIGHTH FIVE YEAR PLAN TOTAL ALLOCATION	HEALTH SECTOR	PERCENTAGE	NINTH FIVE YEAR PLAN ALLOCATION	HEALTH SECTOR	PERCENTAC
5460	120	2.2	10100	309.4	3.06

TABLE SIX
PLAN ALLOCATION- HEALTH SECTOR
(LOCAL BODIES)

LOCAL BODIES ALLOCATION	HEALTH SECTOR (EXPECTED)	HEALTH SECTOR TOTAL	TOTAL NINTH PLAN ALLOCATION	HEALTH SEC PERCENTA
6000 Crores	500 Crores	500+309.4 = 809.6 Crores	16100 Crores	5.02

(Source: Planning Board Documents: 1999)

C-3A·13

(13)

The Right to Health Care is a Basic Human Right!

Towards attaining the Right to health care...

The Government of India has been unable to fulfill it's commitment of ' Health for All by 2000 A.D.' till now. In fact, primary health care services are becoming more and more difficult to obtain for people living especially in urban slums, villages or remote tribal regions. The condition of government hospitals is worsening day by day. Nowadays, in most of the Government hospitals there is inadequate staff, the supply of medicines is insufficient and the infrastructure is also inadequate. There are very inadequate facilities for safe deliveries or abortions in Govt. hospitals. Given the fact that women do not even get adequate treatment for minor illnesses such as anaemia, services for problems such as the health effects of domestic violence remain almost completely unavailable. At the village level, there is no resident health care provider to treat illnesses or implement preventive measures. All hospitals are located in big cities, and here too public hospitals are increasingly starved of funds and facilities. Thus there is lack of availability of government health care services on one hand and the exorbitant cost of private health services on the other. This often leaves common people in rural areas with no other option but to resort to treatment from quack doctors who often practice irrationally. Thus most of the population is being deprived of the basic right to health care, which is essential for healthy living.

The Indian Constitution has granted the 'Right to Life' as a basic human right to every citizen of India under article 21. In article 47 of the Directive Principles of the Indian Constitution, the Government's responsibility concerning public health has also been laid down. Yet the Government is backtracking from fulfilling this responsibility. This is obvious from the fact that the Governments proportion of expenditure on public health services has been declining in successive years.

What can be done in the near future to establish the Right to Health Care?

The year 2003 is the silver jubilee year of the ' Health for all' declaration. On this occasion, Jan Swasthya Abhiyan is launching a nationwide campaign to establish the Right to health care as a basic human right. Some of the following activities are being taken up as part of this campaign–

- We can document case studies of 'denial of health care' in our areas. This process has already started in Maharashtra. Information is being collected in a specific format with the help of a questionnaire. The cases where denial of health services has led to the loss of life, physical damage or severe financial loss of the patient are being emphasised. These case studies would be presented to the National Human Rights Commission. These case studies would help us to depict the real status of provision of the primary health services by the government, would strengthen our demand for improving public health services and would help us in dialoguing with the public health system.

- On the occasion of completing **25 years of the Alma Ata Declaration**, a ***National Workshop is being organised by JSA on 5th September 2003 in Mumbai***, for JSA activists from all over the country. During this workshop, the perspective, issues and campaign strategy regarding Right to Health care would be discussed in detail, and the cases that have been documented would be shared. This would be followed by a ***National Public Consultation on "Right to Health Care" on 6th September in Mumbai.*** The Chairman of NHRC, the Chairperson and Secretary of the Health committee of NHRC and the Health Secretary, Central Ministry of Health and Family Welfare are being invited to this programme which will be in the nature of a public hearing. Various public health experts and legal experts will also speak during this program about the Right to Health Care. Selected case studies of denial of right to health care will be presented to the NHRC, and an attempt would be made to build a social consensus on this issue, so that this can be established as a legal right.
- A report on " Status of Health Care in India" is under preparation, which would give an idea about the availability of health care services, differentials in accessibility to these services, state of health care financing and issues related to health care services for specific sections of the population. Well-known public health experts are authoring various chapters of this report. This report could be released in various State capitals, along with case studies and other information related to the state. This could be done during the 'People's Health Assembly anniversary' from 1st to 8th December 2003 (anniversary of the Kolkata and Dhaka Health Assemblies) and would also be an occasion to highlight the situation of health services in each state and the need to establish the Right to Health Care.
- Filing of a Public Interest Litigation (PIL) to establish the constitutional right to health care is also under consideration.

These are some of the steps being planned to move towards establishing the Right to health care. Let us join this campaign and strengthen the movement to achieve health care and health for all!

Jan Swasthya Abhiyan

Let's all join the fight,
For health as a basic right!

For further details contact: Dr. Ekbal (National Convenor) – ekbal@vsnl.com
Amit Sengupta (Jt. Convenor) – ctddsf@vsnl.com
T. Sundararaman (Jt. Convenor) – sundar2@123india.com
Thelma Narayan (Jt. Convenor) – sochara@vsnl.com
Amitava Guha (Jt. Convenor) – fmrai@vsnl.net
Abhay Shukla (Jt. Convenor and National Secretariat) – cehatpun@vsnl.com
Vandana Prasad (Member, National Secretariat) – chaukhat@yahoo.com
N.B. Sarojini (Member, National Secretariat) – samsaro@nda.vsnl.net.in

Protocol to document cases of
Denial of Right to Health Care

The purpose of these case studies is to demonstrate how specific persons have been denied basic health care that is expected from Public health services. The idea is to capture events where obvious and major violations have taken place, leading to loss of life, disability, serious health or economic consequences. We should focus on availability of those services, regarding which the public health system cannot deny its responsibility. The idea is to document ***structural deficiencies*** and not cases of negligence by individual doctors or staff. However, lack of availability of required medical staff when required, because of significant understaffing should be documented. *The objective is not to target individual public health care providers, but rather to document the serious structural deficiencies that exist, which need to be corrected by major strengthening of the public health system.*

Some of the major types of cases of this kind are outlined below, however any other similar cases, which come to the attention of activists, can be documented.

Some types of cases of denial of Right to Health Care

(This is not an exhaustive list but rather outlines certain broad categories with examples)

A. **General Emergencies:** Cases where a patient with a serious medical problem has been taken to a Govt. health centre or hospital (PHC / Rural / Cottage / Sub-divisional / District Hospital) and has been denied the life-saving or stabilising services expected at that facility. The patient may have unnecessarily been referred to a higher facility, leading to delay in treatment and serious adverse consequences, including death. Examples may include non-availability of:

- ***In a PHC*** - Non-availability of treatment for snakebite or Anti-rabies vaccine; Non-availability of treatment for a child with pneumonia or severe dehydration due to diarrhea resulting in death
- ***In a Rural hospital***: Above or Lack of blood transfusion for a bleeding patient due to accident or bleeding related to pregnancy; Non-availability of emergency drugs leading to serious delay in treatment and death or disability of the patient
- In a ***Cottage / Sub-divisional / District Hospital:*** Above or Non – availability of emergency surgery leading to death or disability of the patient; non-availability of essential or emergency drugs

B. **Women's health care:** Women should receive certain basic health care related to both reproductive and non-reproductive health problems. Denial may include for example:

- ***Maternal Health Care***: Lack of facility or performance of a normal delivery in a PHC or higher facility; lack of facilities for necessary cesarean operation in Rural hospital or higher facility; unavailability of blood transfusion service to a woman before, during or after delivery; lack of abortion facility leading to septic abortion or other adverse consequences
- ***Care for burns:*** A woman reporting with burns in a Rural hospital or higher facility and not receiving care for burns

C. **Major chronic illnesses:** Any facility, PHC or above not regularly giving full range of medication to patients with T.B. leading to deterioration of the patients condition including death; Sub-divisional hospital or higher facility not treating/admitting a case of AIDS

D. **Outbreak** of immunisable or other major preventable illness such as measles, cholera, epidemic hepatitis or malaria – due to failure of basic preventive or public health measures.

E. **Mental Illnesses** - Patients who have been denied health care for mental illness in a CHC or higher facility

Some guidelines for activists documenting the case studies.

- At least two case studies should be collected from each district / by each organisation. The attempt should be to document cases where denial of health care has resulted in **significant loss to the patient**, either in physical or financial terms, to strengthen the case for a human rights violation. Document only those case studies where incidence of denial has taken place in the last 6 months. Collect at least half of the case studies concerning women who have been denied health care. Any case papers / prescriptions or other relevant documents should be collected as supportive documents.
- Take oral consent of the person from whom the information will be elicited. Give that person information about the campaign. Tell him / her that the case study may be presented to NHRC, and in such case would have relevant implications. Fill the questionnaire only after taking oral consent from the person.

Primary Health Center/ Govt. Hospital Services – Survey Questionnaire

Name of patient-

Age-

Sex-

Address-

Date of interview –
Name of Respondent (if different from patient)

Details of care received at PHC / Hospital

- Location of the PHC / Location and type of Hospital –

- Illness / complaints for which PHC / Hospital was visited –

- Total Number of visits to PHC / Hospital for this illness –

- Date of last visit –

1. History of last visit in the patients / attendants words –

(Here we want to collect information regarding the main symptoms of the patient, who gave care and what kinds of examination, investigation and treatment were given)

- What were the perceived shortcomings or deficiencies in care? (As perceived by the patient or attendants)

- According to ~~patient~~ respondent, was there any ***adverse outcome*** because of deficient care? (Death, disability, continued or chronic health problem, severe financial loss e.g. major loan or sale of assets)

2. Medical attention received:

- Name of the doctor who attended ~~to you~~ –

If the doctor was not available at that time, then who attended ~~to you~~ -

1. Nurse / ANM
2. MPW
3. Pharmacist
4. Any other person, specify

- How long after you reached the PHC / Hospital did the Medical Officer / Doctor attend ~~to you~~?

- Was examination / treatment / operation delayed or denied because of non-availability of a nurse, doctor or specialist?

- In case of an emergency did the doctor immediately attend to the patient? During hospital stay, regarding conditions that required immediate care, was the doctor available to immediately attend to the patient?

- Were nurses or hospital staff available to attend to the patient as and when required?

- Do you think that non-availability of any crucial equipment or supply (oxygen, incubator, anaesthetic equipment, blood, emergency drugs etc.) adversely affected the quality of care?

- Were all the equipments required for the examination and treatment of the patient available in working condition in the hospital?

Diagnosis- (as told by the doctor)

3. Medicines:

- Did you get all the required medicines at the PHC / Hospital?

- Did you have to go to any private medical shop to buy some medicines?

- If so, which medicines you had to buy from private medical shop?

- How much did it cost?

- Do you have the prescription?

4. Expenditure:

- Case paper / card made - yes/no

- Case paper fee / indoor fees charged

- Fees / charges for other services :

- Did you receive a receipt for the payment made?

- Were you charged excess money at the PHC / Hospital (more than specified rates)?

- If yes, how much excess was charged?

- Did your family have to sell assets (land, cattle, jewelry etc.) or take loans to pay for treatment in the Govt. hospital?

5. Referral:

- Was the patient refused admission or referred to another hospital without giving first aid care?

- If the patient was referred, was ambulance or other vehicle made available for the same?

- Did the Govt. doctor ask you to avail of any private services (e.g. laboratory services, Sonography / X ray) while you were admitted in the Govt. hospital?

- In case you had to take the patient to a private hospital, which hospital? (name and address of the hospital)

- What was the total expenditure on care at the private hospital / private lab or imaging centre?

- Did your family have to sell any assets (land, cattle, jewelry etc.) or take loans to pay for the private hospital charges?

C-3A.14 (14)

RAHA

MIS

MEDICAL INSURANCE SCHEME

RAHA's SELF FINANCING MEDICAL INSURANCE SCHEME (MIS)

- The Journey of Raighar Ambikapur Health Association began with the organizing committee meeting on June 8, 1969 in Holy Cross Hospital, Kunkuri, Raigarh dist, Chattishgarh State. The meeting was called to discuss a proposal for a Health Association. With the agreement of the participants RAHA was born.

VISION

RAHA envisions a wholesome, sustainable, caring and transformed community of people.

MISSION

1. **To build up local leadership through value – based training.**
2. **To work in partnership with people through an integrated and holistic approach.**
3. **To facilitate preventive, promotive, curative and rehabilitative health care services.**
4. **To promote Alternative System of Medicine.**
5. **To collaborate with like-minded individuals, organisations and government.**

HEALTH CARE SERVICES THROUGH RURAL HEALTH CENTRES

- The Rural Health Centres are established to provide health care services in the most needy areas. The services are provided with the understanding of wholistic health care. The emphasis is on treating the person as a whole and not only the disease.

- RHCs are managed by various church related NGOs. There are certain agreements between RAHA and RHC.

OBJECTIVES

"People's Health in people's Hand"

- To make medical facilities available in the community itself.
- To subsidise the medical care of the members at primary, secondary and tertiary level.
- To encourage people's participation in health care services
- To encourage people to be a caring community and contribute towards the medical care of their fellow beings through membership fee.
- To reduce exploitation from money lenders.

STRATEGY

A movement of people "I AM MY SISTERS/BROTHERS KEEPER"(Genus :4 .9) taking responsibility for each other.

WHO CAN BECOME A MEMBER

Any person (male or female) irrespective of age, caste, colour or creed.

THE MEMBERSHIP FEE

Any person desirous of becoming a member of the scheme shall pay annually a membership fee in kind or in cash equivalent to 2 kg of rice.

DURATION OF MEMBERSHIP

One year.

PRIVILEGES OF MIS MEMBERS ENJOYS

a. **At the Village level:** The VHW gives health education and free treatment on the specified minor sicknesses. For minor ailments they are advised to take home remedies.

b. **At the Rural Health Centre level**: A member enjoys the following privileges:

As Out-Patient –

- Free consultation
- Free medicine (pills) upto Rs.100/- per year

As In-Patient –

- Free consultation
- Fifty percent rebate is given on the total bill
- A pregnant mother, who is an MIS member if admitted for delivery at the Rural Health Centre will be expected to pay only Rs.50/- towards the entire cost of delivery charges.

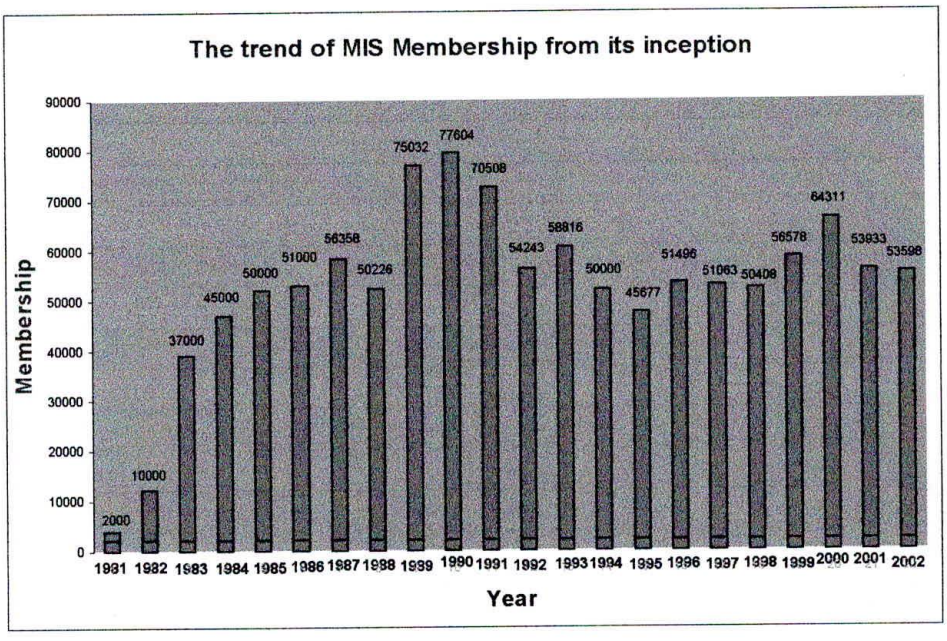
c. **At the Hospital Level**

  - A contribution to the extent of Rs.1,250/- is given on the total treatment per year.
  - Patients contribution towards hospital services is fixed as per the distance.

MEDICAL INSURANCE SCHEME (MIS)

Achievements:

- No. of districts RAHA provides health care services: 4
- No. of Rural Heath Centres coordinated by RAHA : 85
- Medical insurance members benefited : 77,604
- No. of health workers trained and activated : 2200
- No. of TBS trained and activated : 2500
- No. of Traditional Practitioners trained and activated : 850



MEDICAL INSURANCE MANAGEMENT COMMITTEE

The Medical Insurance Scheme is a people's movement. From its inception efforts were made to decentralize the scheme allowing greater participation for the people. The emphasis is on the role of VHW/Dai at the village level and the Rural Health Centre as a secondary level of treatment and support. Now it is considered essential to formally establish Local Committee to administer the scheme at the local level through Medical Insurance Management Committee.

PURPOSE OF THE COMMITTEE

The committee is constituted with a purpose of administering the Medical Insurance Scheme at the beneficiaries level. The committee is an expression of RAHA's purpose of empowering the people to manage their own affairs.

Women's access to health care as a fundamental right

By Sama Team, New Delhi

"Health for all" by the year 2000, a proclamation that has enough potential quite unfortunately has taken a backseat with disastrous result in terms of women's lives. At the outset, it is important to state our position. This will help us better to communicate what we exactly mean by *'women's access to health care as a fundamental right'*. When we talk of women's access to health care, we make it clear that it is not only the physical access to health services that we have in mind. This is not to argue that physical access is unimportant; but to point out that there is more to it. This broader concept of health *('the all encompassing wellbeing'*) and the access to it is what we mean, when we speak of health as a *'fundamental right'*.

Before, we probe into the matter further we will first locate the hurdles that come in the way of women's access to public health services. This can be listed as infra-structural, attitudinal, social, and economic.

All these obstacles are being looked both from the macro and micro-level perspectives. Through these dual perspectives we see both the state and the family in perpetuating the women's subordination; and the latter falling prey to the norms of patriarchal, sexist society. To begin with there is sheer lack of adequacy of Primary Health Centers (PHC) and those existing lack the minimum necessary drugs. Though theoretically they are supposed to cover 20,000 population, our practical experience reveals something quite different. A woman had to travel a minimum of10km distance; For Tuberculosis (TB) drugs, which is such an important and common disease people in the tribal belts have to travel 100-150 km. This becomes all the more problematic for the women who cannot travel alone due to the existing social taboos. Moreover, having deprived of any kind of economic resources, travelling such a long distance just for the sake of one's own medicine becomes problematic and often loose importance. The paradox lies in the fact that twice the amount of money in the budget is allocated to family planning, than in the overall health sector. Even within the health budget, most of the money goes for contraception whereas women's primary health needs are not taken care of. This is because women are not thought to have an existence outside their reproductive functions.

Hence, we not only talk of inadequacy of health facilities but an insensitiveness to understand women issues in general and health issues in particular. This is so because the government planners, medical personnel, who are made to *'treat'* these 'women' do not share the same universe with them and hence often find their complaints as *'vague'* and *'fancy story-telling.'* Moreover, to talk of women as a 'group' often becomes problematic due to the differential treatment that the so-called *deviants* (single woman, lesbian, deserted) received. Here, it would not be out of place to even talk of the differential treatment that mental-health patients and victims of violence undergo. To this one can always add upon the existing inequalities rising from caste, class and the low status of women in general. The women are hence not in a position to decide both at the macro and the micro-level and there is no space open to them where they can feel the urge to ask for themselves. Moreover, patriarchy and the inbuilt gender stereotypes have ingrained in women to shape up subordinate outlook towards their own health needs.

However, having laid these obstacles we have cleared our vision about what is the reality at stake. We do not think that our work ends here. As there is no point in analyzing the world, unless we do not take initiative in changing it.

We would like to take into consideration the campaign strategy to address such a wide range of issues. This would mean the need for a multi-pronged campaign at various levels, right from the grassroots to the highest levels of policy and planning, including the international arena. On the one hand the government cannot shove off its duty; on the other hand it must take the views, wants and needs of all those for whom primary health care is to be provided. Otherwise, this would also lead to another ineffective planning and execution of it would call for another disastrous result.

Why we are highlighting this is because health is a basic right of the people. And it is the government that can and should provide it. Therefore, the task that we set ourselves is not to provide *symptomatic treatments* to the problem. But it is to try out the difficult path. That is, to move the government health structure to fulfill the needs of the people. We further demand that all plans made for the people takes into account socio-economic condition like class, caste, religion and sexual preferences.

Thus taking a Primary Health Care approach, we demand a broader understanding of health as the interaction of socio-economic and political factors. This would help us to address women's need more holistically; and provide preventive, primitive and curative care from a gender sensitive point of view. For this to take place, there is an urgent need for the health movement to make alliances with other movements because health cannot be segregated from larger issues.

It is important to understand that health is not just about illness and treatment. So when there is abject poverty, even the best medical infrastructure will not be able ensure that people would be able to access it, or they would be healthy. In a situation of constant stress due to overwork and low wages, a person cannot be healthy. In a degraded environment, it is not possible for a person to remain healthy. When a family is evicted from its habitat to make way for a development project, (and obviously it is not rehabilitated), can anyone in that family remain healthy? When a person of a disadvantaged caste or tribe is constantly subjected to humiliation and violence by the upper castes, we cannot expect him or her to be healthy. Similarly, when a woman is constantly subjected to subjugation, humiliation and violence within own family, or she is gang raped and tortured in a communal riot, we cannot expect her to be healthy. Neither can we expect the healthcare services to take care of her needs. Therefore, it is important to make linkages of all other issues that affect people's lives, with health.

Subsequently, we come to our central point of contestation i.e. it is important to establish health as a right issue. The government can have millions of excuses for its inability to provide healthcare – budget constraints, population explosion, Indo-Pak tension, debt burden and whatever else. As well as to justify its compulsions to follow the guidelines of international lending agencies, but when it has ratified various international treaties and covenants that underlie healthcare as a basic right, there is always a space to demand its fulfillment and question policies that undermine this right.

\\Pc-09\d\Personal\Amita\6th September event\Women_sacces tohealthc-1.doc

By Sama Team
Sama –Resource Group for women and health
New Delhi

Background to the Campaign on Women's Access to Health (WAHC)

Women's Global Network for Reproductive Rights

From 2003 to 2005 the WGNRR Coordination Office will coordinate the **Women's Access to Health Campaign**, in close collaboration with the People's Health Movement (PHM). The core activities will be centred around, but not restricted to May 28; International Day of Action for Women's Health. The Coordination Office will bring out campaign material to support Network members and other interested groups and will be engaged in activities, meetings and conferences that are organised around the campaign. Campaign participants will regularly receive updates. The reports/articles they send to the Coordination Office will be sent to other participants, in order to stimulate and inform each other.

The campaign will focus on the specific objectives laid down in the Alma Ata Declaration of 1978 (USSR) for the implementation of Health for All by the Year 2000 and show within that framework the missing themes vis-à-vis women's health. We will in this way not just highlight the failure of the implementation of the Alma Ata Declaration, but also show our solidarity with the concept of primary health care which is the larger theme taken up by the People's Health Movement for the next few years. At the May 1999 meeting of all health ministers at the World Health Assembly the call of "Health for All in the Year 2000", as agreed upon in 1978, was reformulated to "Health for All in the 21st century" and the targets reset to 2020. What happened to the Alma Ata vision?
The concepts outlined in the Alma Ata Declaration (1978) will form part of the three subsequent Calls for Action (2003 – 2005). Specific reproductive and sexual health and rights angles will serve to exemplify and strengthen the demands.

The 3-year campaign slogan will be "Health for All - Health for Women". The 3-year core demand is that primary health care be provided for all people and peoples everywhere, taking into account, in theory and practice, women's reproductive and sexual health needs. In 2003 the Campaign's slogan will be directed at national governments: "Governments Take Responsibility for Women's Health". The slogans for the 2004 and 2005 Calls for Action will be decided upon according to WGNRR member's input, since the Network members have indicated their wish to form part of the developments of campaigns.

Background

"Health for All" is really being pushed back by health sector reforms and privatisation with disastrous result in terms of women and children's lives. We therefore need to take up the call for the inclusion of a focus on women's health within the framework of primary health care. This is an important means to reach out to as many people as possible – both rural and urban and the underprivileged everywhere who are currently excluded from any care at all.

Since 1993 the World Bank (WB) has taken a greater role in the development and the implementation of health policies for developing countries, whereas the role of the World Health Organisation (WHO) has been diminished. Government health policies, with the support of WHO and the WB, have been redirected to focus on privatisation, cost-effectiveness and the development of public-private partnerships in the provision of health care. This development has dramatically affected people's health in poor countries and specifically women's health. We find that the under the prevailing circumstances governments have had little say in protecting the needs and interests of their people since they are or claim to be dependent on the Bank for loans and hence 'have to' agree to the conditions placed by this institution.

Over the years governments and religious fundamentalists have denied women's right to make decisions central to their lives. They have done this by implementing policies that are more in the interest of private businesses and cost-effectiveness and less in the interest of equity and quality for all. Religious fundamentalists have been able to influence policy makers with patriarchal attitudes

related to women's sexual and reproductive lives. The right to health also eludes many women who because of deeply internalised subordination and the absence of enabling conditions, fail to claim this entitlement.

Women's right to health has to be addressed by comprehensive primary health care systems and comprehensive social and economic policies all over the world. Our campaign will focus on getting women's needs highlighted at all levels of health policymaking and programmes. We join the People's Health Movement in their efforts to spread support for the primary health care approach as widely as possible and to mobilise through the PHM and our combined networks.

What do we plan to do?
According to the Alma Ata some of the fundamental characteristics of primary health care include:

- Universally accessible health care
- Community participation
- Affordable and appropriate services
- Plans integral to social and economic development
- Prevention, promotion and curative care
- Inter and multi-sectoral collaboration

The characteristics outlined above show that the Alma Ata Signatories recognized health as a political issue related to questions of socio-economic justice. The identified need for community participation and intersectoral cooperation indicates that it was understood that if we were to address not just the symptoms of ill health but its root causes, a radical change had to be made in the medicalised approach to health. The Declaration also called on governments to take up their responsibility towards ensuring that Health for All becomes a reality, a demand that needs to be highlighted in these times of increased privatisation and the shifting of responsibilities away from governments.

We have purposefully chosen to focus on the campaign on women's access to health i.e. not on health services. Although we find health services very essential, they cannot in and of themselves ensure women's health and reproductive and sexual rights. While we wish to address women's needs for basic services that include reproductive and sexual rights, we also want to address the 'enabling conditions' that are essential for women to enjoy good health. International and national policies that result in greater poverty of populations and an ever-growing gap between the rich and the poor, as is currently the case, have a direct impact on women's possibilities to stay healthy or enjoy their reproductive and sexual rights.

Under the banner of reproductive and sexual rights there are several issues that interlink with women's status – and affect their health detrimentally. For instance women are more likely to be infected with the HIV virus than men in sexual encounters; pregnant women are more exposed to the risk of domestic violence; women are less likely to demand and receive health care until they become seriously ill. Some of the issues the women's movement has been demanding attention for over the years are listed below:

- Violence against women
- Maternal mortality and morbidity
- Abortion rights and services
- Sexually transmitted diseases
- HIV-AIDS and PHC
- Communicable diseases like TB and Malaria
- Need for safe and effective, woman friendly contraceptives and policies not driven by population control

No doubt some aspects of the problems/illnesses mentioned above have received some attention within what existed as primary health care in many countries. For instance in Argentina and several other countries up until the mid-1990's pregnant women did have the possibility to have antenatal check ups during their pregnancy; a certain amount of maternal and child care was provided for by health care centres worldwide; free treatment for TB and malaria were offered and programmes were set up to distribute oral rehydration therapy in case of diarrhoea. Above all in many parts of the world free contraceptives were provided in the effort to reduce the birth rates, as part of population control programmes. In fact in the context of India and Bangladesh the complaint has been that primary health care centres often may not have antibiotics to offer clients but definitely have hormonal contraceptives that are highly questionable in terms of their effects on women's health.

Broadening the Campaign Beyond WGNRR's Network

We will work with our members to develop the campaign and the related annual Calls for Action. We propose to broaden the campaign to include other social movements that may not have women's health and reproductive and sexual rights as a central focus. We believe that including a wider range of groups will build solidarity and strengthen our demands of reversing inter(national) health and other policies that have a negative impact on women's reproductive and sexual health and rights and women's access to health and to health care. In particular we are linking with the People's Health Movement (PHM, for more information please visit their website at www.phmovement.org) and coordinating a PHM working circle on the issue of women's access to health.

The Peoples Health Movement (PHM, formerly the Peoples Health Assembly, PHA) has come out of an international initiative that started in 1998. In that year, a group of health activists, doctors, health and drug action NGOs, public health professionals and academicians came together because of their deep concern at the deteriorating health situation for the majority of people, especially in poor countries. The idea was to elaborate an analysis of health policies internationally and its effects on people on a national and local, and use such analysis as a starting point for campaigns at all levels, to demand better health care provisions for the disadvantaged world wide.

Since June 1999 the coordination office of the WGNRR is involved in the coordination, first of the Peoples Health Assembly in December 2000 in Bangladesh, and more recently in international networking under the umbrella of the PHM. Many activities are being undertaken by grassroots organizations all over the world.

What we would like to see happen:

We join the People's Health Movement the next three years in demanding primary health care for all people everywhere. Within that demand we would like to highlight for the year 2003 that **governments take responsibility for women's health!**

C-3A.17 (17)

RIGHT TO MENTAL HEALTH CARE AND REHABILITATION
A BRIEF NOTE

Center for Advocacy in Mental Health, 36B, Ground Floor, Jaladhara Housing Society, 583, Narayan Peth, Pune 411 020, Maharashtra.
Tel: 020-4451084 Email: wamhc@vsnl.net

Population in need of mental health care

Epidemiological surveys in India have shown that 1 or 2 persons in a 1000 may be suffering from a severe mental disorder (SMD) and between 10% – 25% may be suffering from various kinds of common mental disorders (CMDs), largely depression. CMDs may also reach a high level of chronicity and disability, requiring secondary or tertiary level rehabilitative care and treatment. Social and economic vulnerability increases mental vulnerability. Research in India and elsewhere has consistently shown that mental illness is caused by social determinants, including poverty, economic hardships, poor educational, social and cultural status, community upheavals (diasters, communal violence, migration, war), nutritional, health and reproductive health status, domestic violence and other types of gendered violence. The population in need of mental health care at all levels of public health is therefore large.

NEED TO INTEGRATE MENTAL HEALTH CARE IN RIGHT TO HEALTH CARE

Persons diagnosed with a mental illness (PMI) continue to be treated with fear and suspicion, and may be living a life of total dependency, humiliation and loss of human dignity. Mental illness is a health care issue, and mental health care should find a meaningful place in all efforts to build a rights perspective in general health care.

Right to mental health care

The right to basic mental health care and rehabilitation in India can be discussed under 2 heads:

- Institutional care
- Primary health care

Institutional care

Government mental hospitals (40 in number), private mental hospitals and shelters, and Government Hospital Psychiatric Units (GHPUs) provide institution based, tertiary care for persons with mental illness [PMI]. Mental Health law, viz., the Mental Health Act [MHA, 1987], governs institutionalization for PMI. The MHA covers the following areas:

1. Legal procedures for institutional admission and discharge of PMI
2. The Mental Health Authorities (Central and State)
3. Basic minimum requirements for institutional psychiatric care
4. Registration, licensing, and Inspection of institutions and
5. Human rights chapter

In the MHA, we have an already existing public health legislation, which can be strengthened. Institutional care for PMI is also regulated by various PILs, notably

1. *Sheila Barse versus Government of India*, 1989, on the wrongful confinement of non-criminal mentally ill within the jails of West Bengal

2. *Suo moto* action by the Supreme Court, 1999, against Government of India, in the case of the deaths of inmates in the Erwadi Mental health shelter, Tamil Nadu

High Court petitions (e.g. *Sukhri versus Government of Maharashtra*) have also brought policy attention to the plight of PMI within institutional care.

The Human Rights chapter of MHA, with 3 sections, is very inadequate. It has only a general clause prohibiting cruel and inhuman treatment of PMI. It makes no reference to the basic right to mental health care and community rehabilitation of PMI. Because of this large omission in law, MHA has remained an instrument for forced or the 'involuntary commitment' and custodialisation of PMI. The law needs to be reformed so that it promotes accessible, affordable and good quality community mental health care and rehabilitation for PMI.

Most mental hospitals spend between 80 to 90% of the scarce resources on staff salaries. Most of the remaining resources are spent on medicines. Old, dangerous and obsolete drugs are still being used. Shock treatment without anesthesia is still practiced in most Indian hospitals and in private institutions. Psychotherapies are not available. Mental hospital conditions in most public and private hospitals are dismal. Advocates for the right to basic mental health care within the institutional context have demanded at least the following:

1. Adequate housing, half way facilities and rehabilitative care within institutions
2. Basic physical infrastructure, adequate and human living conditions (clothing, toiletries and grooming, bedding, etc.), a clean, hygienic environment, adequate and clean water and sanitation facilities, nourishing and adequate food
3. Adequate and functional medical facilities, emergency medical facilities (especially in the context of shock treatment), basic health care, including gynecological care within the institution, and a fully functioning referral system
4. Clear policy guidelines with respect to psychiatric care and treatment, including providing standard clinical assessments, risk assessments, rational drug treatment and an active regulation of the use shock treatment
5. Non-medical, therapeutic and rehabilitative education and care including psychotherapy, counseling, family therapy, creative healing mediums, life skills training, etc.
6. Clear institutional rationality and proper rule implementation for inter-institutional transfers of PMI (mental hospitals, prisons and jails, police custody, beggar's homes and shelters, remand homes, etc.)
7. RIGHT TO COMMUNITY REHABILITATION of PMI including disability reduction, protection against stigma, skills development for work and employment, creation of employment opportunities, wages, pensions and social security, schemes under right to food and disability benefits.
8. Regard for patient ethics and creation of patient centered services in mental health
9. Regulation of the private sector

PMI is a special population, unlike other populations needing health care. Among them, further marginalized are, destitute mentally ill, criminal mentally ill, mentally ill women and children within custodial institutions (including shelters).

The women's wards within institutions (jails and mental hospitals) are far more inhuman than the male wards. Women live in degrading health and reproductive health conditions, being prone to various types of gynecological morbidities. Little

effort is being made to address the mental health care and rehabilitative needs of most women.

Traumatised and abused destitute children, children with mental disabilities as well as persons with epilepsy are still being custodialised in the mental hospitals.

Primary health care

The National Mental Health Program (NMHP, 1982) is the guiding policy document in mental health, which covers aspects of community mental health care. The policy promises the following salient features:

1. Mental health care at all levels of the existing infrastructure (PHCs, rural and district hospitals, general hospital psychiatric units and the mental hospital).
2. Staff training at all levels of medical and community health care
3. Accessible, affordable and available mental health service facilities at all levels
4. Mental health care for all
5. Community based care
6. Conversion of centralized institution based care into community care by including OPDs, teaching and training programs, extension services in rural areas, etc.
7. Multi-disciplinary staff including psychiatrist, clinical psychologist, social workers, counselors, vocational therapists and other rehabilitation professionals.

This promise of the NMHP has remained merely a vision. Only Karnataka had some show case models in community mental health care until recently, showing the feasibility of community care. Funding for implementation of the NMHP is not provided. Following serious human rights violations in recent times, the program is now being implemented in a few states in the last 2 years, including Maharashtra, as model programs. Most hospitals in India have not taken the initiative of converting their institutions into community based institutions. The few posts making up the multi-disciplinary teams, especially that of the clinical psychologist, are largely not being filled. Posts required for rehabilitation work have not been created. Rehabilitation services have not been started at the community level, though good models are available. Staff training at various levels has not happened. The mental health care service delivery has therefore remained centralized, being confined to custodial care within mental hospitals.

It is necessary to advocate strongly for strengthening and implementation of the NMHP in every state. Maximum human rights violations of mental health care rights happen within custodial institutions, needing urgent intervention through law reform, PILs and community mobilisation. The needs of the special groups, including women and children, must be addressed.

Establishing 'Right to Health Care'

Is it a realistic approach?

More than 50 years after the Independence of our country, we have significant gains in the health sector. Some of the noteworthy gains include the increase in the life expectancy from a mear 36 years in 1951 to 64 years in the year 2000. Infant mortality rate which was as high as 146 [1951] has brought down to about 70 in 2000. In spite of all these gains, today, India is known to have poor health indicators in the global context, even in comparison with many other developing countries. Our health system is **one of the worst in the world** as far as health status of the poor compared to the rich are concerned. There is also vast inequality among the advantaged and marginalised communities and among various geographical groups. In other words a major portion of the **avoidable disease conditions and deaths are borne by the poor and other marginalised**. Following statistics of health status and availability of health care speaks for themselves:

- Infant Mortality Rate [IMR] among the economically lowest 20% of the population is 109, which is 2.5 times the IMR among the top 20% of the population.
- Child mortality [1-5 years] among children from 'Low standard of living Index' group is 3.9 times more than of those from the high living standard group. This shows that majority of 20 lakh children die under the age of five in India every year, are from the poorer sections of the society. It is being pointed out that at least 16 lakhs of these deaths can be avoided every year. This amounts to 4380 **avoidable deaths** every day
- Tribals, account for only 8% of the population, bear the burden of 60% of the malarial deaths in the country
- The richest 20% of the population, despite their overall better health status, 6 times more likely to access hospitalisation than poorest 20%
- Delivery of the richer mother is over 6 times more likely to be attended by a medically trained person than the delivery of the poor mother.

What are the reasons for this inequality?

Government of India has been unable to fulfill its commitment of 'Health for All by 2000 AD' till now. The very concept of **'Primary Health Care'** [PHC] which is presented as the key to attain an acceptable level of health for all is being totally ignored over the years. A careful analysis of our health system clearly reveals **two aspects** why such high levels of inequality in health exist in India.

1. The unsatisfactory indices are an indication of **the failure of public health system** in meeting the basic preventive and curative services of the general population. Primary health care services are becoming more and more difficult to obtain for people especially in urban slums, villages or tribal regions. The conditions of government hospitals are worsening day by day. At the village level there is no village health care provider to treat illness or provide preventive services.
2. Similarly there is a **failure in ensuring other determinants of health** including adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and healthy environment which are all prerequisites for better health.

Besides this the new policy thrust forcing the government to withdraw **from the social sectors and welfare activities** is increasingly threatening the vulnerability of the poorer sections of the society. In the health sector, it is an obvious fact that Government's [both Central and the State] proportion of expenditure on public health is declining in successive years. The public health expenditure in India is abysmally low at Rs. 21 per person per year which is among the lowest in the world.

What should be the Christian response?

Looking at the issue, it can be observed that the massive burden of diseases and death suffered by the marginalised sections of the society **is not just an unfortunate accident**. It consists of the daily denial of healthy life to millions of people, because of the structural injustice within and beyond the health sector. We CMAI members as health workers who are concerned about / working among the poor and marginalised sections of the society in rural and remotest part of the country, often have the first hand information on the denial of health and the resulting consequences.

This gross level of inequality is **morally unacceptable** and should be seen as the denial of basic right to life. A health system that determines the right of person's life based on his ability to pay is totally unacceptable. The overall responsibility of **performance of the health system is the irrefutable duty of the Government** and all other stake holders including the **NGOs, private sectors, professionals, churches etc can contribute and complement** to that effort.

How do we establish the Right to Health?

Health can no longer viewed as just a technical issue to be left to the experts and bureaucrats. **Health is a fundamental right** which needs to be established by systematically establishing the right of every citizen of this country to a healthy life. There is a need to bring about broad transformations both within and beyond health sector. However **given the gross inequalities in access to health care and inadequate state of health services today, one important component of promoting the 'Right to Health' would be to ensure access to appropriate and good quality basic health care services for all.**

Establishing the 'Right to Health Care' is likely to be a process with various phases. A first step towards this effort is ensuring a fundamental right for basic health care under our constitution. Though 'right to life is a constitutional right [under article 21], access to basic health care is not explicitly stated as a legal right of every citizen under our constitution. However, over the years, various judicial interventions and verdicts clearly endorsed this right.

It is expected that with the realization of this right, the public health care system will be obliged to ensure following structure and framework

1. **Adequate physical infrastructure at various levels**
2. **Adequate skilled manpower in all health care facilities and communities**
3. **Availability of a complete basic range of services appropriate to that level and**
4. **Availability of all basic medications**

Similarly the **state will have an explicit obligation to maintain public health** through a set of preventive and promotive services and measures. These should include coverage by immunisation, antenatal care and prevention, detection and treatment of various communicable diseases. This of course needs to be combined with changed budgetary priorities and a higher overall allocation to the health sector.

In this context ensuring 'Health For All' is not an unrealistic approach, but a practical possibility which is imperative for the nation to ensure the dignity of every citizen.

[This note is prepared for the CMAI members to discuss about the 'Right to Health Care' campaign initiated by the Jan Swastya Abhiyan [JSA]. JSA is a national level advocacy network of large NGOs and People's movements connected with health and development. CMAI is a National Coordination Committee member of JSA. The campaign will be initiated with a public consultation on 'Right to Health Care' in Mumbai on 5th and 6th of September, where National Human Rights Commission [NHRC] Justice Anand will be participating. It is expected that NHRC will endorse this Right which will provide a definite boost to the campaign. Next year being the general election year JSA is planning to challenge various political parties in appropriate platforms to commit this in their election manifesto]

C-3A.19 (19)

Another World is Possible! Health care for all is Possible!!

(A brief report of the 'Right to Health Care Seminar Asian Social Forum, Hyderabad)

'Right to Health Care: Moving from Idea to Reality', was a two-day seminar at the Asian Social Forum, Hyderabad arranged by CEHAT (Centre for Enquiry into Health and Allied Themes) in partnership with the National Centre for Advocacy Studies, Pune and the Global Health Council, U.S.A. The seminar took place under the larger theme of 'Social Infrastructure, Planning and Cooperation'. It was a part of the series of events arranged under the aegis of the Jan Swasthya Abhiyan. The Jan Swasthya Abhiyan is a national level platform of health and social organizations working on health issues with a rights based approach. The seminar took the opportunity to emphasise that access to quality health care is not only 1) a human need, 2) a right of citizenship and 3) a public good, but it is also 4) a pre-requisite to good health, which is essential to achieve and enjoy fruits of equitable development. While the 'Right to Health' would be the ultimate aim, the Right to Health Care could be a first step, a tangible and feasible demand. Making this right functional in the existing Legal and Constitutional framework, looking at International Experiences regarding Universal Access to Health Care, working out an Operational and Financial framework required to realize it and last but certainly not the least, Campaign Strategies that need to be adopted - were the topics around which presentations and discussions at the seminar were centered. The seminar was attended by about 200 participants.

The Asian Social Forum- The Asian Social Forum was convened in Hyderabad from 2nd to 7th January 2003. This forum was a prelude to the World Social Forum, which took place in Brazil in late January. The Forum was a response of the growing international movement critiquing the neo-liberal economic policies and capitalist globalisation being imposed on most countries. It was convened in expression of the WSF principle of offering space for free discourse, debate, interaction in the process of mutual learning, informed debate, and participatory formulation of alternative models with the worth and viability to address the challenges of development with justice. About 10,000 people attended the Forum and gave the slogan 'Another World is Possible!' The 'Right to Health Care Seminar' and the various events organized by the Jan Swasthya Abhiyan re-iterated that 'Health For All too is possible'.

The necessity to demand the Right to Health Care- Dr. Abhay Shukla, Co-ordinator, SATHI Cell, CEHAT facilitated the seminar. He spoke of the dismal health scenario in India which makes articulating the right to health care a necessity. India is known to have poor health indicators in the global context, even in comparison with many other developing countries. The per capita public health expenditure in India is abysmally low at Rs. 21 per person, among the lowest in the world. For the vast majority, the key barriers to good health are not the lack of technology but poverty and health system inequity. He stated that the objective of this seminar was to serve as platform for academics and activists, to come together and plan a strategy to realize universal availability of basic health care.

Legal and Constitutional Framework for the Right to Health Care -The theme on the first day of the seminar was 'Legal and Constitutional Framework for the Right to Health Care and relevant International Experiences'. The presenters who talked on the legal aspects were Jean Dreze (Professor of Economics, Delhi School of Economics), Colin Gonsalves (Advocate, Supreme Court and India Centre for Human Rights and Law), John Samuel (Director, National Centre for Advocacy studies) and Brian Lobo (Advocate and activist of a people's organization, Kashtakari Sanghatana).

It was reiterated that even without any specific amendments, the case for basic health care to be provided to all citizens as their right is strong. The 'Right to Life' (Article 21) enshrined in the constitution, as well as the directive principles regarding Nutrition, Standard of living and Health (Article 47), and various Supreme Court Judgments in favour of emergency and occupational health care, illustrate this. The 93rd amendment in the constitution accepting Education as a fundamental right, has strengthened the case of basic social services to be accepted as people's right. The International Covenant on Economic, Social and Cultural Rights, in its Article 12 clearly recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and creation of conditions which would assure to all medical service and medical attention in the event of sickness. The Alma Ata declaration of 'Health for all by 2000' signed in 1978 is yet another declaration which the government endorses. Even so, it was agreed that adequate financial allocation, political will, awareness of this right among people and strong political mobilization will be required to realize this right.

Apart from this the possibility of conducting a study like the PROBE study, which had an important part to play in Education being declared a fundamental right, on the availability and utilization of basic health care services at the grass roots level, was discussed. Dr. Shrinath Reddy, National Human Rights Commission (Health Committee) and Professor of Cardiology, AIIMS, New Delhi spoke on the next day about the active role of the health committee in NHRC to uphold the citizen's right to health care. Some other novel experiences at the village level like the communitisation of law in Nagaland, where the village health committees control the making of health plans as well as their functioning and financing, and village level monitoring of health care services in Dahanu taluka of Thane district were also related. It was stressed that "Rights are toothless wonders without support of law or finance". Therefore the 'Right to Health Care' should

be accompanied by the Right to Information, Right to Participation and Right to Monitor. There is need for strong political mobilization to ensure the implementation of these rights.

International Experiences- Sadnana Hall (Director, Global Partnerships Department, Global Health Council, USA) and Dr. A.H.M. Nouman (Chairperson, PHM Bangladesh Circle) spoke about international experiences in providing Universal Access to Basic Health Care.

Experiences in four countries- Costa Rica, Canada, South Africa and Bangladesh were shared. Costa Rica and South Africa both spend upto 9% of their GDP on health care, in spite of not being rich countries. Costa Rica has the best health outcomes of any country in Latin America. South African health care system faces the formidable challenge of the HIV-AIDS epidemic, with almost one in nine persons affected by year 2000. Given the short time span, which South Africa had in which to develop the National Health System, it had done good progress. On the other hand the much-acclaimed Canadian Health System, is facing skyrocketing costs and plummeting satisfaction levels. Canada has been advised, not to regress from the accomplishments of the Medicare system toward a hybrid privatized system. For Bangladesh too poverty reduction and Village Health Worker Programs seem to be the most effective tools to improve health and access to health care. India can draw valuable lessons from the experiences of these countries.

Operational and Financial Framework- Ravi Duggal (Co-ordinator, CEHAT), Dr. H. Sudarshan (Chairperson, Task Force on Health of Karnataka Government) and Father Sebastian (Director, Catholic Health Association of India) spoke in this session.

The core content of the Right to Health Care, Organising and Managing the Universal Healthcare System, Projection of Resource Requirements and Financing the Health Care System through mechanisms such as Social Insurance were discussed. Dr. H. Sudarshan spoke about his experiences as the chairperson of the Task Force on Health of Karnataka Government. The task force has demonstrated that Health Sector Reforms can take place if necessary political will is present. Corruption in the health sector has been identified as the greatest obstacle for the availability of services to all in an equitable manner. The task force is currently involved in weeding out corruption. The role of the NGO sector in Health, towards operationalising the Right to Health Care was discussed.

Campaign Strategy, The way ahead- Sarojini (Convenor, Medico Friend Circle, Women's Health Activist and Member of SAMA), Dr. Ravi Narayan (Advisor, Community Health Cell, Bangalore) and Dr. T. Sundararaman (Professor of Medicine, Jawaharlal Institute of Post Graduate Medical Education and Research, Pondicherry) have all been active in the People's Health Assembly process and represent the Jan Swasthya Abhiyan. They spoke about the campaign strategies that could be employed to realize universal access to Health Care. Dr. Zafarulla Chaudhary chaired the session.

It transpired that involvement of the communities is the key to success when we look at experiences in other campaigns. Two successful women's health issues which have already received attention are 'Say no to hazardous contraceptives' and 'The Supreme Court case against sex selective abortion'. It was emphasized that making alliances with other movements like the Narmada Bachao Andolan is important because health cannot be segregated from larger development issues.

It was proposed that strengthening the public health system and making it more effective with community basing of health programmes, could be an effective strategy towards gaining the 'Right to Health Care'. There should be a health worker in every village, who will help entitlements of health care services to reach the community. Giving the health worker such a meaning and context will help build a major mobilization of people for this right.

The need for Political Commitment across the political spectrum, Election Manifestoes to carry this programme and Constitutional mandate if the 'Right to Health Care' were to be realized were emphasized. Dr. Zafarulla Chaudhury concluded the session by reminding the gathering that strong opposition, especially from the medical profession is only to be expected in this process. Our strategy to combat would be to invite them to come with us, failing which the only course of action would be to go against them.

Action Plan for the Future- It is planned to form a group of representatives of organizations and individuals who attended the seminar in order to follow up on the strategy to realize the 'Right to health Care'. Some activities that are tentatively being discussed are- A study to assess the availability and utilization of basic health services at the grass roots level, putting forth viable operational and financial mechanisms to make the right functional, and filing a Public Interest Litigation to bring such a right into reality are among a few activities thought of. Systematic efforts would have to be made to include the issue in the election manifestos and generate political will.

The key ingredient to achieve health for all is real political commitment to reach the poor and involve them in the process of change. Without this, no major change is possible; with this, no change is impossible.

L-3A.20 (20)

A brief report on the Hunger Watch Meet
22nd and 23rdFebruary 2003, Mumbai

A group of activists from the Jan Swasthya Abhiyan, met on the 22nd and 23rdFebruary 2003, to form a 'Hunger Watch Alert' in the backdrop of the worsening situation of food security in India. Reports of drought, crop failure, suicides by farmers, starvation and hunger deaths are pouring in from various parts of the country. This includes rural areas of Maharashtra like Wada, as well as metropolises like Mumbai. Jan Swasthya Abhiyan, convened this meeting as a response to high levels of undernutrition, growing instances of hunger deaths and government apathy towards them. The aim was to arrive at a scientific protocol to investigate and document hunger related mortality. Those attending the meeting included Dr. Veena Shatrughna (Deputy Director, National Institute of Nutrition, Hyderabad), Dr. Vandana Prasad (Paediatrician), Dr. Narendra Gupta (Prayas), Dr. Sunita Abraham (Christian Medical Association of India), Sarojini (SAMA and Convenor of MFC), Dr. C. S. Kapse (Professor, Department of Forensic Medicine, D. Y. Patil Medical College), Dr. Neeraj Hatekar (Professor, Department of Economics, University of Mumbai), Sanjay Rode (Ph. D. student, Department of Economics, University of Mumbai), Dr. Abhay Shukla (Co-ordinator, SATHI Cell, CEHAT), Dr. Neelangi Nanal (CEHAT), Dr. Amita Pitre (CEHAT) and Ms. Qudsiya (CEHAT).

Undernutrition in children as well as Adults is well documented in various government publications. This data from NNMB (National Nutrition Monitoring Bureau) 'Diet and Nutritional Status of Tribal Population Report on First Repeat Survey' shows extremely high prevalence of malnutrition (92%), and significant numbers of severely undernourished (20%). This situation of silent hunger hardly seems to draw any action for relief, while incidences of suspected starvation deaths send the government machinery into action to vehemently deny their occurrence. Therefore it was thought that efforts must be made to systematically investigate and document starvation deaths, at the same time keeping a focus on a community diagnosis of a starving population and to gain relief for the entire community. The occurrence of a starvation death could be used as an advocacy tool to highlight the omnipresent undernutrition, and a chronically starved population on the brink of death in case of drought or crop failure.

Participants presented their experiences in the context of investigating suspected starvation deaths and the methodological issues that emerged during the exercise.

Abhay Shukla presented the experiences of Badwani, Madhya Pradesh and Wada, Maharashtra. Narendra Gupta presented those of Baran, Rajasthan and Neeraj Hatekar those of Mumbai slums. The reports of these studies were circulated. Veena Shatrughna presented the methodological issues and existing literature regarding malnutrition and starvation deaths.

Verbal Autopsy Forms was an important tool that was discussed. A standardised form available for the children, and the WHO form available for adults were modified to accommodate specific provisions to diagnose the status of food security for the community, family and individual and used in the Badwani study. Also discussed was which would be the best parameters to assess adult and child nutrition. The Body Mass Index (BMI) in adults and the Weight for Age in children, are the best available parameters for use. The group will also be exploring the importance of Post Mortem findings to diagnose a starvation death. The dearth of information regarding this and the reported facts that forensic experts hardly ever diagnosed 'Starvation' as the cause of death was surprising. This again confirmed that while malnutrition could be quoted in medical reports and death certificates, starvation was a taboo word, to be avoided.

The important methodological issue that came up was whether calculation of three monthly death rates as was done in Badwani was a valid tool in assessing death rates. Weekly death rates had been calculated by the British in case of the Bengal Famine. A study should be done to record seasonal variations and the phenomenon of clustering of deaths and if this is a statistically significant phenomenon. Otherwise there seemed no problem with calculating such death rates.

An important suggestion made was that for effective advocacy the weights of the children in the affected area should be compared with those of middle class children in the same age group. This would bring out the differences more sharply than do figures of percentages in the various categories of undernutrition.

Another stumbling block to prove a starvation death is one has to rely a lot on physical appearance as related by close relations, as anthropometry is out of question. An important proxy indicator would be the weights of siblings. The Nandurbar study done by the Tribal Research and Training Institute relied on weights of mother and siblings. This could be an important tool to decide if the entire community was starving.

Another important issue was that malnutrition, hunger and starvation seem to lie in a continuum. How is it possible to demarcate one from the other. One important finding that was told here was that at adult BMI of 19 mortality rates seem to start rising. Consensus was reached that B.M.I of 16 and less should be used as a cut off point to demarcate starvation from undernutrition. A 30 Kg person (~B.M.I of 16) needs 500 Kcal per day to maintain himself at Basal Metabolic Rates, without any activity. Therefore such a low intake is also an indication of starvation.

The following indicators may serve to define an adult starving population-

- Increased death rates in the community
- No mass disasters, epidemics, or other accidents
- Nutrition indicators below national or state averages
- Reduced food intake from PDS
- Other criterion of reduced food security like eating unusual foods, crop failures, rain failure, suicides, indebtedness, very low incomes, no work

Verbal autopsies should be used in conjunction with the above to assess any starvation deaths.

For children-
- Increased death rates. An exercise must be done to calculate age specific death rates, and compare this with the national averages to define increased death rates.
- To do anthropometry and assess nutrition status of siblings
- Access ICDS records if possible
- Doubling of percentage grade III and IV of the national average can be taken as a starving child population

Verbal autopsies to assess any suspected starvation deaths a statistical exercise may be done with existing data to find out how much does a mortality increase with increasing under nutrition. No sharp cut off points can be seen currently.

It was decided to form a Hunger Watch group, which would go and investigate any suspected cases of undernutrition, and try to diagnose a starving population and do advocacy for relief.

CAMPAIGN STRATEGY

STUDY/COLLATE – INDIAN EXPERIENCE

- DIALOGUE BETWEEN PROVIDERS/CONSUMERS
- DIALOGUE BETWEEN MOVEMENTS/NETWORKS/ASSOCIATIONS (PHM-ISA)
- DIALOGUE LEGAL/ECONOMIST SOCIAL/MEDICAL/PUBLIC HEALTH PROFESSIONALS

(1) EVOLVE CONSENSUS

(2) EVOLVE STRATEGY

(HEALTH CARE CAMPAIGN AS A POLITICAL STRATEGY)

- WHAT – COMPONENTS
- WHERE – LEVELS (ESTABLISH RIGHTS)
- HOW – MEANS/METHODS
- LINKAGES (COMMON PROGRAMME)

(3) ADVOCACY WITH GOVERNMENT

(POLITICAL FAILURE) TO BE CHALLENGED

↓CREDIBILITY ↑CORRUPTION ↓QUALITY

- POLITICAL COMMITMENT (ACROSS POLITICAL SYSTEM)
- ELECTION MANIFESTOS
- CONSTITUTIONAL MANDATE (STRESS)

(4) ADVOCACY/INVOLVEMENT WITH PROVIDERS

(ACADEMIC) RESEARCHERS

- COUNTER OPPOSITION (ALTERNATIVES)
- RE-ESTABLISH ETHICAL BASIS/QUALITY BASIS
- CONFRONT COMMERCIALIZATION (RATIONAL/EVIDENCE BASED CME)

(5) DIALOGUE WITH COMMUNITY/MOVEMENTS/UNIONS

- DEMAND
- FEED BACK
- OWN/SUPPORT

(CONTEXT OF PANCHAYATRAJ AND CONSUMER MOVEMENT) (PEOPLES MOVTS)

- INTEGRATION/ASM/FOLK TRADITIONS

(6) MOVEMENT FOR RATIONAL, ETHICAL

- BRING CAMPAIGNS TOGETHER

NATIONAL CONSULTATION OF EXPERTS ON THE UNIVERSAL ACCESS TO HEALTH
4 AUGUST 2003
PROGRAMME SCHEDULE

THEME: UNIVERSAL ACCESS TO HEALTH CARE

TIME	SESSIONS	PRESENTER	MODERATOR
9.00 am to 10.00 am	Registration		
10.00 am to 10.05 am	Prayer and lighting of the lamp	Ms. Cecilia Alexander	Dr. R.S. Arole, Dr. N.H. Antia, Ms. Tracey Hayes, Dr. Thelma Narayan, and Fr. Sebastian
10.05 am to 10.20 am	Welcome and introduction to the theme	Fr. Sebastian Ousepparempil, Director, CHAI	Ms. Tracey Hayes, Global Health Council, New York
10.20 am to 10.40 am	Universal Access to Health, Perspectives	Dr. Rajnikant S. Arole, Director, Institute of Training and Research in Community Health and Population.	
10.40 am to 11.00 am	Universal Access to Health, Perspectives	Dr. N.H. Antia, Director, Foundation for Research in Community Health.	
11.00 am to 11.10 am	Health Watch Group and DHAF	Dr. Mani Kaliath, HOD, Community Health Department, CHAI	
11.10 am to 11.20 am	Case Study – CHABIJ regional Unit and DHAF, RAHA Health Cooperative	Sr. Prabha, Director, CHABIJ	

C-34.22

C-3A.23

23

Respected Chair, Distinguished Delegates,

I am thankful to the organizers of this event for giving me an opportunity to share my views. When we discuss about the Universal Access to Health Care, I strongly feel that we should understand the national scenario about Health Care. The word health depends on the environments such as social, economical, cultural and political. In today's stinking political scenario of our country, parties and their leaders are struggling for their own existence, so how can they care for National Health?

The Word health care brings to the center of attention The Medical Profession. Major medical institutions are under the control of the private sector comparative to the public sector. It has become a major profit making industry. Now a day a Doctor is created not on the basis of talent but the capability of his or her "Fathers Money". In the public sector the system of reservation has also badly hampered the chances of eligible candidates. Finally the product of this industry remains qualitatively poor and their intentions are not to serve the people only to recover the money they have invested with profit. Ultimately very less moral or ethical values are left with the profession as on today.

Due to the development of Science and the influence of western Culture we have lost a very rich heritage based on a simple and natural life and health care. For. E.g. the food which we are eating contains fertilizer and pesticides, water we drink is also not natural, and the medicines we consume are also totally chemical after paying a high cost .In this situation how can we be expected to have a better health care scenario for the common man.

The so called modern medicine is creating more patients and sickness every day. This is high time to realize the dangers of modern medicine. On this occasion I would like call your attention to that time before the advent of modern medicine in this country as to how people were treated and cured with our natural medicines found and developed by the great Sages and Rishis. Sushrut and Charak were not the product of any medical colleges and Sushrutsamhita and Charaksamhita are not the research product of any ICMR. Culture of ayurvedic treatment is derived from great Gurus whose knowledge was transferred from generation to generation. The institutionalization of traditional knowledge of Health care has created substandard doctors in the field our Traditional systems of medicine.

Today an Ayurvedic or homeopathic physician after completion of their institutionalized training, practice with Allopathic medicine about which they have never ever learnt. Why is this happening? This is because; the knowledge that they have gained through training is not competent enough to make them good Ayurvedic or Homeopathic doctors. Main reason for this is that the teaching faculty is not competent to teach the student about the subject.

Principles of Ayurveda can not be taught by a pre defined Syllabus. It can be learnt only by practice under the guidance of a proper Guru. Any person can learn and practice Ayurveda provided that he should have self-interest and a proper Guru to teach him.

For better access to health care facilities in our country modern medicine can not contribute to the majority of the population because of its high cost and availability. I strongly feel that proper training system to be developed to create good Health Workers based on out traditional knowledge of Ayurveda , Unani etc. In India lacks of health workers practicing across the country without any proper training or license to do so.

These so-called health practitioners treat major population of this country because they are easily accessible to the common man. For e. g. there are so many practitioners of traditional medicine from West Bengal practicing in other states for treating piles and fistula. Piles and fistula is a common problem with most of the people. Today in modern medicine a surgery to be conducted

for this purpose costs minimum Rs. 15,000/- + antibiotics. This can not be affordable to the common man. Here this so called traditional medicine practitioners from Bengal treat such patients with costs ranging from Rs. 2,000/- to Rs. 3,000/- without hospitalization and antibiotics. Like this in our country a number of traditional practitioners are successfully practicing for the treatment of paralysis, arthritis, Asthma, Jaundice etc.. As we are discussing about traditional practices I would like to mention about a practitioner namely Mr. Rambabu Gaikwad of Akiwad, Miraj – Sangli, Maharashtra who treats only paralytic patients.

His clinic starts in the morning at 8.00 and continues till 8 in the evening. He just sees the patient (no physical examination) and gives medicine. He, depending on the condition of the patient fixes dose of the medicine. His medicine for a fresh paralytic patient is only two packets a day (1 gm of herbal powder) costing one rupee per packet. Morning when his clinic starts we can see hundreds of patients already in the Queue from all walks of life. I have personally seen that his patients are getting cured within a period of two to three months. He does not require any MRI or other reports. I am sure even a famous Neuro-physician can not treat and cure paralytic patients with his modern medicine like Mr. Rambabu Gaikwad.

In this vast country we got thousands of traditional medicine practitioners like Mr. Rambabu Gaikwad. Identify such golden jewels and make such knowledge available to common man, through this National Access to Health Care can be achieved. For this purpose the Government along with the NGO's should come forward with an open mind to promote TM / CAM as per the program proposed by the United Nations in 2002 -2005.

Modern medicine has got its own limitation as far as the treatment, medicine are concerned. They do not have a holistic approach. They always depend on the investigation reports for diagnosis. If the diagnostic report is false or misguided patients get the wrong treatment which can be very dangerous. In Indian system of medicine we physically and psychologically assess the patient for diagnosis. Accordingly treatment is given.

Primary educational facilities are to be developed to teach TM / CAM with the help of present practitioners of Traditional medicine and other alternative therapies. (We propose to start Ayurvedic Schools to undertake this activity.)

Last 15 -20 years research in the field of Ayurveda, Traditional medicine and Complimentary alternative medicine I could develop a number of formulation for the treatment of Heart disease, arthritis, jaundice, spine disorders, sinusitis, obesity etc.. Due to extensive research and studies with the cardiac patients we could give a new dimension to cardiology in Ayurveda and Indian system of medicine where we see Heart is a myogenic organ just to manage the function of blood supply and purification system in the body. In the 50's and 60's the western world has given unwanted importance to heart and especially its problems which has been adapted by the entire world even though they could not find out any permanent solution except temporary surgical ones even today which are very risky. Where in our research we see heart problems also as a functional change due to many reasons which can be corrected by a holistic approach. For this purpose we introduced a cardiac health substitute " Cardioflo ^{TM} " the benefit of which is being experienced by thousands of patients. This patent Medicine has been appreciated and tried by doctors even in European countries but still is not acceptable to Cardiologists in our country even though they know the benefit of this medicine. This attitude of practitioners of modern medicine is harmful to Universal Access to Health care for all.

Presently a team of Ayurvedic Doctors are given training to use all these formulae in their practice. Already we have treated thousands of Heart patients all over India successfully.

Through Dhanvantri Manava Seva Sanstha, a newly formed charitable trust we are planning to organize free training programs for Ayurvedic Doctors to exchange our knowledge with them.

Through National Association of TM/CAM Practitioners, India we are planning to organize such practitioners under one roof and conduct training schools for such Doctors. I am of the opinion that it is good to exchange our knowledge with any group working in this same field.

- **Presented At Hyderabad on 4/8/2003 by**

Dr. **Antony Joseph**

Pune

Tel: (020) 7273110, 7274614

Mobile: 9823072620