Programme

National Public Hearing on Right to Health Care
Jointly organised by the National Human Rights Commission and Jan Swasthya Abhiyan
(New Delhi: 16-17 December 2004)
[Venue: Jacaranda, India Habitat Centre]

Day 1: [16 December 2004]

9.30 – 10.30: Inaugural Session
Welcome by JSA: by Dr. B. Ekbal, National Convenor, JSA
Vision of Public Hearing (Dr. K.S. Reddy, Convenor, NHRC Core Group on Health)
Inaugural Address by Dr. Anbumani Ramadoss, Hon'ble Minister for Health & Family Welfare
Remarks by Dr. Justice A.S.Anand, Hon'ble Chairperson, NHRC
Vote of thanks by JSA

10.30 – 11.00 Tea Break

11.00 to 1.30 and 2.30 to 3.45 (two parallel sessions)

1.15 hours for each of the five regions which would include:

a. Reports by JSA regional representatives on key areas of health rights violations (total 20 minutes for region)
b. Brief response by State Health officials on action taken and action plan to protect and establish health rights (7-8 minutes each per State – total 45 minutes)
c. Comments by NHRC panelists – 10 minutes

Time	Group A (Chair:Justice Shri Y.Bhaskar Rao, Hon'ble Member, NHRC)	Group B (Chair: Shri P.C.Sharma, Hon'ble Member, NHRC)
11.00-12.15	Western region	Northern region
12.15 -1.30	Southern region	North Eastern region
1.30 – 2.30	Lunch	
2.30 - 3.45	Eastern region	Urban health care rights in various regions
3.45 – 4.00	Tea break	

4.00 to 5.00 pm: JSA presentation on issues relating to health rights at National level
(Chair Justice Shri Y.Bhaskar Rao, Hon'ble Member, NHRC)
Presentation coordinated by Dr. Amit Sengupta, National Joint Convenor, JSA

(To include major national policy issues such as strengthening primary health care from the human rights perspective, national and state health budgets, essential drug policy, RCH programme etc.)

Day 2: [17 December 2004]

9.30 to 12.30: Parallel sessions on key health rights issues, 45 minutes each

(JSA presentation 20 minutes, discussion 15 minutes, panelist comments 10 minutes)

Group A: *9.30 to 11.00*: Session 1

(Smt. Reva Nayyar, Secretary, Women & Child Development to chair

Shri S.S.Brar, Joint Secretary (RCH), Deptt. of Family Welfare.

Women's right to health care

Children's right to health care

Session 2: *11.00 to 12.30:* Shri Chaman Lal, Special Rapporteur, NHRC to Chair

Dr.P.K.Dave, NHRC Expert Group on Emergency Medical Care:Co-chair (subject to confirmation)

Mental Health Rights

Health Rights in situations of conflict and displacement

Group B: Session 1 *9.30 to 11.00:* Shri V.K. Arora, Addl. DG, Health Services to chair

Dr. D. Banerjee, Vice-Chairperson, JSA-co-chair

Right to essential drugs

Health rights in the context of the Private medical sector

Session 2: *11.00 to 12.30 :* (Dr S.Y.Quraishi, Additional Secretary & Project Director, NACO to chair)

Dr. N.H.Antia, Chairperson, NHRC Core Group on Health: co-chair)

Health rights in the context of the HIV-AIDS

Occupational and environmental health rights

12.30-1.30 Lunch

1.30 to 2.15: Plenary presentation by JSA Rapporteurs [Dr. Vandana Prasad and Mr. Amitava Guha] on the key health rights issues emerging from two parallel sessions

[Chair: Shri S.S.Brar, Joint Secretary (RCH), Deptt. of Family Welfare to chair]

2.30 to 4.15: Towards a National action plan to establish, fulfil and monitor the Right to Health-Care

1. Statement by Mr. Paul Hunt, United Nations Special Rapporteur on Right to Health [Ms. N.B. Sarojini to read out the Statement]
2. People's actions to establish the Right to Health Care (Dr. Abhay Shukla, National Joint Convenor, JSA)
3. JSA-NHRC joint presentation on a National action plan to establish, fulfil and monitor the Right to Health Care (Shri Y.S.R. Murthy, Deputy Secretary (Research), NHRC and Dr. T. Sundararaman, National Joint Convenor, JSA)
4. Responses from Union Health Ministry (Shri P. Hota, Secretary, Health & Family Welfare)
5. Concluding remarks by Dr. Justice A.S. Anand, Hon'ble Chairperson, NHRC
6. Vote of thanks by Shri Y.S.R. Murthy, Deputy Secretary (Research), NHRC

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L-7A.2

National Public Hearing on the right to health care

Jointly organized by the National Human Rights Commission and Jan Swasthya Abhiyan

The programme on started on time with the welcome address delivered by Dr. Ikbal convener of JSA. He welcomed the dignitaries and the delegates. Dr. Ikbal in his address mentioned this event is an historical one as this is the first time a Human Rights Commission was collaborating with civil society agencies in addressing a issue.

Followed by the welcome address Dr. Ikbal shared the vision of public hearing/. Dr. Srinath Reddy in his address mentioned that right to health is a human right and denial of access to health care is violation of human right. He mentioned the need for comprehensive primary health care approach in meeting the health needs of citizens of this country. He also mentioned that the present understanding that the public private partnership for the benefit of the poor needs a critical analysis. Finally he said community participation is crucial in the success of any programme. He concluded his speech by saying that the goal of Jan Swasthya Abhiyan's Right to Health Care campaign is to strengthen accessibility of public health services.

Followed by Dr. Reddy the Honrable Minister for health and family welfare Dr. Anbumani Ramdoss delivered the inaugural address. Dr. Ramdass in his address said right to health care is fundamental right. He referred to the constitution of WHO which says; that every one has the right to enjoy health at the highest attainable standard. He also referred to the Universal Declaration of Human Rights by the General Assembly of the United Nations, which says that all human beings are born free and equal in dignity and rights.

He referred to the WHO's definition of health and said health care is complex issue. He mentioned the need to balance between the various aspects in health care, which include curative preventive, promitive. He also mentioned the determinants of health such as water, sanitation and nutrition. He said the rural population put together to with the urban poor constitute 90% of the population to whom the health care is important, he pointed the need for changes in the health care delivery system, he said he was particularly concerned about the quality. He mentioned about the doctor patient ratio in India he said, even if we put together the practitioners of all system of medicine the doctor patient ratio in India comes one doctor per 800 population. He said the hospital beds available at present in the country, which is about one million barely sufficient. He justified the need for public private partnership by mentioning that the public sector contribution in health care is only 17%, he emphasized the need for streamlining. Here he mentioned about the need for accreditation of health care facilities that area available in the county and the need for health regulatory authority. He also mentioned about need for essential drugs guidelines and said he is concerned about particularly about the list not being available regarding the life saving drugs. While referring to private sector he mentioned about the need for checking quackery.

He said he agrees with all the recommendations put forth by JSA it is commendable for the efforts in delineating the needs.

He said he is deeply concerned about the population growth and said the ministry would try to work hard towards controlling population through non-coercive measures such as massive awareness creation. He said he is also concerned about safe mother hood by which the MMR could be brought down he said he particularly concerned that MMR is stagnant for the past three decades. He said that the prime minister is concerned about two key issues the health and education which are alike his tow eyes.

THE GLOBE

Global Alcohol Policy Alli

Alcohol: No Ordinary Commodity. A summary of the bo Alcohol & Public Policy Group

Alcohol Policy and The Public Good, published in 1994, was a modern landmark in al policy. Here, with the kind permission of the editor of the journal Addiction, we repr summary of its successor, Alcohol: No Ordinary Commodity — Research and public p (Babor et al. 2003). The first part of the book describes why alcohol is no ordinary commodity, and presents epidemiological data on the global burden of alcohol-relate problems. The second part of the book reviews the scientific evidence for strategies interventions designed to prevent or minimise alcohol-related harm: pricing and tax regulating the physical availability of alcohol, modifying the drinking context, drinki counter measures, regulating alcohol promotion, education and persuasion strategie treatment services. The final section considers the policy making process on the loca national and international levels, and provides a synthesis of evidence-based strateg interventions from a policy perspective.

Setting the policy agenda

The purpose of this volume is to describe recent advances in alcohol research that have direct to alcohol policy on the local, national and international levels. Alcohol policies serve the inter public health through their impact on drinking patterns, the drinking environment and the hea services available to treat problem drinkers. Public health concepts provide an important vehi manage the health of populations in relation to the use and misuse of beverage alcohol by hel communities and nation states to design better preventative and curative services. Alcohol po been implemented throughout history to minimise the effects of alcohol on the health and saf population but only recently have these strategies and interventions been evaluated scientific

No ordinary commodity

In many countries, the production and sale of alcoholic beverages generates profits for farmer manufacturers, advertisers and investors. Alcohol provides employment for people in bars anc restaurants, brings in foreign currency for exported beverages and generates tax revenues for government. Alcoholic beverages are, by any reckoning, an important, economically embedde commodity.

However, the benefits connected with the production, sale and use of this commodity come at enormous cost to society. Three important mechanisms explain alcohol's ability to cause medi psychological and social harm:

- (1) physical toxicity
- (2) intoxication and
- (3) dependence.

Alcohol is a toxic substance in terms of its direct and indirect effects on a wide range of body

He also mentioned about the need to work towards checking the trend regarding HIV/AIDS in India. He said there is need for legislative measures in checking discrimination against people affected by HIV/AIDS.

He said his government is concerned about health that is the reason why the new programme is being planned ie the rural health mission in 17 states, which are backwards. About the health budget he said that the governement would increase from the present .9% to 2%.

Finally he said that the judiciary has created havoc in medical education and he would be interested to discus the same with the chairperson of NHRC.

Justice Anand in his remark said that India is welfare state therefore it is the duty of the government to provide health care for all its citizens. He referred to article 21, which talks about right to life and argued right to health leads to right to life. He said without addressing the following three areas it is difficult to achieve development; he referred to poverty, health care and education. He illustrated a case where a patient in West Bengal was denied health care in many places. He also expressed his concerned about the health indictors, though life expectancy has gone up but indicators such as IMR and MMR being stagnated. Regarding access to essential drugs he said only 35%of the population are accessible. Regarding health budget he said it should go upto 3-5%. The inagural session came to an end by vote of thanks by Dr.Sarojini of Sama.

"Legislation enables risks to health to be reduced in the workplace and on the roads, whether the wearing of a safety helmet in a factory or a seat belt in a car. Sometimes laws, education persuasion combine to diminish risks, as with health warnings on cigarette packets, bans on t advertising, and restrictions on the sale of alcohol."

The report is particularly concerned with the increase in alcohol consumption in poorer, develc countries: "All of these risk factors -- blood pressure, cholesterol, tobacco, alcohol and obesity the diseases linked to them are well known to wealthy societies. The real drama is that they n increasingly dominate in low mortality developing countries where they create a double burde of the infectious diseases that always have afflicted poorer countries. They are even becoming prevalent in high mortality developing countries."

The Globe (links to previous issues)
This issue of The Globe (link to index)

Global Alcohol Policy Alliance|Alliance House
12 Caxton Street| London | SW1H 0QS| Tel: 0207 222 4001| Contact Gapa

Home

L-7A.3

WESTERN REGION PUBLIC HEARING ON RIGHT TO HEALTH CARE 29 JULY 2004 BHOPAL, MADHYA PRADESH

Recommendations from the Public Hearing

Legal Measures

- Enactment of a ***State Public Health Act*** in each state, which would outline the mandatory health care services which must be made available to the people as a right at various levels of the public health system. This act would specify which services and standards of care must be made available at the community, sub-centre, PHC, CHC, Sub-district and District hospital levels, as well as the preventive and promotive measures that the government would undertake.
- Enactment of a ***Clinical Establishments Regulation Act*** in each state to ensure minimum standards, adherence to standard treatment guidelines and ceilings for costs of essential medical services in the private sector. For example, the ***Bombay Nursing Home Regulation Act 1949 - Maharashtra***, may be substantially modified and improved to effectively regulate the quality of private medical services in the state.
- Private practice presently allowed to Government health care providers should be legally banned, and those doing it should be promptly punished.

Independent Social Monitoring and Redressal System

- ***Preparing lists of specific services and supplies*** that would be guaranteed at all levels of the public health system; wide dissemination and public display of these lists in all relevant facilities.
- A system of ***regular independent monitoring*** of the functioning of the health care system at all levels – encompassing state, district, city / town, block and community levels. Representatives of state level health sector coalitions, social organizations involved in health-work along with representations from the beneficiary population, in conjunction with relevant health officials, should be entrusted with this independent monitoring.
- ***An effective redressal mechanism*** at block, district and state levels for persons with complaints regarding quality of health care, or those who have suffered denial in any form. This mechanism should be transparent, should involve health sector coalitions and social organizations, and should be independently reviewed on a periodic basis. A department or position of ***Swasthya Lok Ayukta*** may be created especially to address complaints and to ensure that rational guidelines are followed.

Budgetary Measures

- Immediate ***doubling of public health-care expenditure*** by State governments and further increase to at least 3% of the State Domestic Product in next five years in keeping with provisions in the Common Minimum Programme.

- ***Per capita allocation for public health care*** for rural areas should be increased and made equal to that for urban areas.
- Immediate ***doubling of drug budget*** for rural health facilities.

Measures to improve functioning of the health system and attention to special groups

- ***Standard Treatment Protocols*** should be implemented regarding care to be provided at various levels of Health Care Facilities, so that the necessary quality is maintained.
- ***The full range of comprehensive health services should be guaranteed*** at all levels of the public health system, these health services must be ensured as a right. In exceptional cases of failure by the public system to provide any such health service to a patient, there should be a mechanism wherein care may sought from designated private facilities following standard treatment protocols. Such registered and regulated facilities could give relevant care to the patient, and the state could reimburse them at standard rates, ensuring that the patient is not deprived of any essential care at time of need.
- ***Guaranteed availability of essential drugs*** relevant to the level of service, in all public health facilities. A mechanism to ensure that if any health care facility is unable to provide any of the essential drugs that are supposed to be available at that level of health care, the expenses incurred by the patient on this 'outside prescription' should be promptly reimbursed. All health care providers in both public and private sector should prescribe according to the essential drug list, and prescribe drugs by their ***generic names.***
- A comprehensive statewide policy to provide ***Primary Health Services to urban areas.*** Adequate health services need to be provided in all cities and small towns. Expansion of Urban health care infrastructure, especially of health posts and of outreach health services keeping in mind the needs of the growing slum population.
- ***Filling of all the vacant posts*** and construction of buildings for Sub-centres and other facilities.
- A new scheme to provide a ***Community Health Worker in every village or habitation*** of the state should be launched. As part of such a scheme, in tribal areas the Community Health Worker should be operative at hamlet level. For example, in Maharashtra under the ***Pada Swayam Sevak*** scheme, the ***full potential of the Pada Swayam Sevaks (PSSs)***, in tribal districts now needs to be realised ***by upgrading their role*** as has been done in innovative projects. This may be done by ensuring substantially upgraded training, integration of curative and preventive roles and preference being given to women in the selection process.
- Regarding ***women's access to health care***, availability of all services in a woman friendly and sensitive manner at public health facilities must be ensured. This should include assured round the clock maternity services at Sub-centre and PHC level; assured emergency obstetric and neonatal care at CHC level; facility of diagnosis and treatment of Reproductive Tract Infections and of infertility, and woman friendly, quality abortion services. Simultaneously, quality health care for women beyond reproductive health such as availability of services by women doctors; supply of iron tablets to all anaemic women irrespective of being pregnant or not; care for victims of domestic violence, and other services relevant to women's health must be ensured.
- ***Training of staff*** to increase its sensitivity to groups with special health care needs like women, children, old people, the mentally and physically challenged.
- ***Greater sensitivity towards mentally unwell, institutionalised patients***, provisions for proper counseling. Provisions for consent procedures, facilities for legal aid and measures for rehabilitation and family contact.

- ***All coercive measures***, including incentives and disincentives ***for limiting family size***, which result in violations of human rights, ***must be stopped immediately.***
- ***The norms for maintaining quality of service during tubectomy operations must be strictly followed.*** For any violation, of these norms responsible persons must be suitably held accountable and punished. ***The 'camp approach', which often results in poor quality operative care and violation of various aspects*** of women's rights, needs to be seriously reviewed immediately.

The other recommendations are:

1. Public Health facilities should guarantee a Health Centre within walkable distance with qualified doctors and infrastructure.

2. Facility to refer patients with serious ailments to specialized hospitals including transport (Ambulance or Vehicles) with minimum facilities to give life sustaining treatment during transit.

3. Drugs availability at reasonable rate within reach of common man

a) Supply of quality drugs

b) Ban of spurious drugs envisaging violation as grave crime entailing severe punishment.

c) There should be a Drug Price control Policy. Violators should be held accountable, including penal action.

4. Social responsibility of providing 10% of free service or service on nominal charges fixed by the State should be made mandatory for all Corporate Hospitals and Private Nursing Homes with regular accountability entrusted to a body created by the State to monitor the system.

- Visit of Mobile Hospitals with adequate infrastructure and doctors, at least twice a month, to a village to treat the ailing people where there is no hospital facility and refer serious patients to Health Centres or District hospitals.

- To examine the children in all primary and middle schools regularly twice a year and send report to DMs and/or Collectors, along with names and attestation of Head Master and Sarpanchs of the village.

- The diet specialist doctors should prepare a list of food articles available in local area and prepare a chart showing the proportions of food articles to be taken by

children, young boys and girls, pregnant women, old citizens and women from weaker sections, etc. for strengthening the nutrition of body and to end malnutrition. This exercise should be made every year and published in local language, put up on Notice Board of Panchayat offices, Schools and Hospitals of every village.

- It should also publish that the parents should examine their children regarding their hearing problems, vision, speech, etc. immediately they notice any one symptom so that at young age itself the same could be treated.

- The Gram Panchayats (full body) and recognized Non-Governmental Organisations at village, taluq, and district levels should send quarterly reports about the functioning of hospitals in their village stating presence or absence of doctors, the period for which one is absent or no doctor is posted at all, including women doctors, nurses, other medical staff of hospital and availability of drugs to the District Medical Officer, Collector or Commissioner, Director of Medical Services of the State and one to the Health Secretary.

- A Monitoring body should be formed with Chief Secretary as Chairperson, Health Secretary, Director of Medical Services and Secretary in-charge of Vigilance as Members to scrutinize the reports and suggest action to be taken immediately as time-bound programmes. The reports of Monitoring Committees should be placed before the Assembly every six months for consideration of elected representatives.

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NATIONAL HUMAN RIGHTS COMMISSION AND JAN SWASTHYA ABHIYAN

SOUTHERN REGION PUBLIC HEARING ON THE RIGHT TO HEALTH CARE HELD ON 29TH AUGUST, 2004 AT CHENNAI

KEY FINDINGS AND RECOMMENDATIONS IN RESPONSE TO ORAL AND WRITTEN TESTIMONIES

for the States of Kerala, Tamil Nadu, Andhra Pradesh, Karnataka and Pondicherry

1. **Access to Primary Health Care through the public sector health system**
   Primary health care is understood in a more limited way as services made available through Sub-Centre (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs).

   - **Pondichery** received positive community response regarding the availability and quality of primary health care services.

   - There were no complaints from **Kerala** though issues regarding essential drugs, environmental health and trauma care were raised which come within a broader understanding of primary health care(covered in item 5,6,7).

   - In **Karnataka and AP** the irrational **siting of PHCs** (possibly under political pressure) made access to health care very difficult and sometimes impossible. Some of the farthest villages were 40 – 50 kms away, and in other cases there was no easy bus access to PHCs / SCs. In AP subcentres that were supposed to be there were non-existent on non-functional. In Tamilnadu, Karnataka and AP there were problems with regard to quality of care, referrals and staff attitudes.

   Recommendation 1.

   - The siting / distribution and physical accessibility of PHCs and subcentes must be ensured. They should provide good quality services during the prescribed timings. Indicators and mechanisms for monitoring quality of care need to be developed and used. No money should be taken for services that are to be provided free. The citizens charter for services at PHCs should be prominently displayed and implemented. Staff vacancies need to be filled up and staff needs such as quarters, toilets, water supply and electricity need to be ensured. Adequate provision of medicines, laboratory equipment and consumables, registers etc is a basic requirement. Maintaining staff motivation through good management practices will help improve the quality of services and to foster a relationship of mutual respect and trust between providers and people.

- State and Central health budgets would need to be increased as per the National Health Policy 2002 and the Common Minimum Programme commitments. Distribution of the health budget between the primary, secondary and tertiary levels of care would also need to follow norms, such as 65%, 20% and 15% respectively.

2. Urban health care

There were several instances where the urban poor suffered adversely due to lack of access to health care and to basic determinants such as lack of access to safe potable water and sanitation.

Recommendation 2.

- The urban poor should have access not just to family welfare services but to comprehensive primary health care through health centres which cater to 50,000 people.

- Provision of safe potable water and sanitation is necessary to prevent morbidity and mortality due to water-borne diseases.

- User fees in institutions like NIMHANS need to be reconsidered as they have resulted in lack of access to care. Urban poor families including migrants often do not have ration cards and BPL cards. Rural and urban poor patients coming from other places do not carry all these cards (if they have them) when they come to hospital in times of illness.

- Corruption and rude behaviour in institutions like Kidwai Institute of Oncology as well as in IPP VIII Centres need to be checked.

- Pourakarmikas from Hyderabad Metro Water Works and those in other cities and towns need to have access to basic preventive, promotive and curative care, including safety gear and equipment.

3. Private sector health care

The case of death of a teenaged girl following treatment of gastroenteritis by a private practitioner (with an unusual medical qualification) raised the need for:

Recommendation 3.

- Regulation of the private medical/health sector by government and professional bodies. Liability of practitioners and payment of compensation where death or disability results from improper treatment or negligence.

- Unnecessary surgeries such as hysterectomies as was reported from AP should be curbed.

4. **Women's access to health care and gender concerns**
It was painful to hear testimonies from women about the poor treatment they received even for ANC/PNC and family planning services and the lack of respect and privacy.

Recommendation 4

- The camp approach should not be used for tubectomices / sterilizations. Good quality , safe contraceptives need to be available in health centres at different levels, with adequate facilities for screening follow-up and discussion about possible side-effects. Patient feedback on quality of care should be regularly taken and acted upon.

- Medical and health care should be made available to women and children as close to their residence as possible.

- Privacy and respect should be ensured for women and girls during medical examination and treatment.

- The large number of hysterectomies at young ages taking place in AP without adequate medical justification needs to be urgently looked into and curbed. The commercialization of medical practice does not benefit persons or families and requires social control.

- There should be 24 hour PHCs functioning in every taluk for emergency obstetric care and CHCs should have gynecologists and anesthetists. Due to the shortage of anaesthetists medical officers with a 3 – 6 month training in aneasthesia could be authorized to give anaesthesia.

5. **Environment and Health**
Strong testimonies were presented from Kerala, Tamilnadu and AP on the adverse impact on human health resulting from exposure to toxins from industries / factories, and pesticides. This problem exists throughout the country.

Recommendation 5.

- The Department of Health at state and central level needs to have structural mechanisms through which it can function along with other agencies likes the pollution control board, ministry of environment and forests etc. to implement regulatory and preventive measures, and to provide for occupational health and safety, as well as access to medical care where environmental injury has occurred. In short there is need for a public health response to environmental health problems.

6. **Access to Essential Medicines and rational therapeutics**
The use of irrational and sometimes harmful, banned and bannable medicinal drugs and preparations was raised as an issue of concern in Kerala. This problem exists in all states.

Recommendation 6.

- Rational drug policies, essential drug lists standard treatment guidelines and formularies need to be adopted in the public and private sector, and more importantly they should be used and regularly updated.

- Existing and new mechanisms for continuing education of medical practioners and allied health professionals need to be actively used for this purpose.

- Measures to increase consumer awareness and good pharmacy practice need to be widely instituted.

7. **Trauma Care**
This came up strongly from Kerala, but is applicable in all states.

Recommendation 7.

- With the rising number of traffic and other accidents early trauma care using standard protocols need to be ensured through provision of infrastructure and training. Preventive measures such as use of helmets and seat-belts should be mandatory.

8. **Mental Health**

The following problems were experienced by groups working in the different states – lack of access to mental health care by rural poor due to centralized mental health care available mainly in city and town based institutions; stigma, discrimination and abuse; lack of medical and health personnel with adequate training in mental health; non-availability of drugs; lack of public awareness about mental health

Recommendation 8.

- Medical and psychosocial care and support for persons with mental illness should be available in a decentralized manner. This will require adequate training and continuing education. Public awareness and sensitivity also needs to be increased.

9. **Public Health issues**
Other public health issues raised included prevalence of Vit. A deficiency (AP); discrimination faced by patients with AIDS who required surgery (AP); death of TB patients due to lack of access to treatment (Karnataka).

Recommendation 9.

National guidelines regarding these public health issues need to be followed. Increasing community involvement and feeling of community ownership of health institutions and programmes would help in better outreach and quality. Training and involvement of community health workers / social health activists would provide a valuable link.

10. **Follow-up and monitoring of implementation of recommendations arising from the Public Hearings on the Right to Health Care.**

Recommendation 9.

- A mechanism needs to be established at state level for joint monitoring by the Jan Swasthya Abhiyan and officials from the state department of health regarding the follow-up of recommendations. They will report to the NHRC. NHRC officials may also visit to observe and monitor the follow-up whenever necessary. Accountability and communication with the local communities is of greatest importance.

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NORTHERN REGION PUBLIC HEARING
ON
RIGHT TO HEALTH CARE

26TH SEPTEMBER, 2004
LUCKNOW, UTTAR PRADESH

Recommendations at a Glance

Recommendations by The Northern Region Public Hearing, NHRC-Jan Swasthya Abhiyan:

Regulation and Monitoring

- Enactment of State Public Health Acts, which would outline the mandatory health care services that would be guaranteed at all levels of public health system as a right.
- Regulatory mechanism at state level to ensure the quality of private medical services by implementing minimum standards ,standard treatment guidelines and ceiling for costs of essential medical services.
- A system of regular independent review of the functioning of the public health system at state, district and community levels. This review ,every 3 to 6 months should involve JSA and other social representatives.
- An effective redressal mechanism for persons or communities who have suffered denial of health care in any form .This mechanism should involve JSA and other social representatives.

Strengthening public health system

- Tripling the public health budget in next five years, to increase it to at least 3% of SDP as per the Common minimum programme.
- Allocation of adequate budget for drugs, which would involve at least doubling of state drug budgets. Guarantee of essential drug at all levels.
- Provision of adequate infrastructure including buildings, equipments ,vehicles and maintenance for all public health facilities. Filling of all vacant posts at various levels.
- Women are often denied access to health care because of insensitive attitude of health staff and inadequate facilities. Keeping this in mind ,availability of all health services for both reproductive and non reproductive health needs to be guaranteed women friendly manner at all public health facilities.
- Universalisation of ICDS, including strengthening of child health related services. Guarantee of immunization, nutritional supplementation and other essential preventive child health services. Ensuring school health services and mid-day meals.

- A comprehensive statewide policy to provide primary health services to urban areas. Expansion of Urban Health care infrastructure, especially of health posts and of outreach health services.
- A new scheme to provide a community health worker in every village of the state should be launched. This should effectively involve communities,Panchayats and local organizations.
- Regarding mental health, much greater sensitivity towards mentally unwell, institutionalized patients , provisions for proper counseling and measures for rehabilitation and family contact.
- All coercive measures for limiting family size must be stopped immediately. The tubectomy camp approach, which often results in poor quality operative care and violation of various aspects of women's rights, needs to be reviewed.

State level recommendations:

Recommendations for Health Services in Delhi

1. There are three over-arching issues applicable to all public health institutions:
   a. With Delhi being a city-state and the national capital with a historical development of multiple local bodies there is a multiplicity of providers. The respective roles of Govt. of India, Govt. of Delhi and the local bodies need to be clearly spelt out and well coordinated.
   b. There is a need to rationalize and integrate the functioning of the public health agencies. The Dr. Pattanayak Committee had given its recommendations for restructuring the health services of the Municipal Corporation o Delhi in 2001-02 but it has largely been ignored. There is a need to consider its implementation.
   c. Health personnel (including doctors) need to be in position through regular appointments and their performance should be ensured through administrative and community regulatory mechanisms.

2. Strengthening of Primary Level Institutions
   a. Peripheral areas lack institutional coverage; these areas require special attention and should be expanded
   b. Equipment and infrastructure backup should be available in dispensaries and PHCs including laboratory support and emergency backup services
   c. Vacant posts of personnel should be filled up, their allocation rationalized and regular attendance and performance ensured
   d. The Maternal & Child Welfare Centres and Family Welfare Centres should provide full range of primary gynaecologic and paediatric services.
   e. The sub-centre network should e expanded in rural areas that should be linked to the respective PHCs.
   f. Public health programmes and personnel need to be reorganized/restructured and these institutions need to integrate with the local curative institutions.
   g. Involvement of local communities (through Local Health Committees, for example) in local level planning and implementation of services; the departments

of health, water, sanitation and social welfare should be involved and accountable to these local committees.

3. Secondary Level Hospitals

a. 100 bedded hospitals and 30/40 bedded colony hospitals should have full range of secondary level services operational from its inception; hospitals like Sanjay Gandhi Hospital, Mangolpuri took more than 10 years to develop all services – the present new hospitals are in a similar state.
b. The secondary level institutions should be linked with the local primary level institutions with a proper referral mechanism.
c. Secondary level specialty services and requisite equipment and supplies should be available.
d. Rational prescribing practices should be implemented.
e. Special emphasis needs to be given on environmental and occupational health problems

4. Tertiary Level Hospitals (all agencies)

a. The above measures will decrease unnecessary overload at this level.
b. Adequate supply of drugs and supplies, based on rational drug formularies, should be available.
c. Internal medical audit mechanisms should be instituted.

5. With strengthening of these three levels we should be able to ensure that social security services like CGHS, Railways and ESIC should not be sending their patients to private corporate institutions.

6. a. Reporting of notifiable diseases and medical certification of deaths should be strictly implemented by all institutions (government and private) and private practitioners.
b. Public should have access to information about availability of services at each level, availability of beds at a point of time; other linkages like networking of blood banks are also necessary.

7. a. Independent monitoring of health services through social audit
b. Grievance redressal mechanisms within each agency providing public health services.

8. There are 4 state level medical colleges and one national apex institute (AIIMS). There should not be any more increase in medical colleges. The content of medical education needs to be appropriate for operationlising the public health services as detailed above – including raining for managerial roles, a public health perspective and rational therapeutics. Training of field workers need to be strengthened.

Recommendations for Health Services in Himachal Pradesh

- Rationalization of staff
- Filing up of all vacant posts
- Contract system be abolished

- Free diagnostic tests and no user charges
- Each PHC should have a lady doctor
- Per Diem system for different trainings be removed.
- Incentive for trained birth attendant for promoting safe deliveries
- Basic facilities at sub centre level be ensured
- Separate and independent IEC Bureau be established with trained staff in health education.
- Work load of Anganwari workers should be decreased.

Recommendations for Health Services in Uttar Pradesh

- Establish, adopt, recognize health as a fundamental right of all citizens including vulnerable, displaces, slum dwellers and poor.
- The Primary Health care system should be made accountable to Panchayats in rural and urban areas including JSA.
- Privatization or commercialization of health should be totally banned and regulated by the state.
- Poor, marginalized, deprived, migrant and other vulnerable groups should be accorded identity, accessibility and availability of health care system free of cost.
- Indian system of Medicines should be treated at par with modern medicines and should be mainstreamed.
- Social security to senior citizens, children, disabled and women should be specially provided.
- All the policies related to health, child development and women empowerment should be seen in totality and not in isolation.
- All forms of user charges should be removed and health care should be provided free of cost.
- The denial of health care and negligent care should be made accountable to people and arrangement of redressed should be in place.
- The essential drug list should be made public and state should ensure the reasonably quality and adequate essential drugs to all health facilities.
- The incentive and disincentive in family planning programme should be removed.
- Two child norm and coercive population policies should be removed.
- Government should honour the "Health for all goals and adopt the PHA charter

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EASTERN REGION PUBLIC HEARING ON RIGHT TO HEALTH CARE

RANCHI

11 OCTOBER , 2004

Recommendations:

The public hearing on the denial of right to health care that was held in Ranchi on the 11th of October, heard a number of cases of denial from the five states of Bihar, Jharkhand, Chhattisgarh, Orissa and West Bengal.

Of the over 70 cases presented orally and about 150 cases submitted in writing, there were a few recurrent themes.These included

a. High degrees of illegal fees and denial of treatment if these are not paid – in public health facilities.
b. Poor quality of service in many public health facilities.
c. Absence of any services in remote tribal areas.
d. Denial of right to safe drinking water.
e. Lack of food security and malnutrition related illness.
f. Expensive, irrational drug prescription along with lack of availability of essential drugs in public health facilities.
g. Lack of emergency obstetric care services and safe abortion services
h. Lack of emergency services for a wide variety of emergencies -- notably accidents, burns, snakebites.
i. Lack of referral transport system to access emergency services.
j. Poor access to sterilisation services and poor quality of sterilisation services.
k. Weak public health response to epidemics and sudden increase in infectious deaths in certain areas.

After listening to the testimonies the panel has decided to take cognisance of only a small part of them as individual human rights cases . Though the other individual cases are also heart-rending the panel thought it more useful to pursue the systemic causes behind these failures. For these systemic issues that underlie the denial of the right to health care the panel makes the following 15 recommendations which are forwarded to the state governments for implementation.

1. A Vigilance Mechanism must be build up in each state health department with assistance and in coordination with the police department. This vigilance should be proactive and not only responding to complaints. Its focus should be to prevent illegal charges in public health facilities, and private practice inside public health facilities or in public hours.
2. All public health facilities should have display boards that state what are the legal user fees if any , declare that payments other than these are illegal and inform where to register a complaint in this regard.

3. Vigilance also needs to be exercised against unnecessary referrals to nursing homes, clinics, diagnostic services. To be effective on this the state governments have to issue orders disallowing public health staff from referring to nursing homes, clinics or diagnostic services where they have a monetary advantage or commission..
4. Monitoring structures for health programmes should be established/strengthened at the district and block levels with the inclusion of panchayat representatives and civil society partners who are active in advocacy work.
5. Monitoring structures for CHCs, civil hospitals and district hospitals should be established by either strengthening existing patient welfare societies or creating them. These would also have vigilance functions.
6. Independent of the above two there should be a grievance redressal mechanism where those who have been denied quality care- in the private or public sector- can go to for registering their grievance and seeking relief.
7. All areas which have had no doctor for over an year and all those areas which have had no nurse/midwife for over an year should be publicly notified as medically and paramedically underserved and a special package of measures must be undertaken to provide some temporary relief and access to care for these areas. (eg visiting doctor- pvt or public, mobile clinic, NGO, etc). This special package adopted may be made in consultation with all interested parties especially the elected panchayats.
8. States should have a transparent non-discriminatory transfer policy such that doctors and other paramedical staff serve by rotation in difficult areas. During such service in difficult areas a special package of measures including financial incentives to support such doctors should be adopted. These two steps are critical to address the problem of lack of doctors in difficult rural areas.
9. States should have a state drug policy and /or adopt a state drug action plan which ensures that the states formulate an essential drug list and all the drugs on this list are available at all public health facilities without interruption, and that the prescription and use of irrational, expensive drugs and the use of hazardous and banned drugs is curbed in both the private and public sector. This would also need to specify better drug information to both the patient and the prescribers.
10. The state should adopt a time bound action plan/road map by which the critical gaps in the provision of good quality emergency obstetric services,sterilisation services, safe abortion services, and basic surgical emergency services(burns , accidents) can be provided in a network of referral centers such that there is at least one such center per every 100000 population. This action plan should be a detailed publicly stated commitment and should have an year by year milestone, so that even if the entire plan would take ten years to implement, the monitoring committees and the public would know whether each year, that year's goals are being achieved.
11. The most immediate measure for closing specialist gaps in the referral center would be transferring of surgeons and gynaecologists and anaesthetists so that this norm for the provision of emergency and referral level care is met in as many facilities as possible. In the absence of a transfer policy well-qualified specialists

languish in peripheral centers losing their skills while key facilities, which needs their services, go without them.

12. The governments may publicly notify what are the services it would be providing at the level of the habitation, at the level of subcenters,at the level of PHCs, CHCs and district hospitals along with quality indicators. This should be accompanied by similarly graded standard treatment protocols. This is essential for public knowledge and for monitoring. This will also help prevent unreasonable expectations from the public – for certain services may be available only at the district or block level and not at every PHC as may be expected. But this needs to be publicly notified.
13. The governments should set up a medical services regulatory authority- analogous to the telecom regulatory authority- which sanctions what constitutes ethical practice and sets and monitors quality standards and prices of services – both in the public and even more importantly in the private sector.
14. A Public Health and Health Services Act that defines the rights of food security, safe drinking water, and other determinants of health and the citizens' rights to enjoy them along with the rights to medical services that are accessible, safe, affordable needs to worked out. This act would make mandatory many of the recommendations laid down above and would make more justiciable the denial of health care arising from systemic failures as had been witnessed during the public hearing.
15. Implementation of the Supreme Court order regarding food security and the need to universalise ICDS programmes and mid day school meal programmes remains a priority that this panel also endorses.

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RECOMMENDATIONS OF NORTH EAST REGIONAL PUBLIC HEARING ON RIGHT HEALTH CARE GUWAHATI DATE: 28TH NOV 2004

Budgetary Measures:

1. The state Health budget on Health budget on health care to be doubled with immediate effect.

2. The drug budget for PHC and CHC in the state should be doubled.

3. In the pre monsoon season, extra stocks and inventory of all essential medicines to be made available in government hospitals in rural areas to deal with possible disruption in supply.

4. Contingency plan to deal with healthcare arising during and post flood situation in the state with special staff assigned for such work.

Legal Measures:

1. **Enactment of a State Public Health Act** in each state, which would outline the mandatory health care services which might be made available to the people as a right at various levels of the public health system. This act would specify which services and standards of care must be made available at the community, sub centre, PHC, CHC, Sub-district and District hospital levels, as well as the preventive and promotive measures that the government would undertake.

2. Enactment of a **Clinical Establishment Regulation Act** in each state to ensure minimum standards, adherence to standard treatment guidelines and ceilings for costs of essential medical services in the private sector.

3. Private practice presently allowed to Government health care providers should be legally banned, and those doing it should be promptly punished.

4. Policy for primary health care in the state should be adopted and implemented.

5. Standard Treatment Protocol for treating of all common ailments should be prepared and enforced.

6. The clear and distinct regulatory act for private nursing homes should be made.
7. Public hearing should be organized on a regular basis in all the North Eastern State in every district of Assam.

8. Private practitioners should have a uniform and affordable rate to make medical treatment accessible to all.

Measures to improve functioning of the health system and attention to special groups:

1. Standard Treatment Protocols should be implemented regarding care to be provided at various levels of Health Care Facilities, so that the necessary quality is maintained.

2. The full range of comprehensive health services should be guaranteed at all levels of the public health system, these health services must be ensured as a right. In exceptional cases of failure by the public system to provide any such health service to a patient, there should be a mechanism wherein care may be sought from designated private facilities following standard treatment protocols. Such registered and regulated facilities could give relevant care to the patient, and the state could reimburse them at standard rates, ensuring that the patient is not deprived of any essential care at time of need.

3. Guaranteed availability of essential drugs relevant to the level of service, in all public health facilities. A mechanism to ensure that if any health care facility is unable to provide any of the essential drugs that are supposed to be available at that level of health care; the expenses incurred by a patient on this "outside prescription" should be promptly reimbursed. All health care providers in both public and private sector should prescribe according to the essential drug list, and prescribe drugs by their generic names.

4. A comprehensive statewide policy to provide Primary Health Services to urban areas. Adequate health services need to be provided in al cities and small towns.

Expansion of urban health care infrastructure especially of health posts and of outreach health services keeping in mind the needs of the growing slum population.

5. Filling up of vacant posts and construction of buildings for Sub centres and other facilities. A new scheme to provide a community Health Worker in every village of the state should be launched.

6. Regarding women's access to health care, availability of all services in a women friendly and sensitive manner at public health facilities must be ensured. This should include maternity services, pre natal and neonatal care etc.

7. A scheme for community Health Worker in every village should be launched.

8. Urban Health care infrastructure should be expanded and PHC services should be made available in all towns and cities. Emphasis should be given to slum dwellers.

9. Malaria is a major problem in the state. Special action plan to deal with malaria in the north east states with emphasis on vector control and ecological measure along with universal availability of anti malarial drugs.

Independent Social Monitoring and Redressal System

1. Apart from the above steps, a system of regular independent monitoring of the functioning of the heath care system at all levels should be taken up.

2. An effective redressal mechanism at block, district and state levels for persons with complaints regarding quality of health care and for those who have suffered denial of health care in any form.

- Enactment of a ***State Public Health Act*** in each state, which would outline the mandatory health care services which must be made available to the people as a right at various levels of the public health system. This act would specify which services and standards of care must be made available at the community, sub-centre, PHC, CHC, Sub- district and District hospital levels.

- Enactment of a ***Clinical Establishments Regulation Act*** in each state to ensure minimum standards, adherence to standard treatment guidelines and ceilings for costs of essential medical services in the private sector. For example, the ***Bombay Nursing Home Regulation Act 1949-Maharastra***, may be substantially modified and improved to effectively regulate the quality of private medical services in the state.

- The clear and distinct regulatory act for private nursing homes should be made.

- Public hearing should be organized on a regular basis in all the North Eastern States and in every district of Assam.

- Private practitioners should have a uniform and affordable rate to make medical treatment accessible to all.

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L-7A-B4

The Urban Health Services in India: Towards Prevention of Human Rights Violations

[*Submission at the National Human Rights Commission Hearing, National Level, New Delhi, 16th December, 2004*]

An Overview

The focus of public health services planning and development in post-Independence India has been, rightly, the rural populations. The urban population even today constitutes less than 30% of India's people and the urban health indices show a better profile than the rural. Yet several large and small studies have demonstrated the inadequacy of our State and society in providing basic and comprehensive health services, so essential for the Right to Life, to this relatively privileged population. All regional hearings organised by the JSA and NHRC on the Right to Health Care have provided evidence of violation of the right in urban people. While each state and region has its own special features, a national overview and some common issues are being highlighted.

- Urban areas constitute a wide diversity by size of population and land area, condition of amenities and health care services. (Tables in annexure). Water, sanitation, housing and other environmental dimensions become greater problems as concentration of people on land increases.

- Disparity of economic and social status is more marked in the urban areas as compared to the rural. 40-60% of all urban citizens live in the slums or unauthorised colonies with poor socio-economic status, poor housing and low standards of amenities. The health status indices of the different sections demonstrate a direct correlation between socio-economic status, the health of the poor even showing worse figures than the rural in some instances.

- On the other hand, the urban areas have the highest concentration of health services, both public and private.

- Public services in urban areas are relatively low at the primary level, especially in terms of community outreach. The secondary and tertiary services are more highly developed; all secondary and tertiary institutions are situated in urban areas. Private services are high at all three levels. The secondary and tertiary hospitals serve both the urban and the rural people.

- The lack of focus on the planned development of a 'comprehensive health service system' in urban areas has been officially recognised atleast since the 1980s, with the Krishnan Committee report of the central government.

- Major lacunae that clearly exist today are the following:-

i) Lack of access to services by the poor.

ii) Physical mal-distribution of services and mal-distribution of resources within the health services. The lack of peripheral services, multiple authorities providing services and overlapping responsibility of the institutions and agencies, as exemplified by Delhi's health services, leads to overcrowded hospital OPDs and wards. While rationalising of existing infrastructure has been repeatedly recommended, no action has been taken in this direction.

iii) Major weaknesses in functional quality of the public services exist because of the load on them, with a user profile that has lower resources to supplement the services provided than the private sector users. Nevertheless these cannot be reasons to excuse the kind of violation of rights of the citizens and of the patients coming to the institutions. Evidence of gross misinformation, negligence, poor social

interaction by doctors abounds. The rude, aggressive behaviour of paramedics and other staff of health institutions with those who come to these institutions in times of crisis for some solace can only be called criminal.

iv) While our focus is the provision of services by the public sector, impact of the private sector on the pubic services needs to be recognised. The private sector issues largely pertain to services in urban areas where they too tend to concentrate. The issue of free land to private corporates without their fulfilling the obligations in the contract are issues of urban governance. Public funds being siphoned to support the private sector through the social insurance (CGHS, ESI etc.), instead of going to strengthening of public services, are issues of concern. The private services also set up models of engage in greater practice of over-medication and prescribing of unnecessary medical interventions which, besides adding to costs also bring in iatrogenic diseases due to the side-effects etc., which adds to the burden on the public health services.

The Presentations in the Session

1. Mr. S.J.Chander, Community Health Cell, Bangalore, presents conditions from the Southern region, focusing on the issues of barriers to access to services of the urban poor.

2. Dr. C. Sathyamala, Epidemiologist, presents data from a recent study that highlights the impact of economic conditions, and that the poor still rely upon the public services despite the problems they face.

3. Dr. Kamla Ganesh, Retd Professor of Obs. & Gynae, and ex-MCH adviser to the Delhi govt., presenting findings of her excellent investigation into the reasons for maternal deaths of women coming to the IPP-VIII MCH centres for ANC/delivery. Basically highlights the institutional flaws and the need for support to health care personnel in performing their duties.

4. Dr. Sanjay Nagral's presentation on the Mumbai and Maharashtra situation and the impact of public private linkages in terms of access and the quality of services.

5. Dr. Rajib Dasgupta, Centre of Social Medicine & Community Health, JNU, presents the recommendations.

Recommendations for Preventing Human Rights Violations by the Urban Health Services in India

1. Rationalising the structure of health services

- Almost all large urban centres suffer from the problem of multiplicity of health service delivery agencies. The respective roles of state government and local bodies as health service providers in urban areas need to be clearly defined. Should local bodies be confined to primary health care services only? The general trend is that local bodies are resource-constrained and therefore the 'burden' of secondary and tertiary health care institutions are 'borne' by the state governments. Secondary and tertiary care institutions are/will almost as a rule be located in urban centres and also act as referral units for the general/district health services. That argument will *de facto* imply that urban local bodies confine themselves to the primary level only. Though the Bombay Municipal Corporation operates services at all level including medical colleges that is an exception than a rule as the financial health of the organisation supports such endeavours.

    - Recommendations of Committees appointed so far – Krishnan Committee, Pattanayak Committee– to rationalise and integrate existing public health agencies need to be adopted and implemented. The Pattanayak Committee was appointed in the aftermath of the Dengue Epidemic in Delhi to restructure the services of Municipal Corporation of Delhi. It

essentially recommended reorganisation of the services on the basis of municipal wards and suggested changes for personnel and services to that effect. It also recommended strengthening of certain key public health institutions like Infectious Diseases Hospitals. Epidemiology Units and Public Health Laboratories for epidemic forecasting and better management of outbreaks, particularly of infectious diseases.

- Public health programmes operate vertically in most urban areas. Though Ward Health Units exist in some cities/towns, rarely do they deliver integrated comprehensive services. What is delivered is (as is common in the rural system also) selective primary health care or programmes in campaign/mission mode like Pulse Polio. There is a need to integrate and rationalise the manpower and services.

- Prevention programmes need to address all sections rather than target only the poor. Urban local bodies, and their personnel, are oriented largely towards slum populations. However, public health cannot be bought 'off the shelf' and urban local bodies will have to address all sections of the population more comprehensively rather than adopting a sectoral approach. It means that non-slum areas get ignored this is reflected in various house-to-house campaigns. Vector breeding is actually often higher in better-off households that have more containers.

- Support services like blood banks, ambulance services and hearse van services should be networked with all level of institutions for efficient functioning and reduction of response time.

2. ***Strengthening of Primary Level Institutions :***

   - Peripheral areas of towns and cities (generally populated by poorest segments) often lack institutional coverage; these areas require special attention and institutional coverage should be expanded.

- All health posts should provide outreach services to slum and slum like areas through ANM and MPW.

- Monitoring primary health services should be included as a responsibility of the Ward committees.

- New guidelines on the role and functioning of the health post system in view of an integrated and decentralised primary health care programme need to be developed and implemented uniformly across all the Municipal bodies in the state.

- Equipment and infrastructure backup should be available in dispensaries.

- Vacant posts of personnel should be filled up, their allocation rationalised and regular attendance and performance monitored and support provided against the inherent medical and legal hazards of the occupation.

- Maternal and Child Health Centres / Family Welfare Centres should provide full range of primary gynaecologic, obstetric and paediatric services; special emphasis needs to be given to emergency services and institutional deliveries whenever indicated.

- There is a need to train and integrate *dais* who operate in lower income groups of urban areas with the formal primary health care system.

- Public health programmes and personnel need to be reorganised/restructured and these institutions need to integrate with the local curative institutions.

- Communities (through Local Health Committees, for example) should be involved in local level planning and implementation of services; the departments of health, water, sanitation, education and social welfare should be involved and accountable to these local committees.

- The experience of contracting of service delivery to private agencies and NGOs, e.g. School Health Services, immunisation services, IEC field campaigns and cremation ground services should be reviewed; comprehensiveness of services, coverage, follow-up, cost-effectiveness and sustainability should be some of the criteria on which the 'new' services are to be evaluated.

- Birth and death registration procedures should be made transparent and citizen friendly.

3. ***Strengthening of Secondary and Tertiary Level Institutions***

- Primary and secondary level services need to be available and accessible to prevent overload of tertiary hospitals, that is almost a rule across urban centres of India. These institutions should be linked with the local primary level institutions with a proper referral mechanism.

- Secondary level speciality services and requisite equipment and supplies should be available.

- Rational prescribing practices should be implemented. Experience of Delhi and other cities where efforts have been made in this direction should be reviewed and lessons drawn.

- Adequate supply of drugs and other consumables, particularly, live saving drugs and equipment must be ensured. The purchase procedures should be transparent. The model of Tamil Nadu Medical Supplies Corporation can be adopted.

- Special emphasis needs to be given on environmental and occupational health problems.

- Social security services like Central Government Health Services (CGHS) and Employees' State Insurance Corporation (ESIC) and other employee medical benefits in public institutions should not refer patients to the private corporate hospitals and instead should integrate and network with secondary and tertiary level public institutions. This will allow public funds to be used for strengthening of public services rather than be siphoned off to private services. It will also build pressure for the strengthening of public institutions.

4. ***Institutional Structures and Procedures for Constant Monitoring and Strengthening***

- Clinical auditing of deaths of patients can go a long way in making the services sensitive to their own weaknesses in patient management practices. This should be made mandatory and brought back as a live practice so as to improve medical care and prevent negligence.

- Grievance redressal mechanisms must be available within each institution and for public health services as a whole. Measures for informing users of the services about the mechanisms must be a responsibility of the institution and the health services.

- Social audit mechanisms must be instituted to make the services responsive to community needs.

Co-ordinator: Dr. Ritu Priya, Centre of Social Medicine & Community Health, JNU.

L-7A.5

Health of the urban poor in Karnataka

Areas of concerns

By S.J.Chander
Community Heath Cell

Introduction

AT least 22 per cent of Karnataka's urban population lives in insecure and unhygienic urban slums. In September 1999, the Karnataka Slum Clearance Board (KSCB) identified 2,322 slums in the State with a population of around 23.79 lakhs, which is 17 per cent of the total urban population. Bangalore alone accounted for 362 slums with a population of 5.9 lakhs. This appears to be an underestimate of the actual figures.

In 1993 itself the National Sample Survey, 49th round estimated the slum population was at 32.2 lakhs, making it around 23 per cent of the total urban population in the State. The same study estimated the population of Bangalore's slums at 10 lakhs[1]. Bangalore experienced an exponential growth of slums in the 1990s, from 444 slums in 1991 with a population of 1.12 million, to 763 slums with 2.2 million in 1998-99 with a population of, about 20 per cent of the city's population. The most recent data, from the 2001 Census, lists 733 slums in Bangalore. (The Hindu, June 3, 2003)

The present health care services made available for the urban poor are family welfare and family planning oriented. The word Primary Health Care has been used inappropriately by many agencies including the government and voluntary organization. Their understanding is no way close to the definition for Primary Health Care that the World Health Organization (WHO) gave during the Alma Ata declaration in 1978.

It is presumed that urban poor do not lack health care facilities, as most of the health care facilities are concentrated in the urban areas. This may be true but the question for which one must find an answer is to what extent these facilities are really accessible, available and affordable to urban poor. The present model excludes the important elements such as water and sanitation, Health education in the Primary Health Care Approach that the WHO advocates. Treatment of minor ailment is also inadequate and unsatisfactory which is one of the eight elements of Primary Health Care specified by WHO. Recent interaction with some of the community members revealed that some of the urban health centers do not have anti rabies vaccines and treatment for tuberculosis. The health problems faced by the urban poor are largely due substandard living conditions and lack of health awareness. Alcoholism and Tobacco are another major problems, which takes away limited economic resources available for the families. The problem of alcoholism not only takes away the resources, it constantly causes psychosocial problems in the families. Unless these issues are addressed satisfactorily improvement in the health status of the poor cannot be achieved.

[1] Karnataka Housing Revolution, Parvathi Menon in Frontline Magazine, Vol 19, Issue 13 June - July 5,2003

Substance abuse, exploitation by unqualified providers (quacks), and use of hazardous biomass fuels for cooking have direct health consequences that are often overlooked.

Alcoholism

Alcoholism is another major problem that puts pressure on the limited income of the urban poor. The survival of the alcohol industry to a large extent depends on the poor. The major portion of the income that the man earns goes in for alcohol, depriving the families the money for nutritious food and educational needs. One of the serious consequences of alcoholisms is violence, particularly against women. Do we need more studies to confirm to get into action?

Water and sanitation

The urban poor not only suffer from inadequate water supply and sanitation, they also suffer from poor quality of services that area available to them. One fifth of all urban households lack access to water supply and 60 percent of urban households live without access to sanitation. In slums, 40 percent of households are without access to safe drinking water, and 90 percent without access to sanitation. Per capita daily consumption of water in Class I cities is less than 142 litres, reaching a low of 50 litres in some cities.[3]

Recently, Jansahyog a (Bangalore based voluntary organization) collected water samples from 12 slums. The results revealed that all the 12 samples were contaminated. A report published by UNDP titled 'Urban Poverty and Deprivation' gives the following statistics regarding the health status of the urban poor; diarrhoeal deaths account for 28 percent of all mortality, while acute respiratory infections account for 22 percent. Nearly 50 percent of urban child mortality is the result of poor sanitation and lack of access to clean drinking water in the urban slums.[4] One of the testimonies presented for the public hearing in Bangalore, a 14-year-old girl died of gastro enteritis. She was treated by a private practitioner who was a quack. She could have been saved had she been to qualified health personnel. However the primary cause of the problem is due to water and sanitation.

Housing

By the year 1997, the total housing shortages in India was estimated at 13.66 million units, out of which 7.57 million units would be in the urban areas. More than 90% of this shortage is for the poor and the low-income category. In 1999, the Karnataka Slum Clearance Board (KSCB) identified 2,322 slums in the State with a population of around 23.79 lakhs It is estimated that there are about 2,60,000 households in the slums of Bangalore city. Only 10% of the slum household in the Bangalore city has RCC roofing, which is built by government, NGO/CBO and the communities' themselves.5

Land

The living conditions where the urban poor are living in most places are far below the standard for human habitation, lacking potable drinking water, facility for disposal of solid and liquid waste and housing. The majority of the slums are located on the land owned by the Government/Municipality or private landlords. People who are residing on non-declared slum are constantly under the threat of demolition and eviction. Many of the services of

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[3],[4] www.UNDP India-reports-urban poverty

[5]. PROOF Network, Bangalore

government programmes are not extended to non-declared slums. They are deprived of both the health services and basic amenities. The Karnataka Slum Clearance Board (KSCB) has the authority to declare a slum under section 17 of the Karnataka Slum Areas Act 1973

Health care delivery services for the urban poor

The process of urbanization further adds pressure on the limited resources available to the urban poor. The existing health care facilities provided by the Bangalore Mahanagara Palike (BMP) which has; 38 maternity homes, 6 referral hospital, 55 health centers developed under the IPP VIII Programme and 19 family welfare clinics are barely sufficient for the 12 percent of the five million residents of Bangalore city (The Hindu daily 4th January 2003) the same report comments that bulk of the budget goes for solid waste management and salaries of the staff at the dispensaries and hospitals. The report also said that essential drugs are not available for poor free of cost and the poor cannot afford to purchase them from private chemist shops. These services may be geographically accessible but does it cater to the needs of the people living in the slums. Regarding availability, it is the private practitioners who are available at the time of need and convenient to the urban poor.

Health services provided by the BMP are largely family welfare and family planning, which is only one of the eight elements of the primary health care approach, suggested by WHO. These services have many problems such as:

Inadequate staff
Of the 36 vacancies, 9 of them are on study leave ranging from 2-5 years. BMP has recently recruited 6 doctors. Remaining 21 posts are vacant and it is likely to be vacant until the government changes its policy on recruitment. At a group discussion held among the self-help group members around an urban health centers Bangalore, the participants said " *Doctors are not available in the health center, they are very irregular. The doctor comes late and leaves early. If doctor is there, the nurses won't be there. Even if they are available do not provide good care.*"

Corruption
Though services at the all the urban health center are supposed to be given free but none of the services are available free of cost to the urban poor, whether it is during out patient or in patient care. The participants during the group discussion said, *"If they give an injection and tablet they demand Rs.15"* the practice of demanding money for showing the babies to the mother and her relatives after delivery still continues. The staffs at the health center demand Rs. 400 for the male child and Rs.200 for the female child. The women delivered said unless one pays the staff would not attend. A woman stays closer to a health center said they demand money Rs.500 to Rs.600 for conducting medical termination of pregnancies. Many women who are unable to pay carry on with the pregnancy though they don not want another child within a short space.

Ill-treatment
Women who have undergone the experience of deliveries said they the words the health staff use are humiliating. They said the verbal abuse takes place when they were not able to push the baby during labor. Some of them have experienced physical attack such as pinching badly on their legs and thighs. Another women who went to government hospital for treatment of cancer of the esophagus received the worst from the staff. While disclosing her the diagnosis

she was told, " the disease that you got will kill you. When she went for chemotherapy the health staff scolded her when she had to remove her magalsuthra " you are going to die, why do you need this, this has only cultural significance. She said by hearing this she wept bitterly.

People's perception of their needs

A study conducted by Commonwealth Association for Mental Handicap and Development Disabilities (CAMHADD) recently elicited the following as the priority of needs of the urban poor; safe drinking water, toilet, underground drainage, trauma care, education and prevention of alcoholism and empowerment of women to resist alcoholism. The report also emphasized the need for creating better job opportunities and motivation of better living conditions.[6]

A group discussion held recently among the self-help group members in a slum reveled the following: *"They give same medicine for all problems, the medicine they give does not help us get cured."* They gave these suggestion for improving; Doctor should be available till 4.00 pm and treat them well. The place should be kept clean

Conclusion

There is a need for improving the quality of existing services particularly with regard to staff attitude; keeping the health centers corruption free and keeping them clean. The present health care delivery system should move beyond family welfare, family planning to comprehensive primary health care focusing on determinants of health. It should give greater emphasis on preventive and promotive aspects.

[6] Indian Express, 28th February 2003

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Policies Affecting Health Care and Violation of Health Rights

Presentation by the Jan Swasthya Abhiyan

National Public Hearing on Right to Health Care
Jointly organised by the National Human Rights Commission and Jan Swasthya Abhian
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Section I: The Policy Framework

Health services in India at the time of Independence were a function of the socio-economic and political interests of the colonial rulers. The post - independence era witnessed a real effort at providing comprehensive health care, and in extending the infrastructure of health services. However the improvements in our health delivery system did not match the needs of the vast majority of our people. After initial efforts in the first two decades after independence, the country's commitment to providing affordable and easily accessible comprehensive health care services suffered due to lack of adequate resources being pledged for the same. So much so that the Govt.'s "Statement on National Health Policy"(1982) was forced to state "In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern."

Thus, neither the stated commitment of the Government, nor its implementation, was able to make a significant dent in the status of health or in health care delivery systems. In addition, the impact of an urban elitist bias in medical education as well as in medical services detracted from the ability of the Indian State in providing Health care to the poor as well as those in rural India. Continued emigration of doctors, rush for super specialities, development of corporate hospitals and polyclinics, and an incredibly large and near universal trend to irrational use of drugs and technology are all trends that are a consequence of this bias. As a result, the major disease-load of the population has continued to be unacceptably high and, in recent years, health indicators like Infant and Child Mortality Rates have started stagnating after the downward trends seen earlier.

As noted earlier, the Indian State's allocation for health care has been extremely low by global standards, resulting in a large majority of people having to access the private sector. Even the meagre allocation for health has not been optimally utilised, resulting in extremely poor quality of services provided by the public sector. Thus, to a very large extent, health services and health care in India tends to respond to the existing 'market demand'. The vast health needs of the majority of the people do not figure as part of this "demand" for there is neither the awareness nor the organization nor their participation in the making of these decisions. This trend has accelerated since the initiation of neoliberal economic reforms in the country from the late 80s

Neoliberal "Reforms" – Impact on Health Care

This situation was compounded with the initiation of neoliberal economic reforms in the country in 1991. These reforms marked a major shift in the government's policy towards social sectors like health. These policies sought -- by way of fiscal austerity measures -- to cut Govt. spending and subsidies in social sectors, reduce direct taxes, increase administered prices, liberalise trade by reducing tariff rates and providing other incentives for foreign investments, privatise public

enterprises, deregulate the labour market, etc. The policies were designed to clear the path for withdrawal of the State from the social sectors like health, education, food security, etc. The ideological barrage associated with the reforms package served to confer legitimacy to the virtues of the private sector and the market. In the process, the supposed inability of the state to sustain funding of education, medical care and public health, programmes for provision of drinking water, etc., seems to have gained acceptance.

The immediate fallout of the new policies was a cut in budgetary support to the Health sector. The cuts were severe in the first two years of the reform process, followed by some restoration subsequently. Thus, outlay on Health fell from 1.9% of plan investment in 5th Plan to 1.6% in first two years of 90's, and then increased marginally to 1.8%in 8th Plan outlay.This squeeze on the resources of states was distributed in a fairly secular fashion over expenditures incurred under all developmental heads. Health care was a major casualty as the share of states constitutes a major portion of expenditure. A similar kind of squeeze in resource allocation was felt in all programmes, largely financed by the states, including water supply and sanitation. As a result of the rollback on expenditure on health care, the expenditure by the Govt. on health care has fallen from 1.4% of the GDP in 1991 to 0.9% in 2002.

Compression of funds available with states has had a number of far reaching effects. Generally, expenditures on infrastructure (buildings, rentals, salaries, etc.) tend to take up an inordinately large part of total expenditure. They constitute 70-80% (or more) of expenditure for most major programmes, and the trend is most distorted in the case of rural programmes, viz. rural hospitals and primary health centres. Faced with limited funds, the burden of cutbacks are increasingly placed on supplies and materials. Ultimately a skeletal structure survives, incapable of contributing in any meaningful manner to amelioration of ill-health.

Expenditure patterns on health care are grossly skewed in favour of urban areas. Expenditure cuts further distort this picture with the axe on investment falling first on rural health services. As a result of this rolling back of state support to health care the first major casualty in infrastructure development has been the rural health sector. There has been a perceptible slowing down in infrastructure creation in rural areas.

The extent of cuts in health sector funding by the state and the consequent impact, as part of the reform process are, in a sense, peripheral issues. The central issue that needs attention is the theoretical underpinning of the reform process vis a vis state involvement in social sectors like Health. It is important to note that structural adjustment policies are geared to restructure the economy in a certain manner and not to improve welfare measures. Reforms initiated in this country and elsewhere start from the premise that present levels of subsidies to the social sectors are unsustainable. So prescriptions for restructuring of the health sector are designed, not to provide the best possible health care but to maximise outputs from greatly reduced state support.

India's situation in terms of spending of Health Care is different from most developing countries on two counts. At 6% of GDP spent on health care, India spends more on health care in percent terms than most developing countries. At the same time, at 16%, government spending of the total expenditure on Health Care, India ***is one of the lowest in the world***, both in actual terms as well as in percentage terms. It may be contrasted with 70-80 per cent share of expenditure on health care by governments in most of N.Europe, and even the 44 per cent expenditure by the government in the U.S. While successive Five-Year Plans have shown a fall, in percentage terms, in allocation for health care, the present *mantra* of liberalisation is being used to legitimise further privatisation in the health sector. Health expenditure in India is thus already heavily distorted in

favour of the private sector. It should be understood that the extremely low level of public funding in India is not a new phenomenon. In fact successive Five Year Plans have shown a fall in percentage terms, in budget allocation for health care.

There has been little effort towards sustained investments to build up health care infrastructure in the country. To be fair, periods of stagnation have been punctuated by sporadic efforts to enhance public health funding. Mention may be made in this context of the National T.B. and Malaria programmes of the fifties and sixties and the Primary Health Care Programme in the late seventies and early eighties. In the case of all these programmes, much of the earlier gains were frittered away as the initial infrastructure created was not supported in later years by matching investment. In fact between 1985-86 to 1990-91 there was already a major slow down or decline in State expenditures on Medical and Public Health. This was more glaring in the case of capital expenditures for setting up of new infrastructure.

Misplaced Emphasis on Vertical Programmes

This is not to suggest that optimal use has been made of public health expenditure in the country before the reforms process. In fact, quite to the contrary. Much of the blame for what is today being termed the "resurgence of communicable diseases" lies in strategies adopted well before the reforms programme in the country. These strategies relied on various centrally administered programmes (vertical programmes) for disease control and prevention. Such programmes included the National programmes on Tuberculosis, Malaria, Leprosy, Immunisation, Diarrhoeal diseases, Blindness and Family Planning. With no integration at the level of delivery, these programmes were insensitive to local conditions, unresponsive to local needs, highly bureacratised and inefficient. These programmes were accountable to officials situated in the national and state capitals, and had little or no scope for flexibility based on local conditions. Local populations were indifferent and in some cases hostile to such programmes, resulting in fair measure to the very poor utilisation of Government health facilities in many areas.

Oblivious to these trends the government has geared itself towards the show-casing of the "market orientation" of health care policies. Investment in the private hospital sector was very low in the 1970s, but since then it has grown at an exponential rate. This was fuelled by a slowing down of investment by the State and simultaneous incentives given to the private sector in the form of soft loans, subsidies and tax exemptions. In recent years new medical technologies have further added to the impetus, with increasing participation from the Corporate sector. This coupled with the impending entry of insurance multinationals, has cleared the path for the Indian health care sector being taken over by forces that control the global "market" for health care. In the process, the health needs of an overwhelming majority of Indians are being increasingly ignored.

Penetration of the Private Medical Sector

The abandonment of the government's basic duty in providing health care facilities has greatly enhanced the ability of the private sector to penetrate into the health sector. The distinction between health care and medical care is important and needs to be noted. *Health care* involves a lot more than just medical care, i.e. diagnosis and treatment of illnesses. Health care involves nutrition, drinking water and sanitation facilities, good housing, and a lot more. These aspects of health, for obvious reasons are not provided by the private medical sector.

But what of the medical care that is provided by the private sector? There is a fundamental contradiction that exists in the concept of private medical care. By definition private medical care can survive only if it is profitable. What logically follows is that a private medical care provider stands to profit from ill-health—*the more people fall ill and the longer they remain ill, the larger the profit for the care provider!* Additionally, as the poor have less money, much of the so called 'quality'private sector tends to be concentrated more among the better off citizens while the "quacks' serve the poor.

We have commented earlier about the fact that developed economies continue to pledge resources on public funded health care—to the tune of 70-80% of total health care costs. They do so, not out of any altruistic motives, but because conventional wisdom dictates that health care in the private sector is expensive and inefficient. And yet, our government wishes to argue that privatisation of health care leads to more efficient utilisation of resources!

In spite of all the virtues of the "free-market" that are being sought to be foregrounded, the private sector is thriving because of a host of direct and indirect subsidies it receives from the government. It is ironical that a government which declares that it makes poor economic sense to "subsidise" health care for the poor, provides such subsidies to the private and corporate medical sector, which caters exclusively to the needs of the rich. Thus, after providing medical education at a very nominal cost the government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals.

The government also provides incentives, tax holidays, and subsidies to private pharmaceutical and medical equipment industry. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially for expensive new medical technologies. *The government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes, thereby exempting them from contributing to the state exchequer even while being allowed to make huge profits*. Moreover, medical and pharmaceutical research and development is largely carried out in public funded institutions but the major beneficiary is the private sector. Many private practitioners are given honorary positions in public hospitals, which they use openly to promote their personal interests.

The decade of the nineties has seen another transition taking place in the private health sector. Prior to this, the private sector consisted of a large number of individual practitioners and private hospitals and nursing homes run by medical professionals. For the first time, today, we see the entry of the *organised corporate sector* in medical care. As the practice of medicine becomes more technology intensive, the role of the medical professional is becoming narrower. The control of technology has thus become the key factor in determining who or which entity controls private medical care. Corporate entities, given their ability to invest in "state of the art" medical technologies, are fast wresting control of the medical care "industry". Henceforth, the return on investment made by such corporations, and not any esoteric concept of professional ethics, will determine the kind of care provided. As corporates try to maximise profits they will attempt to further push up cost of medical costs by introducing high cost technologies, and expensive diagnostic aids and medicines. This is not merely an imaginary futuristic scenario. In the United States, such an approach to medical care has lead to health care costs being the highest in the world. Alongside the move towards reduced support to health care facilities, the government's new-found fascination with health insurance is designed to facilitate privatisation of the health sector.

National Health Policy 2002

The National Health Policy announced by the Government in 2002 is a continuation of the trends indicated earlier. An examination of the new policy shows that is most eloquent where it is silent. It completely omits the very concept of comprehensive and universal health care and in fact primary health care itself is reduced to primary level care!. In contrast, the National Health Policy of 1983 (NHP 1983) had said: "India is committed to attaining the goal of "Health for All by the Year 2000 A.D." through the universal provision of comprehensive primary health care services". The new policy, thus, departs from the fundamental concept of the NHP 1983 and the Alma Ata declaration of 1978, for "Health for all by 2000" to which India was a signatory. Though it does mention the importance of investing in infrastructure, the new policy is conspicuously silent on the concept of the village health worker -- the first contact in the primary health care system or on the need to have good public referral services. By its silence, the policy provides a framework for the dismantling of the whole concept of primary health care. Significantly, the section on policy prescriptions is entirely silent on the content of the primary health care system.

Similarly while there is talk of the need for standardised regimens of treatment and the need for essential drugs, it does not take on the issue of the need of price control for drugs. Also the policy is practically silent about pharmaceuticals and their impact on health care -- thereby virtually accepting that the Ministry of Health has no role in formulation of the drug policy. This is even more surprising given the fact that a new Drug Policy was announced by the Ministry of Industry in 2002 just a short while after the announcement of the Health Policy. The new drug policy has recommended further relaxation of price and production controls on drugs.

Other important concerns are either ignored or referred to only in passing in the new policy. The importance of an intersectoral approach in health planning is mentioned only to be ignored . In the same way the policy has a four-line section on women's health, without any specific proposals being spelt out. Child health is not even afforded a separate section, and is dealt with through passing references. It is silent on child nutrition in spite of the shameful fact that a half of children below 5 are malnourished in India - a dubious distinction that India shares with only one other country (Bangladesh) in the world.

The policy betrays a total lack of understanding regarding the need to create a medical education system oriented to the needs of primary care, and instead is steeped in the bias of urban specialist-based health care. On the other hand it is entirely silent about the bane of private medical colleges and the need to stop the setting up of new private medical colleges and regulate these institutions.

The section on Research in the policy harps on "frontier areas" and medical research. There is no understanding of the necessity to initiate and sustain research on public health. There is no mention of the necessity to regulate medical research and to develop ethical criteria in this regard.

A perusal of the new policy throws up many fundamental concerns. The policy admits that public health investment has been "comparatively low". The policy recommends welcome increase in public health expenditure from the present 0.9% of GDP to 2.0% in 2010. However the quantum suggested is too little and comes very late. It falls far short of the 5% of GDP that has been a long-standing demand of the health movement and recommended by WHO long back. Moreover the Draft projects that public expenditure in 2010 will be 33% of total health expenditure - up from the present 17%. But even 33% is lower than that of the average of any region in the globe today - India would continue to be one of the most privatised health systems in the world even in 2010! While even the small increase in health financing can make some difference this can only happen if distribution is equitable and if the allocation of resources is to improve services in

backward areas and not for increasing use of technology or subsidy to the private sector. While the document does mention that part of the allocation would be used for strengthening infrastructure it does not say where and other issues of allocation are however apparently not important enough to merit discussion in the policy document. The policy also is eloquent on the inability of states to increase expenditure on health care and laments that the allocation by states has in fact decreased in the past decade. There is a veiled attempt to castigate the states for their inability to increase expenditure. Such insinuations are uncalled for without a detailed analysis of the manner in which the liberalisation process has shattered the financial stability of states.

Top-Down Prescriptions

The new policy, for all the rhetoric on community participation, is replete with "top down" prescriptions. While admitting the wastage involved in running Centrally sponsored and controlled vertical disease control programmes and envisaging their integration in the decentralised primary health care system, it goes on to recommend that we would need to retain many of them! On the other hand the policy is delightfully vague about actual devolution of responsibility and financial powers to Panchayat Raj Institutions (PRIs) and relocation of accountability to appropriate levels of local self-governments. In the absence of such clarity there is the danger of the primary health care system becoming a Collector driven exercise, which is controlled by the Centre — thereby defeating the entire effort at decentralisation. In fact the policy suggests that local self-governments be 'assisted' by social activists, private health professionals, MLAs/MPs and Govt officials.

The policy also has a rather naïve understanding of the reasons for lack of utilization of OPD services by the public. They seem to feel that providing drugs (though an important part) is all that is needed – the poor quality of, or lack of other equipment, the absence of staff as well as the emphasis on Family planning are all not even realised! Again, the vision of further training of and extending the duties of paramedicals totally overlooks the fact that these personnel are already overworked

Prescriptions for Further Privatisation

Numerous formulations in the policy, in various forms, clear the way for even greater privatisation of the health care system. The policy says, "*the NHP will ..... suggest policy instruments for implementation of public health programmes through individuals and institutions of civil society*". This constitutes a veiled attempt to clear the way for sub contracting public health to NGOs. The policy proposes to employ user fees in public hospital, couched in the usual sugar coating of it being introduced for those who can pay. Global experience of user fees at any level shows that they serve only one purpose — to drive out the poor and the indigent. Proposal of user fees in a Health Policy is objectionable. The policy suggests targeting of primary health care for resource allocation but this should not constitute an argument for the legitimisation of the government's retreat from providing comprehensive and quality secondary and tertiary care. The policy hints at this possibility in different sections and also hints at "encouraging" the private sector to occupy the space that would be left vacant. It conveniently forgets that part time doctors will lack commitment even more that present doctors. It also ignores the implications of privatization for the National Health Programs. The policy document also discounts the data that shows that for critical inpatient care 45% of the poorest continue to depend upon the public sector hospitals.

The policy talks about using Indian health facilities to attract patients from other countries. It also suggests that such incomes can be termed as "deemed export" and should be exempt from taxes. This formulation draws from recommendations that the industry has been making and specifically from the "Policy Framework for Reforms in Health Care", drafted by the prime Minister's Advisory Council on Trade and Industry, headed by Mukesh Ambani and Kumaramangalam Birla. Such a proposal, termed by many as "health tourism", will divert our best resources to serve the interests of the global health market and create islands of brain and resource drain within the country. The use of domestic facilities for treating patients from outside the country may be encouraged only if such use is restricted to less than 10% of the facilities of any institution. The policy also, talks of encouraging "*the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages*". Further, there are repeated references in the policy about "valuable" contributions made by the private sector and the need to "encourage" more such contributions. While the policy is repeatedly critical of the public health system (justifiably so) there is no criticism of the ills of the unregulated private medical care system, though reference is made to the need to develop regulatory norms.

In brief, the new policy identifies many of the gross deficiencies of the existing health care scenario, proposes a substantial rise in central government expenditure on health care and has some other positive features like the proposed regulation of the Private sector. However, it constitutes an abandonment of the Alma Ata declaration, and legitimises, further privatisation of the health sector.

Policy on Population Control - Targeting Women

Population control policies in India have changed in nomenclature in the last 4 decades. But what has remained constant is that they have been a major obsession for planners in this country. However, evidence indicates that the programme can hardly be held responsible for the few success stories in population planning in the country - Kerala and Tamil Nadu. Kerala's success in achieving results comparable to the developed world - vis-à-vis both demographic and health indicators - have been widely attributed to factors such as high minimum wages, land reforms, high literacy rates and access to universal health care. Much of Tamil Nadu's success in pegging down birth rates in recent years is being attributed to improved child survival due to the massive statewide feeding programme for undernourished children and improved communication facilities. Both experiences strengthen the maxim that ***"development is the best contraceptive".***

Population control strategies have tended to be paternalistic, prescriptive and coercive. It is a strategy which starts from the belief that the poor breed prodigiously and it is the nation's duty to cap their unbridled fertility. Such programmes are inappropriate not only because they victimise women, but also because they do not work. Such a strategy has undermined the effectivity of the general health care infrastructure as well as the faith that women have in this infrastructure to address their real concerns. Most programmes, have tended to view women as assembly line appendages required to produce babies. Thus a woman's health becomes important only when she is pregnant or lactating. But in India 65% of deaths in women are due to infection related causes and only 2.5% of deaths are related to childbirth. Even among women in the reproductive age group only 12.5% of deaths are due to childbirth associated causes. Gender discrimination starts very early. Girls are more likely to die than boys, between the ages of 1 and 5 years. The risk of dying at that age is **43% higher for girls** -- ***one of the largest sex-based mortality differences in the world.***

In the last decade, driven by the growing consensus against coercive population control, the emphasis has sought to be shifted from Population Control to Reproductive and Child Health (RCH). Unfortunately the gaze of the programme is still firmly fixed on women as targets. Nomenclature notwithstanding, the new policy carries within it the basic core of earlier policies, which made them unacceptable to large sections of women in this country. Women need access to family planning services because of their own health needs. But such access has to ensure that women have a choice, that women are in a position to make decisions about their choice. In order for a policy to centre-stage women's concerns and needs, it should revolve around a package that addresses women's health in all its dimensions and not just their wombs.

The National Population Policy (2000) was an advance because it clearly stated that incentives and disincentives would not be part of the National Policy. It affirmed the "*commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services*". Unfortunately this has translated poorly into actual action and coercion remains a cornerstone of the State's attempts at population stabilisation. In fact many State Governments, have legislated to promote the so called "Two Child Norm" and continue to use coercive methods like laws that disbar people with more than two children from contesting local elections.

The promotion of the two-child norm in a gender insensitive society has led to a number of distortions. The most glaring is the ***rapid proliferation of the heinous practice of sex-selective abortions***. The recent census data showing a rapid fall in child-sex ratios across the country is a matter of extreme concern.

Pharmaceutical Policy

The first comprehensive National Policy on pharmaceuticals was announced by the Government in 1978. Since then the Policy has been revised in 1986, 1995 and 2002. Unfortunately the Policy continues to be formulated by the Ministry of Chemicals and Fertilisers and not by the Ministry of Health. As a result the Policy has always been deficient in addressing issues related to health and access.

The Policy announced in 2002 brought in new changes aimed at allowing a rise in drug prices. In 1995 the number of drugs under price control had been slashed from 142 to 74. This had led to an immediate spiral in drug prices. The New Policy has further reduced the number of drugs under price control to just 25-30. There is a prevailing myth that drug prices in India are the lowest in the world. This is at best a partial truth. Drugs that are still Patent Protected are much cheaper in India due to India's earlier Patent Act. It should be obvious that we would lose this advantage after amendment of the Indian Patent Act of 1970. But off-Patent Drugs (which anyway account for 80-85 per cent of current sales in the country) are not necessarily cheaper in India. In fact, generally, prices for these drugs are higher in India than those in Sri Lanka and Bangladesh. In fact prices of some top selling drugs are higher in India than those in Canada and the UK.

In the New Policy, in one sweep, the volume of pharmaceuticals under price control has been reduced from an estimated 40 per cent to just 25 per cent of the total drug market. Earlier studies have clearly shown that prices of drugs start rising as soon as controls are removed. This was evident in 1995-96, after the last round of price decontrol effected through the Drug Price Control Order (DPCO) 1995. Further, in almost all segments, the brand leader for a particular drug (i.e. the Brand with the highest turnover) is usually one of the most expensive (in some cases twice as

expensive!). This flies in the face of the argument that market forces and competition stabilises drug prices.

The new policy has attempted to justify the price decontrol with the plea that this shall boost R&D expenditure in the pharmaceutical sector. When concerns (legitimate in our view) were raised that amendment of the Indian Patents Act would result in rise in Drug Prices, the ministry of chemicals and fertilisers had consistently claimed that any rise in prices would be kept in check through mechanisms in the DPCO. It is extremely surprising that now that we are moving towards a Product Patent regime (the amendment to the Patents Act is presently pending in parliament), there should be talk of diluting Price Controls. Price Controls have already been diluted in the past decade and only 40 per cent of the turnover of the industry was under price control prior to the new policy. Any further dilution would mean virtual abandonment of price controls. It must also be noted in this context that most country, including virtually all developed countries have mechanisms in place that control prices of drugs.

Pharmaceuticals have an unique characteristic - those who need drugs most are the least likely to be able to pay for them. Thus even a small increase in prices results in the "costing out" from the market of a large number of people. In a country where half a million people die of Tuberculosis - a disease that can be treated by over a dozen drugs - because drugs are unaffordable, such a license to profiteer is inhuman. The imminent rise in drug prices comes at a particularly unfortunate juncture. The public health delivery system is in shambles and large parts of it are being dismantled or privatised. Drug supplies at public health facilities are at an all time low. This has already forced poor consumers to pay for medicines even if they are being treated in public facilities. Any further price rise can only push such patients to the brink of penury.

Any Drug Policy has to start with the premise that drugs are not like any other industrial products or consumer goods. Unlike say, washing machines or cars, availability of affordable drugs may make the difference between life and death for millions of people. A Drug Policy, thus, has to address the issues of quality, indigenous manufacture, availability of essential drugs, review of existing irrational and hazardous drugs, and affordability of drugs that are available. The new policy does not address any of these.

New Directions in Policy

Since the National Health Policy 2002 was announced, there has been a change of Government in the country. Hopes of a change in direction were stoked by some positive declarations of intent in the Common Minimum programme of the newly installed UPA Government. It stated, for example, that: "*The UPA government will raise public spending on health to at least 2-3% of GDP over the next five years with focus on primary health care*". The CMP also underlined its commitment to focus on Primary Health Care. It also stated that: "*The UPA government will take all steps to ensure availability of life-savings drugs at reasonable prices*" However the hopes raised by such positive commitments have been belied in the ensuing months.

The first budget by the UPA Govt. provided no additional budgetary support for health care, thereby rendering meaningless its commitment to increase public spending on health. There have been no concrete moves to impose price controls in order to bring down the spiralling rise in drug prices.

The Government's commitment to Primary Health Care is now being sought to be implemented through the proposed Rural Health Mission. However a reading of the initial drafts of the proposed Mission raise many disturbing concerns. The scheme proposes to hand over large parts

of the public health system to private providers and NGOs. It lays emphasis on the need to levy user fees inorder to maintain the infrastructure. It is not committed to strengthening the public health infrastructure, but instead proposes to fill the gaps in the infrastructure through private sector participation. An impression is being created that the non-functioning of the public health system is a legitimate reason for resorting to privatisation of the structure. The move towards casualisation and privatisation is evident from the fact that the central Govt. has recently advertised for district level posts of district managers and other personnel in six states of India to manage activities of SCOVA (autonomous organisations registered by the state Govts.under the direction of the central Govt.). These personnel are to ensure increasing participation of NGOs and other private institutions in health care. In some states (like Rajasthan) posts of Medical Officers in PHCs are being abolished. In essence, thus, there appears to be a trend towards moving further away from any commitment in providing comprehensive health services by the government.

It is also a matter of deep concern that the Common Minimum programme refers to "*sharply targeted population control programmes in 150 Districts*" This amounts to providing tacit clearance to coercive measures to control population. Not only are such measures violative of basic human rights, they have also been shown to be almost entirely useless in stabilising population. The CMP's position on this stands in clear variance with the National Population Policy 2000, which had been formulated on the basis of a wide national consensus.

Section II: Wide Ranging Impact – Denial of Health Care at All Levels

The consequences of the policies related to health care are being widely felt. Some glaring instances include the following:

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years. We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births.[2] More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and 80s, *has slowed down in the 1990s.*
- **130,000 mothers die during childbirth every year**. The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today. In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births.
- **Three completely avoidable child deaths occur every minute**. The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through better child health care and supplemental feeding programs. The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected.
- **About 5 lakh people die from tuberculosis every year,** and this number is almost unchanged since Independence! 20 lakh new cases are added each year, to the burgeoning number of TB patients presently estimated at around 1.40 crore Indians!
- India is experiencing a **resurgence of various communicable diseases** including Malaria, Encephalitis, Kala azar, Dengue and Leptospirosis. The number of cases of ***Malaria has remained at a high level of around 2 million cases annually*** since the mid eighties. By the year 2001, the worrying fact has emerged that ***nearly half of the cases are of Falciparum malaria,*** which can cause the deadly cerebral malaria.
- A growing proportion of Indians *cannot afford health care when they fall ill.* National surveys show that the *number of people who could not seek medical care because of lack of money increased significantly* between 1986 and 1995. The proportion of such persons ***unable to afford health care almost doubled,*** increasing from 10 to 21 % in urban areas, and growing from 15 to 24% in rural areas in this decade.
- ***Forty percent*** of hospitalised people are *forced to borrow money or sell assets to cover expenses.*
- ***Over 2 crores of Indians are pushed below the poverty line*** every year because of the catastrophic effect of out of pocket spending on health care.
- Irrational medical procedures are on the rise. According to just one study in a community in Chennai, ***45% of all deliveries were performed by Cesarean operations,*** whereas the WHO has recommended that not more than 10-15% of deliveries would require Cesarean operations.
- Due to ***irrational prescribing***, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs.
- The pharmaceutical industry is rapidly growing -- yet only 20% of the population can access all essential drugs that they require. Many drugs are being sold at 200 to 500 percent profit margin, and essential drugs have become unaffordable for the majority of the Indian population.

The above facts, startling as they are in their own right hide severe disparities between the well off and the poor, the urban residents and rural people, the adivasis and dalits and others, and between men and women. They include:

- The *Infant Mortality Rate in the poorest 20% of the population is* ***2.5 times higher*** *than that in the richest 20% of the population.*
- A child in the 'Low standard of living' economic group *is* ***almost four times*** *more likely to die in childhood* than a child in the better off 'High standard of living' group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups[3].
- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The ***female to male ratios*** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls).
- A person from the poorest quintile of the population, despite more health problems, is ***six times less*** *likely to access hospitalization* than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required.
- The delivery of a mother, from the poorest quintile of the population is ***over six times*** *less likely to be attended by a medically trained person* than the delivery of a well off mother, from the richest quintile of the population. An adivasi mother is half as likely to be delivered by a medically trained person.
- The ratio of *hospital beds to population in rural areas is* ***fifteen times*** *lower* than that for urban areas.
- The ratio of *doctors to population in rural areas is* ***almost six times lower*** than the availability of doctors for the urban population.
- Per person, *Government spending on public health is* ***seven times lower in rural areas***, compared to Government health spending for urban areas.

The above are a direct consequence of the virtual dismantling of the public health infrastructure, as shown by the following state of Primary Health Centres:

- Only 38% of all PHCs have all the critical staff.
- Only 31% have all the critical supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs.
- In spite of the high maternal mortality ratio, 8 out of every 10 PHCs have no Essential Obstetric Care drug kit!
- Only 34% PHCs offer delivery services, while only 3% offer Medical Termination of Pregnancy.
- A person accessing a community health centre would find no obstetrician in 7 out of 10 centres, and no paediatrician in 8 out of 10.

L-7A.7

Women's Right to Health Care: Reiterating State Obligation

Background document of the presentation
(based on international and national documents related to the title)

to the

National Human Rights Commission

and the

Ministry of Health and Family Welfare, Government of India

at the

National Public Hearing on Right to Health Care (Jan Sunwai)

(jointly organized by the NHRC and the Jan Swasthya Abhiyan)

Manisha Gupte

Research Assistance: Namrata Kavde

Mahila Sarvangeen Utkarsh Mandal (MASUM)
Pune, Maharashtra

December 2004

State obligation with respect to the right to health care has been understood in international treaties, broadly under the following categories:

Respect: The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health.

Protect: The obligation to *protect* requires States to take measures that prevent third parties from interfering with what article 12 guarantees.

Fulfill and promote: the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

The General Recommendation No. 24 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979) spells out the above state obligations succinctly in the following way:

13. The duty of States parties to ensure, on a basis of equality of men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system that ensures effective judicial action. Failure to do so will constitute a violation of article 12.

14. The **obligation to respect rights** requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health-care providers meet their duties to respect women's rights to have access to health care. For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women punish women who undergo those procedures.

15. The **obligation to protect rights** relating to women's health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations. Since gender-based violence is a critical health issue for women, States parties should ensure:
(a) The enactment and effective enforcement of laws and the formulation of policies, including health-care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services;
(b) Gender-sensitive training to enable health-care workers to detect and manage the health consequences of gender-based violence;
(c) Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health-care professionals guilty of sexual abuse of women patients;

(d) The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.

16. States parties should ensure that **adequate protection and health services, including trauma treatment and counselling,** are provided for women in especially difficult circumstances, such as **those trapped in situations of armed conflict and women refugees.**

17. The **duty to fulfil rights** places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those that emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of Possible breaches of their duties to ensure women's access to health care. The Committee asks States parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions, such as tuberculosis and HIV/AIDS. **The Committee is concerned about the evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health**. They should include information on positive measures taken to **curb violations of women's rights by third parties** and to protect their health and the measures they have taken to ensure the provision of such services.

Women of the World – Women's Health in India

By Victoria A. Velkoff and Arjun Adlakha
International Programs Center, Issued December 1998.

1. Over 100,000 Indian Women Die Each Year From Pregnancy-Related Causes

India has a high maternal mortality ratio—approximately 453 deaths per 100,000 births in 1993. The level of maternal mortality varies greatly by state, with Kerala having the lowest ratio (87) and two states Madhya Pradesh and Orissa having ratios over 700 (UNICEF, 1995). This differential maternal mortality is most likely related to differences in the socioeconomic status of women and access to health care services among the states. The high levels of maternal mortality are especially distressing because the majority of these deaths could be prevented if women had adequate health services (either proper prenatal care or referral to appropriate health care facilities) (Jejeebhoy and Rao, 1995). In fact, the leading contributor to high maternal mortality ratios in India is lack of access to health care (The World Bank, 1996).

2. Few Pregnant Women Receive Prenatal Care

The National Family Health Survey (NFHS) of 1992-93 found in the 4 years preceding the survey that 37 percent of all pregnant women in India received no prenatal care during their pregnancies (IIPS, 1995). The proportion receiving care varied greatly by educational level and place of residence. Nearly half of illiterate women received no care compared to just 13 percent of literate women. Women in rural areas were much less likely to receive prenatal care than women in urban areas (42 percent and 18 percent, respectively). Most women who did not receive health care during pregnancy said they did not because they thought it was not necessary (IIPS, 1995). Thus, there is a definite need to educate women about the importance of health care for ensuring healthy pregnancies and safe childbirths. Another reason for the low levels of prenatal care is lack of adequate health care centers.

3. One in Five Maternal Deaths Related to Easily Treated Problem

Anemia, which can be treated relatively simply and inexpensively with iron tablets, is another factor related to maternal health and mortality. Studies have found that between 50 and 90 percent of all pregnant women in India suffer from anemia. Severe anemia accounts for 20 percent of all maternal deaths in India (The World Bank, 1996). Severe anemia also increases the chance of dying from a hemorrhage during labor.

4. Excess Female Deaths

Several studies have found that one of the reasons for the poor health of Indian women is the discriminatory treatment girls and women receive compared to boys and men (Das Gupta, 1994; Desai, 1994). The most chilling evidence of this the large number of "missing women" (i.e., girls and women who have apparently died as a result of (past and present discrimination). Recent estimates place this number at approximately 35 million (The World Bank, 1996). In other words, there is a deficit of 35 million girls/women who should be part of the population but are not. Differential treatment of girls and boys in terms of feeding practices and access to health care is among the factors responsible for higher female mortality. Causes of death for children aged 1 to 4 show girls dying at a higher rate than boys from accidents and injuries, fever, and digestive disorders—all causes that are related to living conditions and negligence (Government of India, 1995).

1. Respect

Refraining from denying or limiting equal access for all persons;

Abstaining from enforcing discriminatory practices as a State policy;

Abstaining from imposing discriminatory practices relating to women's health status and needs;

Refraining from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments;

Refraining from limiting access to contraceptives and other means of maintaining sexual and reproductive health;

Refraining from censoring, withholding or intentionally misrepresenting health-related information;

Refraining from preventing people's participation in health-related matters;

Refraining from unlawfully polluting air, water and soil, from using or testing nuclear, biological or chemical weapons;

Refraining from limiting access to health services as a punitive measure;

Fundamental Rights guaranteed by the Indian Constitution

Article 14 Equality before law

Article 15 Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.

Article 21 Protection of life and personal liberty

Article 1 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979) defines 'discrimination" against women :

The term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 16 (and article 5) of the General Recommendation 19 to the CEDAW

22. **Compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children.**

Universal Declaration of Human Rights (1948)

Article 1 All human beings are born free and equal in dignity and rights.

Article 2 Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind,

Article 3 Everyone has the right to life, liberty and the security of person.

The International Covenant on Civil and Political Rights (1976)

Article 1

1. All peoples have the right of self-determination (to freely pursue their economic, social and cultural development).

Article 2

1. State Parties to abstain from distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 6

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

The International Convenant on Economic, Social and Cultural Rights (1976)

Article 1 All peoples have the right of self-determination (to freely pursue their economic, social and cultural development).

Article 2 The States Parties to present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind

Article 3 The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

2. Protect

To adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties;

To ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services;

To control the marketing of medical equipment and medicines by third parties;

To ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.

To ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning;

To prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation;

To take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence.

To ensure that third parties do not limit people's access to health-related information and services.

3. Fulfill

To give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation;

To adopt a national health policy with a detailed plan for realizing the right to health.

To ensure provision of health care, including immunization programmes against the major infectious diseases;

To ensure equal access for all to the underlying determinants of health;

To ensure that public health infrastructures provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas.

To ensure the appropriate training of doctors and other medical personnel:

To ensure the provision of a sufficient number of hospitals, clinics and other health-related facilities,

To promote and support the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country.

To include the provision of a public, private or mixed health insurance system which is affordable for all,

To promote medical research and health education;

To adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data;

To take positive measures that enable and assist individuals and communities to enjoy the right to health;

To fulfil *(provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal;

Article 25 of the UDHR

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 12 (of the ICESCR)

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Article 11 (of the CEDAW)

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Article 12 (of the CEDAW)

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

4. Promote

To undertake actions that create, maintain and restore the health of the population;

Such obligations include:

(i) fostering recognition of factors favouring positive health results, e.g. research and provision of information;

(ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups;

(iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services;

(iv) supporting people in making informed choices about their health.

Directive Principles in the Indian Constitution

Article 38 and 38{(i)}| State to secure a social order for the promotion of welfare of the people (in which justice, social, economic and political, shall inform all the institutions of the national life).

Article 47 Duty of the State to raise the level of nutrition and the standard of living and to improve public health -

Article 41 Right to work, to education and to public assistance in certain case

Article 42 Provision for just and humane conditions of work and maternity relief.

Article 43 Living wage, etc., for workers

Special attention needs to be drawn to **Article 39,** which eloquently spells out the ways in which the above may be achieved:

(a) that the citizens, men and women equally, have the **right to an adequate means of livelihood;**

(b) that the **ownership and control of the material resources of the community are so distributed as best to subserve the common good**;

(c) that the **operation of the economic system does not result in the concentration of**

wealth and means of production to the common detriment;

(d) that there is **equal pay for equal work for both men and women**;

(e) that the health and strength of workers, men and women, and the tender age of children are not abused and that **citizens are not forced by economic necessity to enter avocations unsuited to their age or strength**;

(f) that **children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity** and that childhood and youth are protected against exploitation and against moral and material abandonment.

The National Population Policy (India) of 2000 re-introduces incentives and disincentives for the adoption of a small family norm. These are violative of women's right to a life with dignity. Unless promotive measures are adopted by the government, women will never have the power of negotiation within and outside their homes to decide upon the number of children they wish to have.

Some of the promotional and motivational measures for adoption of the small family norm as suggested by the National Population Policy (India) of 2000:

- Panchayats and Zila Parishads will be rewarded and honoured for exemplary performance in **universalising the small family norm**, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.
- The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs. 500 is awarded at the birth of the girl child of birth order 1 or 2.
- Maternity Benefit Scheme run by the Department of Rural Development will continue. A cash incentive of Rs. 500 is awarded to mothers who have their first child after 19 years of age, **for birth of the first or second child only**. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth and BCG immunisation.
- A Family Welfare-linked Health Insurance Plan will be established. **Couples below the poverty line, who undergo sterilisation with not more than two living children**, would become eligible (along with children) for health insurance (for hospitalisation) not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilisation.
- Couples **below the poverty line**, who marry after the legal age of marriage, register the marriage, have their **first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded.**

Recommendations for government action (General Recommendation 24 of the CEDAW)

29. States parties **should implement a comprehensive national strategy to promote women's health throughout their lifespan**. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure **universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.**

30. States parties **should allocate adequate budgetary, human and administrative resources to ensure that women's health** receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs.

General Recommendation 19 of the CEDAW

Violence and Women

Background

7. **Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination** within the meaning of article 1 of the Convention. These rights and freedoms include:

g) The **right to the highest standard attainable of physical and mental health;**

Article 12 of GR 19 of CEDAW

19. States parties are required by article 12 to take measures to ensure equal access to health care. **Violence against women puts their health and lives at risk**.

20. In some States there are traditional practices perpetuated by culture and tradition that are harmful to the health of women and children. These practices include dietary restrictions for pregnant women, preference for male children and female circumcision or genital mutilation.

Beijing Declaration and Platform for Action, Fourth World Conference on Women, 1995.

The BDPFA details out the following strategic objectives that the State need to fulfill with reference to women and health:

- **Increase women's access** throughout the life cycle to appropriate, affordable and quality health care, information and related services:
- **Strengthen preventive programmes** that promote women's health
- **Undertake gender-sensitive initiatives** that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues
- Promote research and **disseminate information on women's health**
- **Increase resources** and monitor follow-up for women's health.

The International Conference on Population and Development (ICPD), 1994

- Endorses a new strategy, which emphasizes the numerous linkages between population and development.
- Focuses on meeting the needs of individual women and men rather than on achieving demographic targets.
- Key to this new approach is empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment.
- Advocates making family planning universally available by 2015, or sooner, as part of a broadened approach to reproductive health and rights, and calls on Governments to make these resources available.
- Includes goals in regard to education, especially for girls, and for the further reduction of infant, child and maternal mortality levels.
- Addresses issues relating to population, the environment and consumption patterns; the family; internal and international migration; prevention and control of the HIV/AIDS pandemic; information, education and communication; and technology, research and development.

Vienna Declaration and Programme of Action, World Conference on Human Rights, 1993.

- Reaffirms the solemn commitment of all States to fulfill their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all.
- Recognises the right of self-determination of all peoples.
- Reiterates that the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights.

- Urges for the full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels.
- Considers eradication of all forms of discrimination on grounds of sex as primary objectives of the international community.
- Endorses that gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated.
- Considers that the human rights of women should form an integral part of the United Nations human rights activities, including the promotion of all human rights instruments relating to women.
- Urges Governments, institutions, intergovernmental and non-governmental organizations to intensify their efforts for the protection and promotion of human rights of women and the girl-child.
- Emphasises the full and equal enjoyment by women of all human rights.
- Stresses the importance of working towards the elimination of violence against women in public and private life.
- Urges the eradication of all forms of discrimination against women, both hidden and overt.
- Recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span.
- Reaffirms, on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels.

Recommendations to the NHRC

and to the Ministry of Health and Family Welfare, GOI

1. stop violation of women's rights in the family planning programme
2. dismantle the "camp approach" in family planning
3. remove disincentives in family planning, especially those related to maternity benefits, ration cards and political participation
4. remove incentives (gun licenses, for example)
5. user-fees, privatisation of health services and exorbitant fees for medical education need to be done away with
6. regulation of the private sector (pharmaceuticals, medical profession, health service providers etc) is essential for people's rights to be protected
7. budgetary allocations to health cannot be reduced. This policy amounts to violation of people's right to health care
8. women should not be seen merely as mothers or potential mothers. Their health needs must be addressed in a holistic manner – mental health, occupational health, problems of ageing, cancers, STDs, RTIs and HIV-AIDS need to be addressed from a gender framework
9. universal access to comprehensive and quality health services, irrespective of capacity to pay is the only way to achieve the right to health care for all Indian people, including women
10. health, being an indicator of the quality of life, cannot be achieved unless measures to improve the social determinants of health are adopted
11. promotive measures, such as access to schooling (and to higher education), gainful employment, job security, equal wages, workers' benefits, access to resources (family, community and national) and the right to inheritance of property (home, land, assets etc) need to be put into place for health and well-being to become a reality for Indian people, especially women

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Relevant Articles and General Recommendations from the :

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (1979)

Article 1

For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 2

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realisation of this principle;

(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;

(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;

(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;

(e) To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise;

(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

(g) To repeal all national penal provisions which constitute discrimination against women.

Article 3

States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

Article 4

1. Adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.
2. Adoption by States Parties of special measures, including those measures contained in the present Convention, aimed at protecting maternity shall not be considered discriminatory.

Article 11

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

GENERAL RECOMMENDATION NO. 24 of the CEDAW

Women and Health (Article 12)

(Twentieth session, 1999)[1]

1. The Committee on the Elimination of Discrimination against Women, affirming that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women, decided at its twentieth session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention.

Background

2. States parties' compliance with article 12 of the Convention is central to the health and well-being of women. It requires States to eliminate discrimination against women in their access to health-care services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement and during the post-natal period. The examination of reports submitted by States parties pursuant to article 18 of the Convention demonstrates that women's health is an issue that is recognized as a central concern in promoting the health and well-being of women. For the benefit of States parties and those who have a particular interest in and concern with the issues surrounding women's health, the present general recommendation seeks to elaborate the Committee's understanding of article 12 and to address measures to eliminate discrimination in order to realize the right of women to the highest attainable standard of health.

3. Recent United Nations world conferences have also considered these objectives. In preparing this general recommendation, the Committee has taken into account relevant programmes of action adopted at United Nations world conferences and, in particular, those of the 1993 World Conference on Human Rights, the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. The Committee has also noted the work of the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and other United Nations bodies. It has collaborated with a large number of non-governmental organizations with a special expertise in women's health in preparing this general recommendation.

4. The Committee notes the emphasis that other United Nations instruments place on the right to health and to the conditions that enable good health to be achieved. Among such instruments are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Racial Discrimination.

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[1] Contained in document A/54/38/Rev.1, chapter I.

5. The Committee refers also to its earlier general recommendations on female circumcision, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), disabled women, violence against women and equality in family relations, all of which refer to issues that are integral to full compliance with article 12 of the Convention.

6. While biological differences between women and men may lead to differences in health status, there are societal factors that are determinative of the health status of women and men and can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities.

7. The Committee notes that the full realization of women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their lifespan by means of a food supply that is safe, nutritious and adapted to local conditions. To this end, States parties should take steps to facilitate physical and economic access to productive resources, especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met.

Article 12

8. Article 12 reads as follows:

"1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.

"2. Notwithstanding the provisions of paragraph 1 of this article, States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

States parties are encouraged to address the issue of women's health throughout the woman's lifespan. For the purposes of the present general recommendation, therefore, "women" includes girls and adolescents. The general recommendation will set out the Committee's analysis of the key elements of article 12.

Key elements

Article 12 (1)

9. States parties are in the best position to report on the most critical health issues affecting women in that country. Therefore, in order to enable the

Committee to evaluate whether measures to eliminate discrimination against women in the field of health care are appropriate, States parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture.

10. States parties are encouraged to include in their reports information on diseases, health conditions and conditions hazardous to health that affect women or certain groups of women differently from men, as well as information on possible intervention in this regard.

11. Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

12. States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors that differ for women in comparison to men, such as:
(a) Biological factors that differ for women in comparison with men, such as their menstrual cycle, their reproductive function and menopause. Another example is the higher risk of exposure to sexually transmitted diseases that women face;
(b) Socio-economic factors that vary for women in general and some groups of women in particular. For example, unequal power relationships between women and men in the home and workplace may negatively affect women's nutrition and health. They may also be exposed to different forms of violence which can affect their health. Girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy. Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability;
(c) Psychosocial factors that vary between women and men include depression in general and post-partum depression in particular as well as other psychological conditions, such as those that lead to eating disorders such as anorexia and bulimia;
(d) While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby

adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.

13. The duty of States parties to ensure, on a basis of equality of men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system that ensures effective judicial action. Failure to do so will constitute a violation of article 12.

14. The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health-care providers meet their duties to respect women's rights to have access to health care. For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried [1] or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women punish women who undergo those procedures.

15. The obligation to protect rights relating to women's health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations. Since gender-based violence is a critical health issue for women, States parties should ensure:
(a) The enactment and effective enforcement of laws and the formulation of policies, including health-care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services;
(b) Gender-sensitive training to enable health-care workers to detect and manage the health consequences of gender-based violence;
(c) Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health-care professionals guilty of sexual abuse of women patients;
(d) The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.

16. States parties should ensure that adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees.

17. The duty to fulfil rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those that emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care. The Committee asks States parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions, such as tuberculosis and HIV/AIDS. The Committee is concerned about the evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health. They should include information on positive measures taken to curb violations of women's rights by third parties and to protect their health and the measures they have taken to ensure the provision of such services.

18. The issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

19. In their reports, States parties should identify the test by which they assess whether women have access to health care on a basis of equality of men and women in order to demonstrate compliance with article 12. In applying these tests, States parties should bear in mind the provisions of article 1 of the Convention. Reports should therefore include comments on the impact that health policies, procedures, laws and protocols have on women when compared with men.

20. Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.

21. States parties should report on measures taken to eliminate barriers that women face in access to health-care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women's access, such as high fees for health-care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and the absence of convenient and affordable public transport.

22. States parties should also report on measures taken to ensure access to quality health-care services, for example, by making them acceptable to women. Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity.

23. In their reports, States parties should state what measures they have taken to ensure timely access to the range of services that are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning.

24. The Committee is concerned about the conditions of health-care services for older women, not only because women often live longer than men and are more likely than men to suffer from disabling and degenerative chronic diseases, such as osteoporosis and dementia, but because they often have the responsibility for their ageing spouses. Therefore, States parties should take appropriate measures to ensure the access of older women to health services that address the handicaps and disabilities associated with ageing.

25. Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.

Article 12 (2)

26. Reports should also include what measures States parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period. Information on the rates at which these measures have reduced maternal mortality and morbidity in their countries, in general, and in vulnerable groups, regions and communities, in particular, should also be included.

27. States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.

Other relevant articles in the Convention

28. When reporting on measures taken to comply with article 12, States parties are urged to recognize its interconnection with other articles in the Convention that have a bearing on women's health. Those articles include article 5 (b), which requires States parties to ensure that family education includes a proper understanding of maternity as a social function; article 10, which requires States parties to ensure equal access to education, thus enabling women to access health care more readily and reducing female student drop-out rates, which are often a result of premature pregnancy; article 10 (h), which requires that States parties provide to women and girls access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning; article 11, which is concerned, in part, with the protection of women's health and safety in working conditions, including the safeguarding of the reproductive function, special protection from harmful types of work during pregnancy and with the provision of paid maternity leave; article 14, paragraph 2 (b), which requires States parties to ensure access for rural women to adequate health-care facilities, including information, counselling and services in family planning, and (h), which obliges States parties to take all appropriate measures to ensure adequate living conditions, particularly housing, sanitation, electricity and water supply, transport and communications, all of which are critical for the prevention of disease and the promotion of good health care; and article 16, paragraph 1 (e), which requires States parties to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights. Article 16, paragraph 2 proscribes the betrothal and marriage of children, an important factor in preventing the physical and emotional harm which arise from early childbirth.

Recommendations for government action

29. States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.

30. States parties should allocate adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs.

31. States parties should also, in particular:
(a) Place a gender perspective at the centre of all policies and programmes affecting women's health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women;
(b) Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS;
(c) Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion;
(d) Monitor the provision of health services to women by public, non-governmental and private organizations, to ensure equal access and quality of care;
(e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;
(f) Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

GENERAL RECOMMENDATION NO. 19 of the CEDAW

Violence against women

(Eleventh session, 1992)[2]

Background

1. Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.
2. In 1989, the Committee recommended that States should include in their reports information on violence and on measures introduced to deal with it (General recommendation 12, eighth session).
3. At its tenth session in 1991, it was decided to allocate part of the eleventh session to a discussion and study on article 6 and other articles of the Convention relating to violence towards women and the sexual harassment and exploitation of women. That subject was chosen in anticipation of the 1993 World Conference on Human Rights, convened by the General Assembly by its resolution 45/155 of 18 December 1990.
4. The Committee concluded that not all the reports of States parties adequately reflected the close connection between discrimination against women, gender-based violence, and violations of human rights and fundamental freedoms. The full implementation of the Convention required States to take positive measures to eliminate all forms of violence against women.
5. The Committee suggested to States parties that in reviewing their laws and policies, and in reporting under the Convention, they should have regard to the following comments of the Committee concerning gender-based violence.

General comments

6. The Convention in article 1 defines discrimination against women. The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.
7. Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention. These rights and freedoms include:
(a) The right to life;
(b) The right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment;

[2] Contained in document A/47/38.

(c) The right to equal protection according to humanitarian norms in time of international or internal armed conflict;
(d) The right to liberty and security of person;
(e) The right to equal protection under the law;
(f) The right to equality in the family;
(g) The right to the highest standard attainable of physical and mental health;
(h) The right to just and favourable conditions of work.

8. The Convention applies to violence perpetrated by public authorities. Such acts of violence may breach that State's obligations under general international human rights law and under other Conventions, in addition to breaching this Convention.

9. It is emphasized, however, that discrimination under the Convention is not restricted to action by or on behalf of Governments (see articles 2 (e), 2 (f) and 5). For example, under article 2 (e) the Convention calls on States parties to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise. Under general international law and specific human rights covenants, States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation.

Comments on specific articles of the Convention

Articles 2 and 3

10. Articles 2 and 3 establish a comprehensive obligation to eliminate discrimination in all its forms in addition to the specific obligations under articles 5-16.

Articles 2 (f), 5 and 10 (c)

11. Traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them of the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms. While this comment addresses mainly actual or threatened violence the underlying consequences of these forms of gender-based violence help to maintain women in subordinate roles and contribute to their low level of political participation and to their lower level of education, skills and work opportunities.

12. These attitudes also contribute to the propagation of pornography and the depiction and other commercial exploitation of women as sexual objects, rather than as individuals. This in turn contributes to gender-based violence.

Article 6

13. States parties are required by article 6 to take measures to suppress all forms of traffic in women and exploitation of the prostitution of women.

14. Poverty and unemployment increase opportunities for trafficking in women. In addition to established forms of trafficking there are new forms of sexual exploitation, such as sex tourism, the recruitment of domestic labour from developing countries to work in developed countries, and organized marriages between women from developing countries and foreign nationals. These practices are incompatible with the equal enjoyment of rights by women and with respect for their rights and dignity. They put women at special risk of violence and abuse.

15. Poverty and unemployment force many women, including young girls, into prostitution. Prostitutes are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them. They need the equal protection of laws against rape and other forms of violence.

16. Wars, armed conflicts and the occupation of territories often lead to increased prostitution, trafficking in women and sexual assault of women, which require specific protective and punitive measures.

Article 11

17. Equality in employment can be seriously impaired when women are subjected to gender-specific violence, such as sexual harassment in the workplace.

18. Sexual harassment includes such unwelcome sexually determined behaviour as physical contact and advances, sexually coloured remarks, showing pornography and sexual demands, whether by words or actions. Such conduct can be humiliating and may constitute a health and safety problem; it is discriminatory when the woman has reasonable ground to believe that her objection would disadvantage her in connection with her employment, including recruitment or promotion, or when it creates a hostile working environment.

Article 12

19. States parties are required by article 12 to take measures to ensure equal access to health care. Violence against women puts their health and lives at risk.

20. In some States there are traditional practices perpetuated by culture and tradition that are harmful to the health of women and children. These practices include dietary restrictions for pregnant women, preference for male children and female circumcision or genital mutilation.

Article 14

21. Rural women are at risk of gender-based violence because traditional attitudes regarding the subordinate role of women that persist in many rural communities. Girls from rural communities are at special risk of violence and sexual exploitation when they leave the rural community to seek employment in towns.

22. **Compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children.**

23. Family violence is one of the most insidious forms of violence against women. It is prevalent in all societies. Within family relationships women of all ages are subjected to violence of all kinds, including battering, rape, other forms of sexual assault, mental and other forms of violence, which are perpetuated by traditional attitudes. Lack of economic independence forces many women to stay in violent relationships. The abrogation of their family responsibilities by men can be a form of violence, and coercion. These forms of violence put women's health at risk and impair their ability to participate in family life and public life on a basis of equality.

Specific recommendations

24. In light of these comments, the Committee on the Elimination of Discrimination against Women recommends:

(a) States parties should take appropriate and effective measures to overcome all forms of gender-based violence, whether by public or private act;

(b) States parties should ensure that laws against family violence and abuse, rape, sexual assault and other gender-based violence give adequate protection to all women, and respect their integrity and dignity. Appropriate protective and support services should be provided for victims. Gender-sensitive training of judicial and law enforcement officers and other public officials is essential for the effective implementation of the Convention;

(c) States parties should encourage the compilation of statistics and research on the extent, causes and effects of violence, and on the effectiveness of measures to prevent and deal with violence;

(d) Effective measures should be taken to ensure that the media respect and promote respect for women;

(e) States parties in their report should identify the nature and extent of attitudes, customs and practices that perpetuate violence against women, and the kinds of violence that result. They should report the measures that they have undertaken to overcome violence, and the effect of those measures;

(f) Effective measures should be taken to overcome these attitudes and practices. States should introduce education and public information programmes to help eliminate prejudices, which hinder women's equality (recommendation No. 3, 1987);

(g) Specific preventive and punitive measures are necessary to overcome trafficking and sexual exploitation;

(h) States parties in their reports should describe the extent of all these problems and the measures, including penal provisions, preventive and rehabilitation measures, that have been taken to protect women engaged in prostitution or subject to trafficking and other forms of sexual exploitation. The effectiveness of these measures should also be described;

(i) Effective complaints procedures and remedies, including compensation, should be provided;
(j) States parties should include in their reports information on sexual harassment, and on measures to protect women from sexual harassment and other forms of violence of coercion in the workplace;
(k) States parties should establish or support services for victims of family violence, rape, sex assault and other forms of gender-based violence, including refugee, specially trained health workers, rehabilitation and counselling;
(l) States parties should take measures to overcome such practices and should take account of the Committee's recommendation on female circumcision (recommendation No. 14) in reporting on health issues;
(m) States parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control;
(n) States parties in their reports should state the extent of these problems and should indicate the measures that have been taken and their effect;
(o) States parties should ensure that services for victims of violence are accessible to rural women and that where necessary special services are provided to isolated communities;
(p) Measures to protect them from violence should include training and employment opportunities and the monitoring of the employment conditions of domestic workers;
(q) States parties should report on the risks to rural women, the extent and nature of violence and abuse to which they are subject, their need for and access to support and other services and the effectiveness of measures to overcome violence;
(r) Measures that are necessary to overcome family violence should include:
(i) Criminal penalties where necessary and civil remedies in case of domestic violence;
(ii) Legislation to remove the defence of honour in regard to the assault or murder of a female family member;
(iii) Services to ensure the safety and security of victims of family violence, including refuges, counselling and rehabilitation programmes;
(iv) Rehabilitation programmes for perpetrators of domestic violence;
(v) Support services for families where incest or sexual abuse has occurred;
(s) States parties should report on the extent of domestic violence and sexual abuse, and on the preventive, punitive and remedial measures that have been taken;
(t) That States parties should take all legal and other measures that are necessary to provide effective protection of women against gender-based violence, including, inter alia:
(i) Effective legal measures, including penal sanctions, civil remedies and compensatory provisions to protect women against all kinds of violence, including, inter alia, violence and abuse in the family, sexual assault and sexual harassment in the workplace;

(ii) Preventive measures, including public information and education programmes to change attitudes concerning the roles and status of men and women;
(iii) Protective measures, including refuges, counselling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence;
(u) That States parties should report on all forms of gender-based violence, and that such reports should include all available data on the incidence of each form of violence, and on the effects of such violence on the women who are victims;
(v) That the reports of States parties should include information on the legal, preventive and protective measures that have been taken to overcome violence against women, and on the effectiveness of such measures.

CHILD HEALTH; KEY STRATEGIES AND INTERVENTIONS

National Public Hearing On Denial Of Health Care Services

Organised By Jan Swasthya Abhiyan and National Human Rights Commission

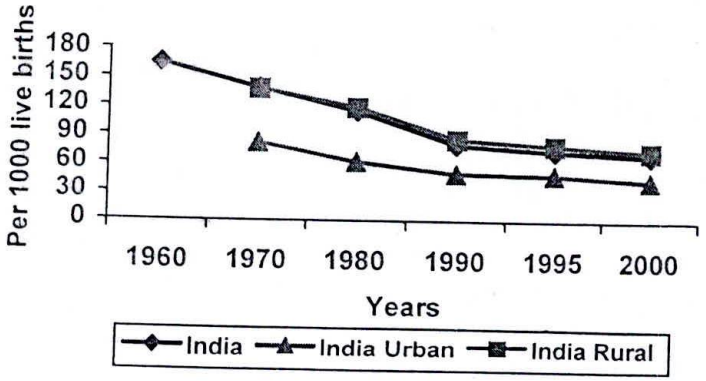
The India Habitat Centre, New Delhi 16th-17th December, 2004

The Situation

Infant and child morbidity and mortality indicators have been used as sensitive parameters of the overall state of health and status of health care of any given population. It is broadly accepted and substantiated by various large and small surveys that the state of child health in India is far from satisfactory and that gains made in the early years after independence have slowed down or even plateaued. Residual problems seem to be more intractable and demand greater systemic changes in the overall socio economico political context as well specifically in the systems of health care themselves. Factors of class, caste, geography and gender complicate the situational analysis of the smallest health problem and confound any planning that does not adequately take them into account.
Simultaneously, solutions that are technocentric rather than oriented towards public health, overall trends of cutting back on public health expenditure and promoting privatised systems of health care and consequent escalations in costs of health care are putting 'health' out of reach of a vast proportion of our children.
This paper does not intend to go into a description of status of child health since the data that exists is largely uncontested, or if at all, errs on the side of showing a picture better than what exists in our experience. Nevertheless, some facts are presented below to set the stage for our recommendations;

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years. We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births. More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and 80s, *has slowed down in the 1990s*. (See diagram below)

IMR Trends in India 1960-2000



The current annual reduction rate deaths is estimated to be 2.3 % each year and if India intends to achieve MDGs by 2015, it should be three times the reduction rate.

- **Three completely avoidable child deaths occur every minute**. If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala, then ***18 lakh deaths of under-five children could be avoided every year***. The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through interventions aiming at prevention of child malnutrition through education of families like prenatal care, newborn care, optimal infant and young child feeding, (exclusive breastfeeding during first six months, continued breastfeeding along with appropriate and adequate complementary feeding beginning after six months to two years or beyond) , hygiene etc., and for older children supplemental feeding programs. The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected. Only about 40% babies are exclusively breastfed and 33% are given timely complementary feeds.
- Diarrhea, dysentery, acute respiratory infections and asthma continue to take their toll because we are unable to improve environmental health conditions. ***Around 6 lakh children die each year from an ordinary illness like diarrhea.*** While diarrhea itself could be largely prevented by universal provision of safe drinking water and sanitary conditions and ensuring optimal infant and young child feeding. These deaths can be prevented by timely administration of oral rehydration solution, which is presently administered in only 27% of cases.
- Survivors are underweight and underdeveloped as we see from the existing data half of our under three children are underweight and their development is potentially compromised.

Poverty and gender

- The *Infant Mortality Rate in the poorest 20% of the population is **2.5 times higher** than that in the richest 20% of the population.* In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family.
- A child in the 'Low standard of living' economic group *is **almost four times** more likely to die in childhood* than a child in the better off 'High standard of living group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups.
- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The ***female to male ratios*** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls).
- Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.

- 11-100 million children are wage labourers. Many more participate in a major way in household work and sibling care activities. Many thousand of these live on the streets in grave danger to their health and welfare.

- 3-10% of all children suffer from disability. The services that exist for children with special needs are highly inadequate.
- According to NACO estimates on the basis of prevalence, 55,000 children would be already infected with HIV /AIDS in the year 2003. Of course, many more would have a parent or parents who are affected or who have been orphaned.

Key Strategies

Of course, overall strategies for combating poverty and discrimination on grounds of gender and caste are an absolute requirement for any health care intervention. More specifically, as malnutrition sets in during first three years, focus must be on under threes starting from pregnancy. Food security of the under three, safe water and sanitation play a huge preventive role. Following this, interventions need to be made in the specific programmes, schemes and delivery mechanisms relating to child health and development. Adequately trained and skilled Anganwadi workers, nurses ,village health workers and ANMs, Functional PHCs and subcentres, availability of medical doctors/paediatricians at appropriate levels of primary care, availability of neonatal units with trained staff. availability of free essential drugs including those required for PPTCT are other major requirements.

At the outset, it needs to be acknowledged that rectifying the situation requires a multisectoral and comprehensive approach to child health involving all sections of society but necessarily families, the health care system, education, labour and welfare systems of the country and governance at all levels. Convergence cannot be left to the will or competence of implementing individuals but needs to be set into systems that are workable.

Based on our experience, the key strategies that would make the maximum dent on the existing situation of child health are as follows:

1. Ensuring that good quality antenatal care is accessible to all women.
2. Ensuring that all home deliveries are carried out by trained birth attendants and promoting institutional delivery by providing access and good quality maternity services. (prevention of neonatal mortality due to asphyxia and prematurity)
3. Adopting 'Preventing child malnutrition early' approach rather than a treatment approach
4. Preventing the proportion of deaths due to sepsis in the neonatal period.
5. Promoting early and exclusive breastfeeding for the first six months, and adequate complementary feeding after six months by good communication of correct

information, skilled assistance and help and supporting breastfeeding women by maternity entitlements and crèches on work sites.

6. Ensuring the food security of children by strengthening the PDS and making appropriate food available for children through it, by promoting correct child feeding practices, offering supplementary nutrition to all children through universalising the ICDS and the mid day meal scheme.
7. Ensuring meaningful growth monitoring through tracking the individual child, care of childhood illnesses, deworming, iron supplementation, health checks and vaccination through a systematic and functional convergence between the AWC and PHC systems.
8. Ensuring systematic school health checks in all schools, public and private with capacity building of personnel on adolescent health issues including 'life skill training'.
9. Making elementary education, including ECCD, free and universally available.
10. Ensuring that this is inclusive for children with special needs.

Recommendations

We understand that many of these concerns are being addressed through fresh planning vis a vis RCH II, ICDS, the Rural Health Mission and other policies and programmes being considered by the Ministry of Health and Family Welfare.
Jan Swasthya Abhiyan members have also been making recommendations to some of these through the National Advisory Council as well as by participating in planning sessions organised by the Ministry.

In order to translate the strategies enumerated above to realities on the ground, some firm steps will have to be taken. Our recommendations for immediate action are as follows;

1. The **national health policy** barely takes cognizance of child health issues. This should be reworked immediately giving due space and priority to child health and preventing malnutrition in children.
2. All positive changes will require enhanced **budgetary allocations** for health and child health and development in particular. We recommend an overall increase in the health budget by a minimum of 0.5% of the GDP each year over and above the current 0.9%. Programme-specific increases are mentioned in points that follow.
3. ANMs and AWW can be made responsible for registration for **maternity entitlements** and maternity benefit schemes for better coverage.
4. A large **cadre of dais** need to be identified and trained to cover the needs of women giving birth at home while centres are being set up to allow larger numbers to choose institutional delivery.

5. Identify and ensure optimal infant and young child feeding as a major preventive intervention for growth and development.
6. Inclusion of **infant and young child feeding indicators** in the ICDS, MPR and Nation/State/Division/District/Block/Circle/Village/ urban slum level monitoring and review systems.
7. Introduce village child health and development report cards compiled by the PRI/and frontline workers into block/district and so on.
8. Setting up of a **National Resource Centre on Infant and Young Child Feeding**, linked to State Resource Centres and District Resource Units/training teams.
9. Mechanisms to implement the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 as amended in 2003 should be in place at district level with Annual review plans.
10. The **Crèches for Working and Ailing Mother's Children Scheme** with revised norms and enlarged outlay needs to be revived and made available to the full range of women's groups. Currently, approximately 15000 Crèches are provided under the Scheme where as the need is for 8 lakhs. The Scheme has been evaluated and the norms need urgent revision. Funds need to be allocated for expansion of the Scheme to meet the need. Cost of Day care/ crèche arrangements is estimated at Rs 15 per day per child (Care/ nutritional supplements/ learning activities/ health care) .It is estimated that 60, million children 0-6 years require this service. Anganwadi come crèche scheme needs to be made operational wherever necessary.
11. **Crèches at working places** provided under Labour Legislation require to be enforced. Funds from the industry via Cess Acts can made available and manpower requirements can be co-ordinated with training strategies to develop a range of trained crèche workers. (It may be noted that the collection of cess in Delhi has not yet been started despite the fact that the Act was passed in 1996)
12. Universalisation of the **ICDS** with priority to dalit, tribal and urban areas should happen in accordance with the Supreme Court judgement by design. This requires a credible plan to extend the reach of ICDS to all 14 lakh habitations in the country in a time-bound manner, say within two years. Adequate funds need to be made available for his to happen as well as to support the state budgets for nutrition through the ICDS.
13. All sanctioned projects that are not "operational" should be operationalised immediately, as per Supreme Court orders.
14. The allocation for nutrition per child should be increased to Rs 3 per child per day.
15. Iron supplementation should be made available to all children along with periodic deworming.
16. Staffing gaps pertaining to the ICDS should be met with urgency.
17. Basic infrastructural requirements such as running water, toilets, separate space for cooking, weighing machines and toys should be ensured on a priority basis.
18. Anganwadi workers to get adequate remuneration and suitable skills training to perform their role as health communication agents and nutrition counsellors especially for infant and young child feeding.
19. She should not be asked to perform several other roles she is asked to do

presently.

20. There should be a **systematic convergence** between the AWW, ANM and any proposed or existing village health worker/ASHA/ Mitanin through processes such as pre fixed mother and child health days (CARE model).
21. All **village health workers/ASHA** etc should have a clear mandate to give priority to child health interventions specially for **infant and young child feeding** and should be trained appropriately (Mitanin model, Gadchiroli model, CARE model)
22. This convergence (between 'health, family welfare, women and child development and education) should systematically extend to district and block level (UP GVS model, CARE model). Representatives of groups working on relevant health issues (JSA, BPNI, Right to Food Campaign etc) should be included at all levels, from State to district, wherever possible.
23. **Vitamin A** supplies need to be ensured and maintained.
24. **Immunisation drives** such as pulse polio must be organised carefully to ensure that routine immunisation is not being neglected.
25. Measles coverage must be achieved to 100% on a priority basis.
26. Nutritious cooked mid-day meals should be provided to all children up to class 8 throughout the year.The minimum norm of Rs 2 per child per day for 'conversion costs', proposed by the Commissioners of the Supreme Court, should be extended throughout the country. Full quality safeguards must be in place.
27. All states should extend mid-day meals to Class 8 from 1 July 2005 at the latest.
28. Strict instructions should be issued to the effect that central assistance for mid-day meals is intended as a supplement to the resources already provided by state governments, and not as a substitute for them.
29. The proceeds of the **Education Cess** should be clearly ear-marked for elementary education including ECCE and nothing else. The Cess should be paid into a dedicated non-lapsable account. The additional financial allocations associated with the Cess in 2004-5 (i.e. the net addition to financial allocations already made in the interim budget) should be clearly spelt out by the Central Government. Also, these allocations should be made available immediately and not at the end of the financial year.
30. The **school health scheme** needs to be made mandatory for all private and public schools and should include annual general health checks, vision and dental checks, immunisation and deworming, iron supplementation and adolescent health counselling.

Prepared for Jan Swasthya Abhiyan by Dr Vandana Prasad (Consultant Paediatrician), Dr Arun Gupta (Regional Coordinator, International Baby Food Action Network(IBFAN) Asia Pacific, Dr Jean Dreze (Delhi School of Economics) and Ms Devika Singh (Consultant, Mobile Crèches).

Presentation on Mental Health Rights during

National Public Hearing organised by NHRC and JSA

I. Background

This presentation is a compilation of issues related to people with mental illness in India and is based on their experiences. The compilation is a result of collective effort of a group of people comprising of those who have had personal encounters with mental illness, field staff of organizations involved in mental health and other stakeholders. Information has also been gathered from secondary sources to substantiate the claims made in this document.

Health Economics

a. Assessment of burden in mental illness

Estimation of the Global burden of disease with disability adjusted life years (DALYs) shows that Mental and neurological conditions are among the most important contributors; for instance in 1999 they accounted for 11% of the DALYs lost due to all disease and injuries. Among all the mental and neurological disorders, depression accounts for the largest proportion of the burden. Almost everywhere, the prevalence of depression is twice as high among women as among men. Four other mental disorders figure in the top 10 causes of disability in the world, namely alcohol abuse, bipolar disorder, schizophrenia and obsessive-compulsive disorder.

b. Social Impact

Negative social attitudes towards the mentally ill are the barriers to reintegration, and acceptability. These adversely affect social and family relationships, employment, housing, community inclusion and self-esteem. Equally they create barriers to equality of treatment options and limit accessibility to best treatment practices and alternatives. Unfortunately, often medical and hospital personnel also share negative attitudes towards people with mental illness.

c. Economic Impact

The economic impact of mental disorder is wide ranging, long lasting and large. Measurable causes of economic burden are health and social service needs, impact on families and caregivers (indirect costs) lost employment and lost productivity, Crime and public safety.

Studies from countries with established economies have shown that mental disorders consume more than 20% of all health service costs.

In the case of poor people with mental illness in Rural areas, families are unable to go for treatment because in addition to the cost of transport, the accompanying family member loses a days wages.

d. Legal Impact

The laws related to mental health in India - such as the Mental Health Act 1987 and other laws related to contracts (including marriage and property), contribute to marginalization of people with mental illness.

- The marriage and Divorce act permits legal separation of life partners if one of them is found to be mentally ill. Procurement of certificates of insanity from the concerned doctors has resulted in legal separation of couples. Doctors often issue false certificates to those desiring to divorce their wives.
  A recent example is the Agra mental asylum case (*The price of Insanity*, TEHELKA, July 10, 2004)
- Denial of property rights - as per the law, persons with unsound minds cannot sign any property related documents or contracts. The Mental Health Act 1987, provides for guardians to manage the affairs of persons with mental illness.- Siblings also take advantage of this clause to deny property rights to the person and in fact ensure that the illness persists so that he is not well enough to demand his/her right.
- The act authorizes the police to assist in cases where the patient is violent and needs to be hospitalized. The ignorance of the police to distinguish a mentally ill from a criminal makes them give the same kind of treatment to both.

II. Determinants of Mental Health

i. Socio economic factors

The relationship between poverty and high prevalence rates of psychiatric disorders can be explained in two ways, which are not mutually exclusive. First, poor people are exposed to greater levels (quality and quantity) of environmental and psychological adversity, which produces high levels of stress and psychological distress. They have major difficulties accessing information and mental health services. In India, these services are so limited that they remain out of reach for the poor: information is often not available to illiterate populations, transport is difficult and costly, and responsibilities of the health services is low. Not only do these factors contribute to chronicity and more disability, but they may also trigger non-psychotic forms of mental illness, especially depression and anxiety disorders. Considerable evidence points to the social origins of psychological distress and depression in women, both of which conditions affect them disproportionately. Families of people with mental illness have to face the twin challenges of earning a livelihood, caring for the person as well as meeting the high costs of illness in the family

ii. Social attitudes and Belief system

Social attitudes and belief systems are attitudinal hurdles in accessing treatment. This coupled with stigma and discrimination manifests itself in subjecting the person with mental illness and his/her family to social boycott and other human rights abuses.

Social boycott – this results in preventing people with mental illness from participating in social functions, marriages, ceremonies and going to religious places.

> In a village in Jharkhand, a girl aged 19 years, developed mental illness and started spending time in the village temple even during odd hours of the night. The villages suspected that she was praying to spirits and practising witchcraft. They feared for the lives of their

C. Gender issues - Women who are mentally ill are often subjected to physical and sexual abuse. Destitution of women with mental illness is common as evidenced by admissions at Banyan, where there are women from all over the country.

Recently in North Karnataka, a young girl with mental illness aged about 18 years was found wandering on the streets almost naked. Field workers of Samuha took her to the hospital and on examination, she was found to be pregnant.
In a village meeting, when this issue came for discussion, all the men hanged their heads in shame. It is a reminder that our society is cruel, unkind and miles away from civilization.

In another instance a woman with mental illness and dementia wandered into the neighbouring district. No one knew who she was or where she came from. She was spotted by the staff of an NGO and taken to a short stay home for women, where on medical examination, she was found to be pregnant. After delivery, the child was handed over to a childless couple for adoption.
Once treated, she regained her memory and remembered where she came from. But she has no clue about her pregnancy and the child. She is now in the state home for women, where she is in long term care.

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Violence against women is a public health concern in all countries, an estimated 20 % to 50 % of women have suffered domestic violence. Surveys in many countries reveal that 10% to 15 % of women report that they are forced to have sex with their intimate partner. The high prevalence of sexual violence to which women of all ages are exposed , with the consequent high rate of post- traumatic stress disorder explains why women are most affected by this disorder.

Mental health problems related to violence are also poorly identified. Among victims, women are reluctant to disclose information unless asked about it directly. When undetected, violence – related health problems increase and result in high and costly use of the health and mental health care system.

d. Family Support system

The above incidents are also indicative of the lack of family support systems particularly among poor families. Families often out of sheer desperation or helplessness, abandon the person with mental illness and resort to chaining or locking up the person in the home.

BasicNeeds together with its partner organizations have come across several such cases, where blacksmiths were asked to make shackles for the person with mental illness.

III. Current scenario

i. Denial of services

Accessibility - According to the WHO Project atlas 2002, the India profile shows availability of 3,500 psychiatrists, 1000 psychiatric social workers and 1000 clinical psychologists. Most of them work in cities and big towns whereas the 70% of people with problems live in rural areas. The District Mental Health program makes treatment available in a mere 100 districts across the whole country. Presently however the district mental health program is operational in a mere 27 districts.

Availability and Affordability - District hospitals have the provision to procure (indent) the required drugs listed in the rate contract list. But the authorities hardly indent medicines. In district hospitals and some hospitals in capital cities where a department of psychiatry exists, due to non-availability of drugs the doctors prescribe medicines and poor people find it extremely difficult to buy the medicines.

It is observed that doctors ask the patients to come to their private clinics and also prescribe medicines (including unnecessary medicines) to be purchased from specific medical shops often owned by family members.

Insisting on BPL card for free medicines is another issue – poorest of the poor finds it extremely difficult to get these cards. Urban Migrant populations find it difficult to get a BPL card.

Long term stay of patients in psychiatric institutions - A recent study (Reddy 2001) indicates that nearly half 48% of our mental hospital beds are even now occupied by long stay patients. Most of the 250 odd patients in PINPAS have been in hospital for five years or more, not because they have require active psychiatric intervention, but because they have been abandoned by their families.

Similarly across the country, psychiatric patients are abandoned to the care of hospitals and families give fictitious addresses.

a. Almost 2/3 of long stay patients have been in hospital for over 5 years and one fourth have stayed for more than 15 years.

b. In some hospitals the proportion of such patients is truly incredible: Purulia - 92%, Srinagar - 90%, Pune - 73%, Baroda - 72%, Calcutta - 70% and Indore - 68%.

c. Males account for over half of the long stay patients and sadly most of them are in their most productive years 20 - 39 years.

d. 69% of such patients were diagnosed with schizophrenia

e. In the larger and academically oriented institutions a vast majority of long stay patients are voluntary boarders: Bangalore - 98%, Hyderabad - 83%, Rinpas - 78%, CIP Ranchi - 75%, Trivandrum - 76%.

ii. Limitations → The limitation of presently available psychiatric services is that they are largely Institutional in nature and urban based. Moreover they are inadequate.

iii. Absence of quality assurance and audit - presently there is no mechanism for user audit of services for people with mental illness and they are entirely at the mercy of the service providers. This puts them at risk of abuse and violence.

iv. Development services - psychiatric services at present are clinical in nature. Facilities for after care and transfer of care to the community are very few and urban based.

IV. Recommendations / Issues for action

A. Mental Health law reforms

The government needs to set up a Policy and Law Reform Think Tank with participation from all stakeholders, especially the primary stake holder- the users of the service and significant individuals in their lives. We need to move away from the premise that the users of the service are unable to comment on determine what they want. The voluntary sector and private sector need to have a stake in policy at the planning stage. It will take away the need for adversarial roles that we tend to adopt.

The government needs to be represented by all its arms that have a role in the care of people with mental illness. Ministry of Health, Ministry of social justice and Empowerment. Ministry of Human resource development and Ministry of Law need to be key players. This Think Tank could also include parliamentarians to be able to lobby for legislative change eventually.

A . Legal Measures

- The Mental Health Act (1987) puts unrealistic minimum standards for the psychiatric and private nursing homes while Section 6 (2) of the Act exempts the government mental hospitals, they need to be included.
- Misuse of MHA Sec 18(3), to convert voluntary to involuntary admission, thereby abridging the right to seek discharge from hospital.
- Fabricated/manipulated institutionalization / medical certificates often become the means for getting rid of an inconvenient wife (Sections 19 & 20).
- MHA Sec 81 can be abused to perform hysterectomies/non-therapeutic research on women patients. Women are unable to access legal aid under MHA Sec 91, prior to commitment u/s 20, owing to disempowerment.
- MHA only talks of mental illnesses, which are' dangerous and unfit to be at large', it does not speaks of mental illnesses, which need care and treatment and not hospitalization. Women are in so far afflicted with such disorders. One of the major need is diversification of services mid-way between the family and the hospital, so that they are centers for treatment and houses of custody.
- There is need of putting obligation on the on the central and state mental health authorities, psychiatric institutions and magistracy in order to provide treatment to persons with mental illness in least restrictive environment and interact with welfare agencies within civil society to assist the rehabilitation and integration of persons with mental illness. Sec 81 needs to be amended to distinguish between therapeutic and non-therapeutic research.

B. Budgetary measures

Measures need to be taken to ensure that mental health receives due attention in terms of allocation of resources. The percentage of allocation of resources should be based on the need but not less than 5% of the total budget.

C. Measures to improve functioning of health services

- Human resources for mental health – Human resource development for mental health has been very restrictive and largely medical in its orientation in the past fifty years. The other sectors, especially disability sector have evolved models, which are interesting in spite of their limitations. They have created community-

based cadres of service providers and have included caregivers and users of the service in provision of care.

The second step that the government can take is to mainstream mental health issues and skills into existing training curricula of all helping professionals. The need is to institutionalize linkages with existing providers of training for teachers, nurses, doctors, graduates and postgraduates in psychology and social work and facilitate inclusion of basic mental health issues and skills in their existing curricula. The modules for such integration can be made by the Technical resource Group proposed earlier.

- Quality assurance and standards of care

  Mental health services need to have mechanisms for assuring quality. In the present scenario, quality assurance is not being provided by any of the sectors. Institutional care still has some statutory parameters to follow, but the other components of care are largely unmonitored and there is a lack of accountability. There is a need for standardized protocols of care based on evidence and consensus for service provision.
- Facilities at the district level for <u>diagnosis, treatment and care</u> by qualified and trained mental health personnel. Paramedical support for mental health and development (standard treatment protocol)

- <u>Study and research</u> on alternative good health care systems such as AYUSH (Ayurveda, Unani, Sidda and Homeopathy)

D. Provision of Services for mental health

a. Supervise domiciliary after care program which facilitates the transfer of care from the institution to the community. This should include financial compensation for caregivers.
b. Promotive mental health services such as barefoot counselors – early identification and referral
c. Access to all poverty alleviation and welfare programs
d. Proactive district legal aid committees who can be approached in cases of human rights violations, exploitation and abuse.
e. Provision of specialized services to all Vulnerable groups → women, children, the aged, destitute, sexual minorities, victims of natural and man made disasters such as violence, terrorism and riots, victims of dowry, child sexual abuse etc.

VI Social Monitoring system

a. User Audit - There is also a need for consumer and civil society led ongoing quality audit of services so as to ensure a decreased risk of violation of rights of people with mental illness. This quality assurance is only possible through a public- private partnership.

Lok Adaalats and communities should also be part of the audit mechanisms.

VII. Information Education and Communication

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VII. Information Education and Communication

a. Cultural and locally appropriate educational material needs to be developed in collaboration with NGOs
b. Mental health website
c. Need for training medical professionals and strengthening undergraduate medical curriculum
d. Development of a National mental health resources center
e. Mental health should become part of school curriculum and teachers training

IX Ethical guidelines

There is a need for periodic review and effective implementation of ethical guidelines in issues such as Use of ECT, drug related research etc.

L-7A-10

Right to Essential Drugs

Modern Medicines form an essential component of modern Health Care. But it needs to be understood that while a very large number of drugs are present in the market today, only a small fraction of these provide significant benefit. Further, out of these, i.e. about 2000 drugs which have been proved through research to be effective and safe, only about 300 are considered 'essential'. Essential Drugs (EDs) are those which can cater to the majority of the needs of a population in a country and hence according to the World Health Organization they must be available at all times in adequate quantities in the relevant health care centres. Countries should be self-reliant in the production of the EDs, and the EDs should be accessible and affordable to all.

Unavailability of EDs can cause death or serious complications, which may lead to long-term impairment of health. Hence availability of EDs is a human right. In India however, this right is being violated in both public and private sector.

Access to essential Drugs in India is compromised at various levels. Estimates say that only about 20% of the population has access to all essential drugs they need. While the country is largely self-reliant in production of essential drugs, and in fact exports in excess of 40% of the total volume of drugs produced, our own people are denied access. This denial takes place today because drug prices continue to be high and thus unaffordable, the public health system spend too little on procuring drugs, and there is widespread production and prescription of irrational and hazardous drugs.

Our suggestions about key policy measures to ensure availability of EDs to all the people are as follows:

Availlability of EDs in the Public Health Care Facilities

In the public health services, a graded ED list should be prepared which would list which drugs should be available for Primary Health Care with Community Health Workers, (CHWs), in Sub-centres and Primary Health Centres (PHCs); for secondary health care in Community Health Centres (CHCs), Rural Hospitals (RHs) and for tertiary care in District Hospitals and Medical College hospitals. The National Essential Drug List (NEDL) needs to be graded accordingly. The lists of EDs which must be available at different health care centres must be widely, readily available and the list for the relevant centre should be available at the centre. The authorities have to ensure that the patient does not have to buy any medicine included in this list. If in exceptional cases the patient has to purchase any of the medicines from this list, this expense should be reimbursed to him/her. Unless this provision is made, there would not be any effective mechanism for people to ensure that they get EDs without paying from their pocket. Unavailability of EDs in sufficient quantities is a violation of human rights as it can jeopardise life and health of the people.

Annual requirements of these health care centres need to be estimated and accordingly supplies, inventories need to be maintained. This is not being done and there are gross, frequent shortages of EDs at all levels, as has been complained by health-activists and borne out by available studies. To give an example, only about 20% of the patients go to the Primary Health Centres and even half of their requirement is not met. A large proportion of patients are given prescriptions to purchase medicines or have to pay the doctor for these medicines, which the doctor keeps with him as private stocks.

One study indicates that the drug-supply to the PHCs needs to be doubled to cater to the current drugs needs. In Maharashtra, this would require only Rs. 100 million, compared to the overall health budget of the Maharashtra govt. of Rs. 20000 million. It is thus possible to ensure the availability of EDs at all times, and this availability should be part of the basic health services as a matter of human right.

The drug companies in the public sector have been marginalized during the last 20 years. This process needs to be halted and public sector drug companies need to have an important role to play

in the supply of life saving, essential drugs, as this availability can not be left entirely to the market forces.

For the procurement of drugs for the Public Health facilities, a transparent procurement mechanism similar to that adopted by the Tamil Nadu Medical Service Corporation should be adopted.

Access to EDs in the private sector

An estimated 90% of the annual drug consumption of about Rs. 20,000 crores in India is through private purchases made by households. A large proportion of this sale consists of sale of unscientific fixed dose combinations and of non-essential drugs. Though EDs too are available and sold in significant proportion, they are not accessible to every body because of lack of adequate purchasing power. The primary barrier in the effective accessibility of EDs in the private sector is their high prices due to profiteering by the drug companies. This profiteering of the is seen from various indicators like -

- The higher share prices and bonuses of drug-companies.
- Huge price-differences between the branded formulations in the retail market and corresponding formulations in the generic drug market.
- The procurement prices of some drugs by the Tamil Nadu Medical Services Corporation (a public sector procurement agency) are as low as 2 to 10% of the retail market prices of these drugs.

Drugs are not only a life saving essential commodity but also the one in which 'consumer pays but doctor decides'. Moreover, patients are in need of urgent relief and hence have very little choice but to buy the prescribed medicines urgently at whatever price the medicines are available in the retail market. Unlike in the West, in India most of the patients are out of any institutional coverage, and hence are further vulnerable to face the powerful drug industry as individual buyers of medicines.

All these factors together make a strong case for including all EDs in the Drug Price Control Order (DPCO). In 1994 the government announced its new policy on Drugs and Pharmaceuticals. While continuing the trend set in 1986, the Govt. reversed all positive features of the 1978 drug policy which had helped to built a self reliant industry, the best of its kind in the third world, and comparable to those in many developed countries. In the new policy the Govt. granted major concessions to the industry in terms of reduced price and production controls. They included the slashing down of the number of drugs under price control and increase in returns allowed for bulk drug manufacture. Further the DPCO of 1995 (based on the 1994 Drug Policy) has used purely market based criteria for selection of drugs in DPCO and has totally neglected Essential Drugs as a criterion. Thus, over the years the number of drugs under price control has been slashed from 343 in 1978, to 166 in 1987, and to 74 in 1994. The 2002 Policy and the new DPCO seeks to further slash the span of price control (to about 25-30 drugs only) but the new DPCO has been stayed by the Courts because of a Public Interest Litigation challenging the new order. Hence many of the even life saving drugs are currently not in the DPCO. This policy has to change and all EDs have to be included in the DPCO.

Price controls need also to be matched with production controls to ensure that companies do not shift production from essential drugs that are under price control to drugs that are not essential but are outside controls. Otherwise there will be shortages of EDs and proliferation of non-essential drugs.

Weeding out of Irrational and Hazardous Drugs

Irrational and hazardous drugs, which exist in the market, are an unnecessary burden on consumers, and take away resources from what should be spent on essential drugs. While the Drug Technical Advisory Board (DTAB) is supposed to monitor the presence of such drugs, its functioning has been far from satisfactory. There is urgent need to revamp the DTAB, broaden its powers and have the DTAB play a proactive role in weeding out such drugs from the market.

Adverse Drug Reaction Monitoring

These efforts need to be matched with the setting up of Adverse Drug Reaction Monitoring centers across the country, so that there is an ongoing mechanism to monitor the incidence of adverse drug reactions. All developed countries have such mechanisms, and it is indeed a shame that India, with arguably the second largest scientific manpower in the world and the most developed pharmaceutical industry in the developing world, is yet to set up an effective mechanism to monitor hazards related to drug consumption.

Quality Control

It is estimated that 40% of drugs consumed in the country are substandard or spurious. Over the years a large number of companies (including "reputed" large pharmaceutical companies) have been indicted for producing sub-standard drugs. In addition, recent reports indicate that the production of spurious drugs has become a major problem. In order to address these it is necessary that the Drug Control mechanism be strengthened. This would include pledging resources to have a much larger number of Drug Inspectors, and changes in the Drugs and Cosmetics Act to provide more powers to Drug Inspectors. A transparent mechanism by which consumers and health professionals can file complaints about drug quality should also be instituted.

Unethical promotion of Drugs

Drug Companies use a variety of unethical methods -- ranging from providing wrong information, suppressing information, to providing monetary and other inducements -- in order to promote a host of irrational and hazardous drugs. It is necessary to formulate a "Model Code of Conduct" for drug promotion and also to institute a mechanism that monitors and regulates promotional activities of drug companies.

Amendment to the Indian patent Act 1970

As per the provisions of the TRIPS agreement under the WTO, India is required to amend its Patent Laws to provide for a TRIPS compliant regime. There has been extensive debate within the country about what the contours of India's Patent Laws should be. The 1970 Act served the country well and was instrumental in development of the indigenous industry – *to a point where the Indian pharmaceutical Industry is the leader in the developing world.* It is thus imperative that any fundamental changes in the 1970 Patents Act need to be carefully examined, so as not to compromise the interests of the country, both in terms of our ability to safegaurd the health of our people and our interest in promoting a self-reliant indegenous Pharmaceutical Industry.

There is a wide consensus that domestic laws, while being TRIPS compliant, need to make full use of "flexibilities" available in the TRIPS agreement. This was reiterated in unequivocal terms by the WTO Doha Declaration on TRIPS Agreement and Public Health (2001), which, *inter alia*, commented that countries have the sovereign right to enact laws that safeguard domestic interests. It recognised the gravity of public health problems in developing countries and clearly provided that member countries had the right to protect public health to promote access to medicines for all.

In pursuance of the necessity to make India's Patent Laws TRIPS compliant, the Indian Parliament has enacted two legislations through the Patents (Amendment) Acts of 1999 and 2002. In order to fulfil the conditions in the TRIPS agreement, a Third Amendment is now to be tabled in Parliament. The Patents (Amendment) Bill of 2002 did not make full use of the flexibilities available in the TRIPS agreement, which were further emphasised in the Doha Declaration.

The draft Bill, is entirely inadequate in addressing domestic concerns relating both to health care and development of the indigenous industry. The least that that the Indian government needs to do is to pro-actively use the space created by the Doha declaration in order to ensure that all newer EDs which have Public Health importance are kept out of the new patent regime. Otherwise in coming years, Indian people will be increasingly denied their right to essential drugs.

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Concept Note on the Private sector in Health Services for NHRC Hearings

Any attempt to locate the role of the private sector in health services within a rights framework has to take into account the extent of poverty and the type of services provided by this sector. Since the private sector caters to those who have the ability to pay for services, there is serious concern regarding accessibility, especially for a large percentage of the population that lives below the poverty line. Another important concern is that the private sector focuses only on curative services and therefore fragments a comprehensive approach that includes the preventive, promotive and rehabilitative inputs in the health services. The private sector has grown over the last three decades due to a weak public health service infrastructure and recent policies that have offered a variety of subsidies, has furthered this process. The abdication of the state to provide health services has 'pushed' people to the private sector as a result of which only those who are able to pay for services can access these services.

The private sector occupies a significant presence in the delivery of health services at the primary, secondary and tertiary levels of care. Over the last two decades there has been a significant growth in the number of institutions providing health services across states and rural/urban areas. The increase in the number of institutions is reflected in the utilization patterns as well. Studies show that a significant proportion of the population utilizes the services of private practitioners, trained and untrained, for minor ailments requiring out patient care.

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For in patient care requiring hospitalization one finds that there has been a shift from the public to the private sector especially among the upper and middle classes. While those belonging to the lower income groups rely much more on the public sector they are also accessing the secondary and tertiary level private hospitals.

It is well established that the private sector is characterized by plurality and heterogeneity. At the primary level it consists of individual practitioners, at the secondary level there is enormous variation in the size of operations, bed strength, and types of services and cost of services. The tertiary level consists of specialist hospitals with varying patterns of ownership (trust, corporates, private limited concerns), type of services and also cost of services. Given this heterogeneity with little or no regulations as a result serious concerns have been raised by health researchers and activists regarding access, price, quality, type and equity for people who utilize these services. Another important concern is that the private sector provides curative services for the treatment of a number of communicable diseases. These curative interventions constitute an important input into the strategy for prevention of communicable disease, therefore, it must be mandatory for private institutions to report cases treated to the public health service system. Suitable systems for reporting by the private sector to the public health services need to be worked out. In the treatment of communicable diseases the private sector needs to follow the standardized treatment procedures as prescribed by the National Disease Control Programmes.

It is often assumed that the private sector provides better quality of services as compared to the public sector. Studies have shown that there is variability in standards in terms of training of personnel and infrastructure across levels of care that influences the quality of the services given. Similar variability is seen for pricing of services with no transparency in the pricing of services. Often a patient accessing a private facility cannot anticipate the cost that he or she is likely to incur at the end of the treatment process. Given the profit motive of the private sector unnecessary testing, procedures and irrational use of drugs have been reported in various studies. The high cost incurred is a burden, especially for those who belong to the lower income groups. Studies have shown that high costs of medical care are a major cause of rural indebtedness for lower income groups. The world over, especially in countries where organized healthcare systems exist, insurance is an important mechanism of financing healthcare, whether provided by private providers or public facilities.

Insurance is an important financing mechanism to sustain a private health economy at one level and at another level insurance is also a mechanism to regulate and control medical practice. In Canada, Europe, Australia, Japan and some Asian and Latin American countries insurance operates with a publicly controlled/regulated healthcare system and hence it is sustainable but in the USA, as also in India, insurance deals largely with private markets and hence insurance in such countries is grossly inequitable and unsustainable. India has to learn from the non-USA experience in developing its health insurance markets.

In the absence of professional or governmental regulations, the private sector cannot be held accountable. There is lack of transparency and information for the person seeking care and there

are few mechanisms for redressal of grievances arising out of unethical practices and medical negligence in the private sector. The inclusion of medical services in the private sector under the Consumer Protection Act was a mechanism for dealing with cases of medical negligence. There were a few cases that were filed with consumer courts in different parts of the country and there have been some landmark judgements. However these are few when compared to the extent of the problem since majority of cases involving medical negligence go unreported.

At this juncture it is important to address the problems within the private sector and evolve mechanisms covering various aspects.

- Review, amend and implement the existing legislations concerning various aspects of the private sector.
- Evolve effective review, monitoring and regulation of standards of private medical and paramedical institutions and for different levels of service providers. At the Central and State levels there is a need to enact an Act for clinical establishments for hospitals, nursing homes, clinics, pathological labs, diagnostic centres addressing issues of standards and quality of care.
- Evolve mechanisms for periodic audit of clinical interventions in private nursing homes and hospitals with reference to gynaecological and obstetrics, cardiology, orthopaedics.
- Create a mechanism for social audit for reviewing quality in private hospitals, medical and paramedical colleges/institutes.
- Registration of imaging technologies and Assisted Reproductive Technologies be made mandatory.

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- Review and evolve operative criteria for assessing 'profit' and 'non profit' status of hospitals.
- Private hospitals undertaking research have to be registered with the appropriate government institution.
- For all human clinical research trials must have clearance under the appropriate clause under the Drugs and Cosmetics Act. Mechanisms for getting clearance, reasons for giving the clearance by the appropriate authority, providing information regarding the research undertaken and its results should be made public.
- Direct government subsidies should not be given to corporate hospitals. For any past violations of conditionalities, appropriate compensation should be paid by these corporate hospitals to the government before any new business deals are made. The compensations must include penalty for the occupation of the land and non-provision free/concessional services over the period of violations.
- Build systems for reporting and monitoring of cases treated in the private sector to the public sector.
- Transparency with regard to pricing of services.
- Proper maintenance of medical records and access to patients to these records.
- Abide by the conditionalities when receiving government subsidies.

Rama V. Baru and Imrana Qadeer
Centre of Social Medicine and Community Health
JNU, New Delhi
Ravi Duggal, CEHAT, Mumbai

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Annexure

Summary of Qureshi Committee report

The terms of reference, laid down by the government of Delhi to the constituted high level committee of enquiry for hospitals in Delhi (Chaired by Justice A. S. Quereshi), in 2001 were

a) To review the existing free treatment facilities extended by the charitable and other hospitals who have been allotted land on concessional terms/ rates by the government.

b) To suggest suitable policy guidelines for free treatment facilities for needy and deserving patients uniformly in beneficiary institutions in particular to specific the diagnostic, treatment, lodging, surgery, medicines and other facilities that will be given free or partially free.

c) To suggest a proper referral system for the optimum utilization of the free treatment by deserving and needy patients.

d) To suggest a suitable enforcement and monitoring mechanism for the above including a legal framework.

Findings and recommendations.

The inquiry that lasted for eleven months tabled the following findings and recommendations.

The existing free treatment facilities extended by charitable and other hospitals who have been allotted land on concessional terms/rates are inadequate, erratic and far from what was desired. The reasons that were mostly attributed by the hospitals were on various fronts.

1) Few hospitals questioned the financial prudence and viability of ventures on offering free services. They feel it to be an unwarranted and huge financial burden.

2) Other hospitals present their case in a different way, they claim to be the purchasers of the land and feel in no way obliged for free services.

3) But some hospitals, who agree that they had been either allotted or leased land from the government, claim that free service is not mentioned in any of the agreements.

4) A few hospitals who claim that they are not charitable hospitals and therefore not liable for free services.

5) In the government's conditionality there is no precise definition of the 'poor', who can be considered eligible for free treatment. And there has not been an agreement over what constitutes free services.

The policy guidelines and recommendations of the inquiry are

- The government needs to intervene and to take action against all cases who have contravened the terms and conditions of allotment. The allotments and leases could be cancelled and necessary fresh agreements specifying fresh and uniform terms and conditions. The committee also suggests that the tariff subsidised has been too low and could be charged on nominal market rates. And the new agreement should look into the reconstitution of the managements with at least three nominees of the Delhi government on board of all managements. And all defaulters should be made to pay compensation which could be constituted as a welfare fund to benefit the poor.
- Regarding the policy for treatment the committee recommends certain guidelines. They would include on the issue of free treatment the committee

defines **free treatment to be completely free and not partly free**. The patient virtually will not have to pay anything in both O.P.D. and I.P.D. including medicines and medical consumables. The extent of offering free services would be 10% of the total beds in I.P.D. and 25% of the total number of patients in O.P.D. uniformly.

- Every hospital should have committee to screen and if necessary investigate to ascertain the patients who are really poor and deserve free services. And all such services rendered should be directed to a newly constituted monitoring cell under D.G.H.S. on periodic basis. And there should be strict penal provisions for any non- compliances.
- All patients referred should be through hospitals with referral letters to the monitoring cell stating and justifying the reasons for referral to a super speciality hospital. Individual or institutions or other bodies of government or non-government are not eligible for any references.
- The committee recommends a drastic overhauling of the existing legislation and suggests bringing in a new legislation that would be comprehensive and properly monitoring all private medical institutions irrespective of just free services but also on other larger and pressing issues.

Indraprastha Apollo Hospital

The Indraprastha Apollo Hospital is a collaborative venture with the government of the Delhi. The Delhi government has purchased the land of 15 acres for Rs 4 crores and has leased out to the hospital for a period of 30 years. The government collects a token rent of just one rupee from the hospital as subsidy with an agreement that stipulates to treat poor patients free of service and that would be one thirds of the total number of beds. The hospital was planned to be a 600 beds hospital and hence it is believed that 200 beds will be for poor

patients. However on inquiry it was found that there had not been any free services for 200 beds but only 140 beds out of a total of 650 beds is being earmarked for free services. And the services that are offered are also not totally free.

The paradox is that the Delhi government owns 26% of the equity shares valuing Rs.23 crores of the hospital, it has further invested Rs.15 crores in the construction of the hospital, has its appointees on the board of management and still, the result is far from the desired. An overall investment of Rs.40 crores and further subsidies in terms of land import of equipments have all meant nothing for the Delhi's poor. And the reasons cited are huge economic burden if such services are rendered, which is indeed far from true. It is indeed a blatant violation of an agreement and a fraud on public funds invested in the whole project.

L-7A.13

Summary of presentation on Environmental and Occupational health rights at National Public hearing on Right to Health Care, 16-17th December 2004

Presentation by Occupational Health and Service Committee and the Corporate Accountability Desk of The Other Media

In India, child mortality rates due to environmental hazards and toxins are on the rise, with about 55% originating in perinatal period. Apart from traditional environmental risks, modern hazards like air pollution, exposure to agro-industrial chemicals and toxic wastes are increasingly influencing people's health and wellbeing in India. It is estimated that India spends about Rs. 4,660 crore every year to make up for health damages caused solely by ambient air pollution alone (Aggarwal et al, 1999). A World Bank study found that one person in Delhi dies every hour due to air pollution-related respiratory diseases.

Death and injury caused by environmental pollution are preventable. However, because it is the poor and people from socially oppressed castes that are predominantly and disproportionately affected by pollution and environmental disturbance, preventive measures are slow to come. This is a form of environmental racism that is prevalent in our health and environment policies. In fact, the National Health Policy is very shallow in terms of its discussion of environmental/occupational health, and does not analyse environmental health as a class or caste issue.

The National Health Policy 2002 (NHP 2002) has only now reached the stage where it has acknowledged Environmental and Occupational Health as an issue: *"The ambient environmental conditions are a significant determinant of the health risks to which a community is exposed."* It goes on to state that *"This Policy envisages that the independently-stated policies and programmes of the environment-related sectors be smoothly interfaced with the policies and the programmes of the health sector, in order to reduce the health risk to the citizens and the consequential disease burden".* The policy also recognized "sub-standard" working conditions and vulnerability of workers, specially children in such kind of workplaces. Therefore, the policy explicitly stated: *"NHP-2002 envisages the periodic screening of the health conditions of the workers, particularly for high- risk health disorders associated with their occupation."*

This understanding of the effects of environment on community and worker health is not new. The Factories Act and the Workman's Compensation Act recognise the impact of the workplace environment on workers, and mandates preventive, diagnostic and rehabilitative measures to protect worker health. However, the law is not implemented, at least in part because resources and incentives are not provided to implement the law.

Similarly, it is not known, or likely, that the NHP's lofty vision is matched by commensurate budgetary allocations. Indeed, research on environmental health finds no mention in the health research section of the NHP 2002. The Policy states that it "envisages an increase in Government-funded health research to a level of 1 percent of the total health spending by 2005; and thereafter, up to 2 percent by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also on the sub-types of HIV/AIDS prevalent in the country."

Despite the obvious link between health, and the living and working environments, coordination between the Ministries of Environment, Health and Labour is pathetic.

This is evident from the fact that the public health care system does not work to detect, treat or prevent environmental or occupational diseases. Neither does the health department seem to see a role for itself in environmental and occupational health issues.

Issues relating to occupational health:

- It is estimated that between 100,000 and 150,000 workers are killed in workplace accidents and that there are two million new cases of occupational diseases per annum. (Stirling Smith)
- The official estimates for deaths at work are incomplete partly due to poor reporting mechanisms, but greatly due to non-applicability of legislations on a large section of work places that constitute the bulk of workforce, that is in the informal sector.
- Informalization of work has added more uncontrolled workplaces and more insecure workforce - women and children.
- Deaths from occupational diseases will be greater than those from accidents.
- The majority of these deaths are preventable, without expensive imported technology.
- Occupational safety and Health is neglected as a development issue and as a human rights issue.
- The Factories' Act does not give rights to workers and trade unions to approach courts in cases of violation of occupational safety at workplaces.
- Because pollution-impacted people, including workers and contract workers, are predominantly and disproportionately from poor and politically disadvantaged communities, they do not have the political or economic strength to sustain long-drawn legal cases, or to fight for the implementation of favourable court orders subsequently.
- Doctors (Factory doctors, government or private doctors) are not trained to detect Environmental and Occupational Health problems either in individuals or in communities and to report them as an important preventive tool.
- Pollution control measures, environmental standards or pollution norms are made with an attention to the financial health of the industries that are regulated than to the health of workers, the community or the environment.
- The amounts given as compensation to workers for lifetime injuries due to occupational hazards are meager.

Some of the key issues relating to Environmental health:

While the kinds of industries and the number of people living within the impact range of pollution may differ from place to place, the problems faced by and the demands of workers and communities living along or near the fenceline of polluting factories is identical throughout the country.

Issues with regard to health in pollution-impacted communities:

- High rates of morbidity among exposed people, especially women and children. Because women, children stay at home and, hence, in a polluted atmosphere all day long, they (along with and factory workers living within the pollution-impacted community) are worse affected than men or others who may have relief from pollution for at least the time that they leave the polluted environment to work elsewhere.
- Children are routinely identified as one of the most affected groups.
- Pollution-related diseases are treated symptomatically and without any real understanding of toxic injuries.
- For most pollution-impacted communities, medical expense takes a disproportionate share of income. Added to that, health problems – particularly for the daily wage earners who constitute the bulk of the pollution-impacted -- also mean a loss of income due to lost work days.
- Regulatory authorities regularly stand the Precautionary Principle on its Head. Anecdotal evidence, testimonies of pollution-impacted people, complaints and even simple studies seem to be inadequate to move district authorities, the health department and the Pollution Control Board into action. Rather than act on this evidence, they demand conclusive proof of harm from complainants or belittle their claims as exaggerated, or motivated by greed.
- Flawed values and belief system: Many officials at regulatory authorites believe that pollution is inevitable, and that communities – particularly the poor and workers – cannot be choosy about the kinds of jobs or "development" they get. They also recommend "reason" and "patience" to complainants, saying that the pollution has to be reduced gradually keeping in mind the need to balance the interests of the industry and the community. This attitude condones pollution and authorizes the ongoing exposure of communities to pollution.
- Alarmingly, the Health Department is noticeably absent from the discussion around the issue of health in pollution-impacted communities. In the absence of any steps to stop exposure to pollution, there is little that can be done to improve the health status of pollution-impacted communities.
- The local Government and medical and emergency infrastructure (hospitals, police, fire department) lack the training, understanding, infrastructure and resources to deal with an industrial accident or emergency. None of the communities hosting a hazardous plant is any better equipped today to deal with a Bhopal style disaster than it was 20 years ago.

Recommendations to address issues of Environmental and Occupational health within the health and environment policy framework:

1. Recognizing and addressing Environment and Occupational Health issues as integral part of community health issues by facilitating greater interaction between Health, Labour and Environment ministries.
2. Seeking out and engaging with labour organisations and community groups in developing an understanding of the health issues and the solutions.
3. Update the list of scheduled occupational diseases under Workman's Compensation Act based on the Precautionary Principle, and initiate a process to prepare a similar schedule and compensation mechanism for communities resident near polluting industries.

4. Improvement in the existing infrastructure and institutions like Employees' State Insurance Corporation, Public Health Care centres to detect, diagnose, treat and report Environmental and occupational health problems.
5. Expansion of the ESIS to include the informal sector. ESI Corporation may already have the financial strength to do so and may not require additional finances.
6. Notify areas around polluting industries as "Zones of Environmental Health Concern."
7. In the health administration infrastructure (ESI, PHC, GH etc) covering "Zones of Environmental Health Concern," deploy specialised environmental health cells or retrain existing health department staff to deal with a) long-term monitoring health among pollution-impacted communities; b) providing long-term specialised health care to people living, working within such Zones; c) cases of acute poisoning by industrial chemicals.
8. In such zones, set up Local Area Committees, involving elected panchayat leaders, representatives from women's self-help groups and public interest organisations with a demonstrated commitment to working on issues of pollution and/or health. Such committees should be vested with authority and provided training to monitor health and the functioning of health care infrastructure, report on pollution incidents, and supervise efforts to reduce pollution.
9. Stop Ongoing Exposure, Stop Pollution: Working with the Ministry of Environment and the Central Pollution Control Board, the Ministry of Health should deploy a plan for toxics use and release inventories in factories, and for reducing the use of toxics in a timebound manner.
10. Deploy an emergency plan to contain the damage already done to children's health, and initiate measures for the rehabilitation of children's health.
11. Operationalise the Polluter Pays Principle: Polluting industries maximize their profits by externalizing the costs of pollution to the community in the form of transferred health care costs to repair pollution-related health damage. These industries should be made to pay for the health care of pollution-impacted communities and for the specialized health care infrastructure required in such communities.
12. Operationalise the Precautionary Principle, and use the Precautionary Principle rather than a cost-benefit analysis to guide decision-making on the matter of environmental health. Pollution standards and pollution-control mechanisms should be based on health criteria rather than on issues of economic viability of industries.
13. The Health Department should play a proactive role in ensuring that practices to prevent harm are followed within industries. They should do this by coordinating with the Factories Inspectorate.
14. The Health Department should facilitate the routine monitoring of workers health data that is required to be, but is not, collected under the Factories Rules to identify problems (if any) of occupational diseases among them.
15. The Factories Inspector should be directed to diligently perform his/her functions, particularly in regard to maintaining industrial safety and ensuring emergency response by industry. The Inspector should also ensure that only trained workers are deployed on hazardous jobs and contract workers are not used for such activities.
16. Hospital infrastructure in the areas near polluting industries should have trained personnel and equipment to deal with cases of industrial injury and poisoning.

17. The District Administration should be instructed to assist the victim or his/her survivors in accessing compensation and/or pension. An interim compensation fund should be created with advance contributions from polluters.
18. NHRC should direct the Pollution Control Board to show zero tolerance to polluters.
19. A National Commission on Pollution Impacted Communities (including workers and communities) should be constituted to understand the special needs of pollution-impacted communities, and recommend specialised infrastructure to deal with the same.

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Health Rights in the context of HIV infection and AIDS

Presentation by the Jana Swasthya Abhiyan
National Public Hearing on Right to Health Care
Jointly organised by the National Human Rights Commission and
Jan Swasthya Abhian
(New Delhi: 16-17 December 2004)

HIV/AIDS is a developmental issue that calls for social and political action. It is also a public health issue that requires people-oriented health and medical interventions. Such responses require democracy, pro-people inter-sector policies, good governance, people's participation and effective communication. They should be rooted in internationally accepted human rights and humanitarian norms ['People's Charter on HIV/AIDS' by People's Health Movement].

The widespread abuse of human rights and fundamental freedom associated with Indian constitution has emerged as a serious issue in the last two decades after the origin of epidemic in India. Protection of human rights is essential to safeguard the human dignity in the context of HIV infection and AIDS. This paper draws upon five important areas where violation of human rights in the context of HIV infection and AIDS in health sector has been reported in India.

1. Universal Access To Treatment For PLHAs Through Public Health System

Providing equitable access to comprehensive treatment for HIV infected people is crucial to the overall HIV infection and AIDS scenario in India. Comprehensive healthcare for those who have infected with HIV/AIDS include opportunity for them to lead healthy lifestyle which include cost-effective nutritional input, psycho-social support ect., access to treatment for the opportunistic infections and access to anti-retroviral therapy. The inability of people living with HIV/AIDS to access treatment is violating the 'Right to Life' under the India's constitution. The 'Right to Life" guaranteed by the constitution has been interpreted by the Supreme Court to include the "Right to Health' [Eg. Vincent Panikulangara Vs Union of India, 1987]. Many international commitments for which we are a signatory also mandate the state to provide access to treatment for those who are affected by HIV/AIDS [Eg. UNGASS Declaration of Commitment].

The Alma Ata Declaration of 1978 promised health for all by 2000 through primary health care approach. Verticalisation of public health systems, changing economic priorities, invasion of private interests into political decision-making and lack of political determination lead to undermining of our public health system. This breakdown of public health and primary health care systems over the last two decades has proved to be highly detrimental to the capacity of our health system to cope with the treatment and care of HIV/AIDS.

One of the important components of treatment for the HIV/AIDS infected people is Anti-retroviral Therapy. Effective therapy inhibit the viral replication and reduces the viral load. This results in lower frequency of opportunistic infection and helps the infected people to lead more productive lives. The decision taken by the Government of India to provide treatment to one hundred thousand people starting from 1st of April 2004 in six high prevalence states was an important step. However the majority the people who require anti-retroviral therapy are outside this commitment. It has also

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been noted that the pace at which the programme is rolling out even in the identified states is not at a desirable level and also some of these states are facing logistic problems. One major reason for this is the collapse of our public health system which make it handicapped to handle and monitor Anti Retroviral Therapy. Though the programme has been announced as free of cost, it is totally objectionable that certain elements of cost recovery from users have nevertheless been brought into the public provision of Anti-Retroviral Therapy through the back door. The present programme does not offer any second line therapy making people who fail in the first line therapy highly vulnerable.

Informed consent and proper counseling of patients is essential and should be mandatory before starting the treatment. The counseling should include detailing the nature of life long treatment, possibility of resistance, toxicity of anti retroviral drugs. Provision of anti retroviral should ensure maintaining and respecting the right to confidentiality of the PLHAs, proper monitoring of the patient clinically and also providing necessary psycho-social support. Another important point of caution is the likelihood of abuse of Anti-retrovirals by the unregulated private health sector in India [as in the case of tuberculosis treatment where hundreds of different treat regimes, most of which are irrational are being practiced by the doctors]. This should be avoided as such a practice can result in drug resistance as well as exploitation of the patients.

Increased cost of anti-retroviral drugs decreases government's ability to procure medicines. The impact of TRIPS on cost of drugs will be one aspect that will make treatment out of reach for most of Indian PLHAs. Government of India should make maximum use of the provisions available within TRIPS and also pursue other options like overhauling and expanding system of price control of medicines. Revamping of public sector drug manufacturing units is another crucial step in making sure the availability of medicines at critical times.

Recommendations

1. Governments should develop and strengthen health system based on comprehensive Primary Health Care principles and include the treatment and care interventions for peoples living with HIV and AIDS under it.
2. Government should ensure free and universal access to treatment for opportunistic infections, provision of anto-retrovirals whenever necessary and required monitoring tests to all people living with HIV and AIDS. Make nutritional inputs and psychosocial support part of HIV and AIDS care. Special attention should be paid to gender issues and treatment access of women living with HIV infection. There is increasing number of children living with HIV/AIDS and their need for treatment should be also be attended to.
3. Cost recovery elements in the present programme to provide anti-retroviral therapy in select high prevalence states should be stopped.
4. Treatment protocol required for the administration of anti retroviral drugs and drugs for opportunistic infection should include guidelines for counseling and informed consent. Take necessary steps to ensure that the same protocols are followed by the private sector.
5. Ensure the availability and affordability of all essential medicines including those required for the treatment of people living with HIV and AIDS, by expanding the DPCO and making the process of price control transparent.
6. Make use of the flexibility available with in TRIPS agreement and include supporting provisions in to the amendment to the patent Act. Accessibility and availability of medicines should be

ensured by limiting patents to new chemical molecules and revamping the existing compulsory license mechanisms.

7. Revitalise the public sector pharmaceutical manufacturing units so as to cater to the needs arising out of situation under TRIPS.

2. Prevention of Parent To Child Transmission

Perinatal transmission of HIV infection accounts for about 2.74% of all HIV infection in India. In the absence of any preventive steps, the risk of vertical transmission from an infected mother to child is about 30 to 35%. Historically the prevention of parents to child transmission was looked only as a technical/clinical issues of treating the mother and child to prevent vertical transmission. However it needs to be viewed from a rights perspective of all the people in child's life whose well being will enable fulfillment of child's life.

Unfortunately our weak health system provides limited access for anti-natal care leaving many who require preventive measure against vertical transmission out of reach. Unless the health systems are equipped to provide ante-natal care services to most of pregnant women, the chances of most of the infected pregnant women accessing Voluntary Counseling Testing [VCT] and Prevention of Parent To Child Transmission [PPTCT] are rare. The availability of VCT and PPTCT should be universal by making it part of health systems based on primary health care strategy.

Right to autonomy and bodily integrity is recognised in all law including the fundamental rights in the constitution – article 21 – right to life and personal liberty. However despite the recognition of the right to autonomy and bodily integrity in the law, large number of women visiting the ante natal clinics in India are routinely prescribed HIV test as part of a battery of tests. In India a number of cases have already been reported where pregnant women are subjected to HIV screening without proper pre test counseling and on diagnosis of HIV infection, they are denied post test counseling. It should also be ensured that HIV infected pregnant women are not coerced into abortion by health system staff or relatives and the choice should be given to the pregnant women. Availability of voluntary testing facilities with compulsory provisions for pre and post test counseling is a must for safeguarding the mothers right to take an informed decision regarding testing, continuation of her pregnancy and also for receiving treatment for PPTCT.

PPTCT programme which look only at the right of the child and ignoring the rights to life of people connected with the child is unacceptable. Treatment and care should also be made available to HIV positive mothers and other infected members of the family. Adequate support systems need to be built within the community for the affected and infected children.

The risk of transmission of infection to child through breast milk is about 15 percent. But given India's high infant mortality rate, the protection benefits of breast feeding against Diarrhoea and other life threatening infections far outweigh the risk of transmission through breast feeding. Every HIV positive women has the right to an individual evaluation of the best feeding option for her child. If she decides so, all required support should be made available to enable this.

Recommendations

1. Ensure that women visiting antenatal centres are not targeted and taking informed consent and pre and post test counseling should be part of any screening for HIV infection in pregnancy.
2. Accepting or refusing testing should not have detrimental consequences to the quality of prenatal care offered.
3. Access to PPTCT should be universal. It should not be viewed in isolation as a procedure to prevent vertical transmission and all people related to the life of the child especially the mother should get anti-retroviral drug therapy, if required
4. Women's reproductive health rights should be respected in aspects of the programme to reduce the risk of parents to child HIV infection. Woman's decision based on proper informed consent should be mandatory for all important decisions including continuation of pregnancy, PMTCT intervention, breast feeding of the child etc.

3. Consent and counseling issues related to testing/screening for HIV

The principle of consent is based on the fundamental principle of autonomy of an individual, which has been recognised within the meaning of the right to life and personal liberty under Article 21 of the Constitution of India. Based on this principle, the most important reason for taking consent from a person before testing and treatment is to respect human dignity and bodily integrity. Another reason for taking consent is clinical; as the efficacy of any treatment improves substantially through a patient's co-operation, faith and confidence. For those delivering treatment, obtaining consent also provides a defense to a criminal charge of assault or battery or a civil claim for damages or trespass to a person. Therefore, it is necessary for a health care worker (including counsellor) to take consent and explain the implications and risks involved as part of the duty to care. Mandatory testing, which is not based on informed consent, is a violation of the right to autonomy and has had have negative public health consequences and has proven to be detrimental to HIV prevention efforts.

The concept of consent has three discrete but equally important aspects: first, consent is valid only if the person giving it is competent to do so; second, consent must be properly informed; third, consent must be given voluntarily. The patient/client has a right to all the information relevant to the decision of whether or not to consent to a particular diagnostic test, a test to determine the line of treatment or the line of treatment itself. Informed consent implies informing the patient/client of the implications of the tests and treatment and risks involved in the treatment prior to taking consent from the patient. Therefore, consent for necessitates (a) a duty on the health care worker to take informed consent from the patient, as a part of the duty to care; (b) a right of the patient to have knowledge and information of the options available and the risks involved in testing and treatment, so as to enable the patient to make an informed choice.

The question that arises is how much should be disclosed to the patient to ensure that consent is informed. In England, the standard of care which a doctor is required to exercise in discharging her/his duty to inform the patient of risks inherent in the treatment is the same as that required by a doctor in his diagnosis and treatment, namely to act in accordance with a practice accepted by a body of skilled and experienced medical professionals. In the U.S., the doctor must disclose all "material risks"; what are material risks is based on the "prudent patient" test i.e. a risk is material "when a reasonable person would attach significance to the risk." In Canada, the doctor must

disclose known, probable, special or unusual risks. The law requires that objective and subjective factors be taken into consideration. The objective factors are what a reasonable patient would complain of, the subjective factors are the "particular concerns" and "special consideration affecting a particular patient" to determine whether the patient would have refused treatment if informed of possible risks. In Australia, the doctor has a duty to warn the patient of a material risk inherent in a proposed treatment. It would be a material risk if a reasonable person would attach significance to it. This duty is subject to therapeutic privilege. In India the concept of consent is not fully developed in tort law and references may be made to the principles laid down in the Indian Contract Act and the Indian Penal Code.

There are situations where consent cannot be taken from the patient and is taken from the next of kin or guardian of the patient. This is also referred to as proxy consent and is particularly relevant in the case of children. Consent for diagnosis and treatment of children is generally taken from the parents or an adult next of kin of the child. However, in certain circumstances law recognises that a child may consent depending on the age of the child and the ability of the child to understand the nature of the diagnosis or treatment. In England, a young person of 16 years of age may be treated as an adult and is presumed to have the capacity to decide. In most states in the U.S., minors who are at least 12 years of age can consent for an HIV test or treatment. The paramount consideration remains the best interest and welfare of the child when evaluating which actions are permissible, even if consent is taken from the minor. However, under the NACO Policy consent for testing has to be taken from the minor's guardian. Studies and experiences have indicated that a large percentage of minors are sexually active and take drugs and need services related to sexual health and HIV etc. Experiences have also shown that minors are unwilling to access services with a guardian. Many minors such as those living on the streets have no guardians and want to access services independently.

Law provides for exceptions in certain circumstances. Thus, if a person is unable to give consent because s/he cannot understand the nature and consequence of the diagnosis or treatment due to mental incapacity, medical practitioners are under a duty to act in the best interest of the person. In England, no person can give or withhold consent to treatment on behalf of a mentally incapacitated patient. The medical practitioner has a duty to assess the capacity of the patient and make an informed decision about the treatment. If the patient lacks capacity, then the medical practitioner is to act in the best interest of the patient. Similarly, during an emergency where, for instance, obtaining consent from an unconscious patient would not be possible, the medical practitioner can lawfully treat the patient and is required to act in the best interest of the patient so as to preserve life.

In light of the above, it is indicative that health programme that does not maintain the dignity of patients or deprives them of their basic rights is violative of their fundamental and human rights. No individual should be made to undergo a mandatory test for HIV. A person, who has the mental and physical capacity to make a decision, has an absolute right to choose whether to consent to testing and/or medical treatment, to refuse it or to choose an alternative. It is also important that informed consent is taken in writing after explaining to the patient, in a language that s/he understands, the risks and implications of a particular test or treatment. The patient has a right to refuse and/or withdraw consent prior to the test being conducted. Principles relating to consent also mandate pre and post-test counselling as fundamental to any process of obtaining informed consent.

Recommendations

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1) Ensure that consent to testing for HIV has to be accompanied by pre and post test counselling.

2) Ensure that consent for HIV testing, treatment and research is taken in a language and manner that is best understood by the person.

3) Ensure that the counselling is of a high quality and that it is done in a non-judgmental and sensitive manner. The protocols for pre-test and post test counselling and training of counsellors should be reviewed through a consultative process.

4) Ensure that every institution involved in HIV related testing, treatment and research should develop counselling protocols for women and children to ensure that decision-making is independent and informed.

5) Ensure that persons between the ages of 12 and 16 years be allowed to consent for a HIV test and only in cases where the health care provider evaluates in writing that the person lacks the capacity to consent should consent be taken from the parent/guardian. A clear policy needs to be developed for the same.

6) Ensure that that protocols for taking consent for treatment is developed that includes giving information in a language and manner best understood by the person, on risk and benefits of the proposed treatment the alternatives that may be available, including the nature of the HIV disease, the treatments available for it (including the possible failures, toxicity etc), the stages when they can be administered, their duration, the likely expenses, the when they can be administered, their duration, the adherence requirements.

7) Formal training of counsellors should be made mandatory and training facility should be made available at various regions of the country.

8) Norms for testing and counselling should be part of 'code of medical ethics' prepared by the Medical Council of India [MCI} and MCI and state medical councils should take action against those registered medical practitioners who are violating the norms.

9) Ensure that any proposed research on HIV/AIDS is thoroughly examined for ethical standards and that consent protocols are developed to inform the potential research subject in a language and manner best understood by him/her of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study, the discomfort it may entail and the right to abstain from participation in the research or to withdraw consent to participate in the research at any time.

4. Stigma and Discrimination in health care settings

Discrimination lies at the root of all legal and human rights issues in the HIV/AIDS context. It is because of the fear, ignorance and stigma associated with HIV/AIDS that PLHAs are treated prejudicially and unequally.

However the reality is quite different and discrimination is rampant vis-à-vis PLHAs in the healthcare setting. This is further accentuated for certain marginalized populations. For instance women, sex workers, drug users and prisoners find themselves discriminated in healthcare irrespective of their HIV status. The positive status of such individuals/groups, however, further marginalizes them and decreases access to health services even more. Those who do not fall within these populations but are HIV+ also suffer immense discrimination in healthcare. Not only would increase in access to healthcare benefit PLHAs, it would have a positive public health impact on society at large in preventing the spread of the epidemic.

The Right to Healthcare

The right to be treated equally and the right to health are fundamental rights guaranteed under the Indian Constitution and basic human rights found in all international human rights documents. In the Indian constitutional context it is the State's obligation to provide healthcare for all. However, the right of equality and healthcare is available only against the State and not against private bodies. Therefore, it is the widely felt experience of many PLHAs that they are discriminated against and refused treatment by private healthcare institutions due to their positive status. Even state-run healthcare institutions discriminate against PLHAs in many ways. These include an outright refusal to treat, physical isolation in wards, early and inappropriate discharges, delays in treatment, on condition of higher charges being levied and prejudicial comments and behaviour.

It has been held by the Indian Supreme Court, however, that both public and private healthcare institutions have a duty to treat all those in emergency situations although the latter is not obliged to treat persons in other circumstances. Yet, both public and private healthcare institutions continue to discriminate based on HIV/AIDS status.

Anti-discrimination Legislation

In certain jurisdictions medical standards prescribe that a healthcare worker must treat every patient as HIV positive and carry out medical procedures and take precautions based on this assumption. These jurisdictions also prescribe anti-discrimination legislation that makes treatment of PLHAs obligatory even on private healthcare.

In India however, there is an absence of anti-discrimination legislation. Therefore, private healthcare is free to refuse treatment to PLHAs, as it almost always does.

Manifestations of Discriminatory Practices

As mentioned above, many PLHAs are denied their basic fundamental right to health due to the discriminatory practices carried on by healthcare institutions. Discrimination manifests itself in many ways in a healthcare setting. For instance, PLHAs have their case papers often hung on their beds with bold and conspicuous notations on them indicating their positive status. This is done in order to 'warn' others and leads to prejudicial comments and mistreatment by healthcare staff.

Bodies of people deceased due to HIV/AIDS-related causes are treated in an undignified manner. Often healthcare staff refuses to handle such bodies. If they do, then the bodies are often dumped in plastic bags with 'HIV' written across the bags, which is unnecessary. Even after this the unclaimed bodies are not disposed off with dignity but are left to decay. Sometimes relatives are charged extortionate amounts for handling of such bodies.

Hospitals have been seen to refuse treatment to PLHAs stating that PLHAs can be treated from home and that admission in the institution is unnecessary. PLHAs are also discharged early by hospitals, prior to completion of treatment; on the pretext that the PLHA's health is improving and does not require supervision. Healthcare institutions sometimes grant a bed to the PLHA but discharge him/her in a few days without having analysed his/her condition or prescribed any treatment.

Sometimes PLHAs are treated by healthcare institutions and in the middle of treatment are asked to do an HIV test. Once the test results are seen as positive the PLHA is removed from the institution in the middle of treatment.

Pregnant women in private nursing homes are tested for HIV by a single, non-confirmatory ELISA test. If they are found positive, they are refused treatment at the nursing home, and are directed for delivery to public hospitals.

User charges are being imposed by public hospitals even though treatment in such institutions is meant to be free. Accessibility to treatment, therefore, is further reduced. Inaccessibility or denial of treatment causes PLHAs to access quacks instead, and to rely on spurious medications. The long-term consequence of this will be their worsened health condition and the increase of society's overall vulnerability to HIV infection.

Public hospitals too deny treatment to PLHAs. They often try to avoid surgical procedures on some pretext. This includes suggesting a non-invasive but inappropriate course of treatment. This method of treatment, and sometimes-outright refusal, is often meted out to PLHAs from certain marginalized communities such as injecting drug users and sex workers on the basis of their appearance. The only study done on patient-to-healthcare worker transmission by the Centre for Disease Control, United States Government indicates that the chances of such transmission are remote and the paramedical staffs is more at risk than the physician or surgeon. (CDC data shows that of the 52 cases 48 were of paramedical staff.) There are no similar studies in the Indian context but anecdotal data show similar trends. It may be pointed out that the results may be different considering the difference in the manner and context in which the health care sector functions.
It was reported that doctors, well informed about the manner in which HIV may be transmitted, refuse to touch HIV+ patients, thereby increasing the stigma among less trained personnel and attending family members. Healthcare workers sometimes disclose the status of PLHAs to colleagues although the same is totally unnecessary. This sharing of information leads to discrimination by the entire healthcare staff due to the stigma surrounding the infection and already marginalized populations; separate wards, which can be in most shabby conditions, are maintained for PLHAs and also labelled as such.

Concerns of Healthcare Workers

There is a right in law of a health care worker to a safe working environment. Due to the fear, ignorance and stigma around HIV/AIDS, many healthcare workers are afraid to treat PLHAs. Such fear can be mitigated if healthcare workers are provided a safe working environment. This in turn may reduce the discrimination suffered by PLHAs.

It has been argued, even by public healthcare institutions, that providing basic universal precautions to healthcare workers is not a matter of priority. As such, it has been seen that these universal precautions, (including gloves and sheet, and in the HIV context, post-exposure prophylaxis (PEP[1])), which ought to be considered an essential part of the functioning of healthcare institutions, whether dealing with HIV or any other condition, are not provided to healthcare workers. In these circumstances, it is contended that they are free to deny treatment to PLHAs.

NACO is supposed to reimburse expenses incurred on PEP and Universal Precautions to public healthcare institutions. Even though NACO policy envisages provision of PEP and Universal Precautions, in reality, the same is not available. Where available, red tapism prevents reimbursement of costs as assured. Also there is no proper government policy on universal precautions and this is not treated as a priority issue.

The healthcare workers argue that the institution owes them a standard of care, which necessitates provision of universal precautions. In the absence of these precautions would a healthcare worker be justified in refusing treatment, especially with public hospitals and their emergency wards being burdened as they are?

Certain other issues that require discussion arise in the healthcare context. For instance, whether the healthcare worker have a right to refuse treatment to a person who shows symptoms of HIV/AIDS but is unwilling to be tested. This is of special significance especially in the public healthcare setting where the duty of the state to provide health care is of paramount importance.

What are the rights of the healthcare worker in the event of being infected in the course of employment? In such an event the institution is bound to take care of the worker's medical needs, especially in light of the fact that the healthcare workers have a right to a safe working environment including universal precautions.

It is the experience of many persons that because of their positive status, healthcare institutions charge them large amounts of money, which are otherwise not charged to those with other illnesses. This is often done on the pretext that the healthcare worker needs to spend an extra amount for protective gear. Thus the burden of providing universal precautions falls on the PLHAs, making access to care even more remote.

Recommendations

1) The government should make efforts to ensure that discrimination of PLHAs and those associated with HIV/AIDS in both the private and public health sector is prohibited. This can be achieved through legislation and sensitization programmes with healthcare workers.

2) Ensure that health care workers including paramedical staff have the right to a safe working environment where they are provided with universal precautions, PEP etc for which protocols should be developed.

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[1] PEP is a combination drug regimen, which if administered within a certain time, can prevent the healthcare worker infected by needle stick injury from becoming HIV+.)

3) Ensure that health care staff is provided with training on the effective use of universal precautions, reporting in case of exposure and PEP administration.

5. Confidentiality issues in healthcare settings related to positive status

The concept of confidentiality is rooted in the fundamental human right of privacy - every person has the right to a sphere of activity and personal information that is exclusive to him/herself and that s/he has the right to disclose as s/he pleases. This is a right that has been guaranteed by both international human rights documents and under the Indian Constitution.

Confidentiality is an extension of this right of privacy and plays an important role in the HIV/AIDS scenario where stigma and discrimination are rampant. As discussed later, this is not only an issue of the individual interest but also one that actually serves the general public interest. In the context of confidentiality the main issue that requires to be addressed is whether a positive person has the right to confidentiality about his/her HIV status. It is important to note that confidentiality is fundamental in any public health strategy and especially important in a physician-patient relationship where trust is a foundation. After all, if such a relationship cannot guarantee confidentiality it will only lead to fewer and fewer people accessing health services.

Approaches to the Issues around Confidentiality

The debate over this issue has taken the form wherein two apparently polarised views have emerged – the rights of the individual versus the rights of the community. It is argued that by protecting the right of confidentiality of an individual the larger community is not made aware of the prevalence of the pandemic and is therefore at greater risk of getting infected. This should be remedied by full disclosure of the positive status of all persons.

The counter-argument states that the debate on the individual versus the community is a false debate and in reality protecting the rights of the individual strengthens the community itself. This argument posits that if confidentiality is maintained it engenders trust and faith in the public health system and assures people that they will not be exposed to stigma and discrimination. This in turn encourages greater numbers to test themselves and access counselling and allied services thus having a positive impact on behaviour change and awareness. On the other hand if disclosure is made it will only discourage persons from accessing health care and testing themselves thus suppressing the pandemic and creating greater hurdles for control efforts.

It is therefore contended that maintaining confidentiality does not contribute to the spread of HIV/AIDS. Indeed, if employed in the appropriate context and in creative and culturally sensitive ways, confidentiality can help to decrease the spread of HIV/AIDS. For instance, in the Indian context, the principle of confidentiality may require to be adapted where voluntary testing centres function under tremendous space constraints and do not have the luxury of separate counselling areas/rooms. Systems need to be evolved to ensure that confidentiality is respected even in circumstances where a counsellor/healthcare worker is forced to discuss a patient's status in the presence of others, as is often the case.

Also, it is sometimes seen that a woman's test result is not collected by her, but by a male member of the family. Sometimes a patient is too ill to go to collect the test result him/herself and a friend or relative does so instead. In these circumstances the question whether the healthcare worker should give the results to the relative or whether s/he should insist on the patient collecting the results. Either choice raises different issues. For example, the situation at the patient's home may not be amenable to maintaining confidentiality. If the policy is that the relative may be given the result, a method of monitoring whether she/he has the informed consent of the patient to collect the result will have to be evolved.

Whether it is appropriate for the counsellor to make home visits despite the likelihood that family members may become aware of the patient's condition is a question that will have to be addressed in a culturally sensitive manner. This dilemma is compounded in cases where ART (Anti Retroviral Treatment) is being provided and follow up treatment is necessary, but where the person does not return for treatment.

Young people including adolescents are unable to access health care services including HIV testing and sexual health information because many health care providers do not view them as having rights equivalent to adults and therefore would often violate the principle of medical confidentiality. One of the key issues in testing and reporting of results is whether or not to involve a youth's parents/guardians in the process. Many young people may not wish to involve anyone in decisions relating to sexual or reproductive health services or HIV testing and treatment. In other countries the age at which a minor can access confidential testing varies between 12 to 16 years.

Breach of Confidentiality

Breach of confidentiality manifests itself in many ways. Due to the stigma and fear surrounding HIV/AIDS, it is the experience of many positive persons that once their status is disclosed they are denied many services especially in the healthcare and employment setting. Often test results are shared, without the HIV positive patient's consent, with other healthcare personnel, family members, relatives, neighbours, friends, colleagues and employers. Instead, maintaining confidentiality is seen to benefit and integrate positive people into mainstream society.

In the healthcare setting, it is seen that some hospitals have a practice of writing HIV in block letters on patient case papers. These papers go from department to department for tests etc. Also, it is common that these case papers are attached to the patient's bed. These practices are ostensibly to warn healthcare workers to be more wary of occupational exposure when providing services to PLHAs, but often result in discriminatory practices. Strategies need to be evolved so that the health services may be provided to PLHAs without compromising on either the right of health care workers to a safe working environment or the duty of confidentiality. Such strategies, it is suggested, would include mechanisms of ensuring availability of universal precautions (gloves etc) to health care workers and clear and enforceable rules regarding confidentiality.

Often hospitals assign separate wards to HIV/AIDS patients. This exposes positive persons to breach of confidentiality and discriminatory practices.

In the employment setting confidentiality is breached at various stages. During recruitment employers often insist on knowing the status of the prospective employee and doctors, working for the employer, divulge the same. This occurs even at stages of routine medical examinations during

employment. The question that arises in such circumstances is whether a doctor is obliged to inform the employer and how this is balanced with the duty of confidentiality towards the patient. Some employers argue that the employee's immediate superior should be informed of her/his HIV status, to facilitate informed action in emergency situations. It has also been argued that the duty to maintain confidentiality would vary in circumstances where the employee remains regularly absent from work. Policy and rules with respect to these issues need to be clearly identified.

Breach of confidentiality is also seen in other situations such as at the time of an insurance claim. The question that arises often in this context is whether a healthcare worker is under an obligation to disclose the HIV status of a person to an insurance company enquiring into the cause of death or whether an alternative answer would suffice.

Exceptions to Confidentiality

The case for maintaining confidentiality limits non-disclosure. Although confidentiality is maintained between the healthcare worker and patient it is the duty of the positive person to notify his/her spouse/sexual partner/needle-sharing partner of his/her positive status. This is where counselling plays a vital role. However the argument in favour of disclosure sometimes goes to the extent of contending that the duty to notify the partner is not just the positive person's obligation but also extends to the healthcare worker.

It is important to note that the law does recognise exceptions to the rule of confidentiality. Such exceptions arise in a situation when the public interest to disclose outweighs the public interest to maintain confidentiality. It has also been held that disclosure is permissible (to another doctor) if it is for the treatment/interest of the patient. Confidentiality can also be breached when a person is compelled by law to breach it. Although there is no clear policy, some courts have held that where a special relationship exists (such as between counsellor and client) and there is a foreseeable danger to an identifiable third party, confidentiality can be breached by a healthcare worker. This reasoning could be applicable in a situation where, despite extensive counselling, a person continues to engage in high-risk activity for example refuses to practice safer sex with his/her sexual partner. In a situation where a person refuses to disclose HIV status to partner and is unable to have protected sex, the healthcare provider would need to assess if the client would face any dire consequence as a result of the disclosure and only then decide to disclose or not. For example women who test positive first might fear abandonment and violence on disclosure.

Beneficial Disclosure

Closely linked to the principle of confidentiality is the notion of beneficial disclosure. This implies disclosure that is made for the benefit of the affected individuals including the PLHA, his/her sexual and drug-injecting partners and family. Beneficial disclosure is voluntary, respects the autonomy and dignity of the affected individuals and maintains confidentiality as appropriate. Apart from beneficial results for the people affected, it is intended to lead to greater openness about HIV/AIDS in the community and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV. Such beneficial disclosure maintains individuals' human rights, prevents discrimination, and improves public health in the form of prevention and care efforts.

Promoting beneficial disclosure with its elements of voluntariness and confidentiality serves a direct public health function, because it encourages people to access HIV prevention and care services. Beneficial disclosure also serves the purpose of opening up the HIV/AIDS epidemic. As more

people feel able and willing to disclose their status, there grows a critical mass of individuals and families within a community, and indeed within a nation, who are openly involved in dealing with the pandemic in positive and supportive ways. The challenge is to create an environment in which people will come forward for testing, counselling, prevention and care.

Recommendations

1. Information that is taken, disclosed, recorded in connection with HIV counselling, testing, treatment or research should be kept confidential.

2. Ensure that disclosure of information imparted in confidence cannot be divulged unless with written informed consent.

3. Make sure that Health Care Institutions institute data protection measures to protect confidentiality of PLHAs.

4. Ensure that protocols are developed for disclosure to partner based on existing laws and policies. The protocols would need to address the issue of violence and abandonment that women might experience on disclosure. A health care worker notifying a partner should follow the protocols.

5. Confidentiality of minors accessing HIV and related services should be ensured to improve their accessibility to such services. A clear policy should be developed for the same.

L-7A.15

Health Rights In the Context of Conflict and Fundamentalism

(Renu Khanna SAHAJ, PUCL-Vadodara Shanti Abhiyan)

Introduction

The last thirty years have seen protracted conflict in several parts of India. And it appears as though we have to live with (or rather live in) situations of chronic conflict. I believe that it is imperative to draw attention to the gendered health consequences of conflict and the violation of women's reproductive and sexual rights and make these an important part of our right to health care agenda. This presentation thus explores consequences of conflict on women's reproductive and sexual health and rights and identifies certain issues that need to be addressed. It examines the obligations of the State as defined in the General Comment No. 14 of the Committee of Social, Economic and Cultural Rights and the General Recommendation 24 of Article 12 of CEDAW.

My own interest in the issue of violence against women in conflict situations has been sharpened because I have witnessed at close quarters the worst kind of state supported and state sponsored violence against Muslims in early 2002. Some would argue, and I agree, that the state violence on Muslims continues till this day. I will use the case study of the violence in Gujarat, the State I work from, to highlight the health consequences of violence and the issues that need to be addressed.

Nature of Conflict

Conflict and wars have always existed through history and rape and other kinds of sexual violence have always been used as weapons to subjugate the 'other'. However, in the post colonial period, because of majoritarian nation – state building, violent struggles & military repression have increased in multi cultural and multi ethnic countries of our region (Manchanda 2000). Resurgence of ethnicity and nationality, politicized religion, globalization driven economic policies, revolutionary class struggles, separatist and autonomy struggles and the general failure of the democratic agenda, have all contributed to radicalized politics. Smaller groups are asserting their right to cultural survival and political power and seriously challenging the state as the sole source of legitimate political power and the concept of the state as a neutral umpire.

Technology and the strategy of annihilation have resulted in wars not simply being fought on the 'front'. Sites of confrontation with the 'other' are the market place, the school, the community well or the water tap. Institutions of the State (like the police and to some extent even the lower judiciary in India), are subverted to further the divisive agenda of the State. The objective is to destroy the social fabric of society, and the

strategy is to create institutional terror, to permeate social relations, and psychologically demoralize the community by creating suspicion and hatred.

Analysis reveals that conflict and violence in several parts of the region are initiated and sustained by a nexus of, usually, right wing fundamentalist forces and their agents at various levels (APDC 2000, Manchanda 2000). Here by fundamentalist, I do not mean fundamentalism as defined in just the religious sense. I define fundamentalism to denote dogmatic rigid worldviews, intolerance of the 'other', and construction of an entire frame work, not often amenable to reason, and a certain system of (il-)logic to legitimize a worldview.

Violence in Gujarat

The violence in Gujarat began after a carriage of a train carrying Hindu activists, was set on fire, in Godhra, on February 27, 2002 There are several theories around who set the train on fire. The dominant version is that following an altercation between the Hindu activists and a Muslim tea seller, and possibly an attempted molestation of the tea-seller's young daughter, on the Godhra railway platform, a Muslim mob set the train on fire. In the Godhra train burning, fifty-eight people were killed many of them women and children. The activists were returning from Ayodhya, a north Indian town, where they supported a campaign led by the Vishwa Hindu Parishad and allied organsiations, to construct a temple of the Hindu God Ram on the site of a sixteenth century mosque destroyed by Hindu militants in 1992. The VHP claims that the mosque was built on a site that was the birthplace of Ram.

Between February 28 and March 2, 2002 a three day retaliatory killing spree by Hindus left hundreds dead and thousands homeless and dispossessed. The looting and burning of Muslim homes, shops, restaurants, and places of worship was also widespread.

The Gujarat government chose to characterize the violence as a "spontaneous reaction" to the incidents in Godhra. Findings of several independent human rights groups, and civil liberty organizations, indicate that the attacks on Muslims throughout the state were planned, well in advance of the Godhra incident, and organized with extensive police participation and in close cooperation with officials of the Bharatiya Janata Party (Indian People's Party, BJP) state government.

The attacks on Muslims are part of a campaign of Hindu nationalist organizations to promote communal tensions to further the BJP's political rule-a movement that is supported at the local level by militant groups that operate with impunity and under the patronage of the state. The Hindu nationalist organisations, collectively referred to as the *sangh parivar* (or "family" of Hindu nationalist groups) promote the argument that because Hindus constitute the majority of Indians, India should be a Hindu state, contrary to the spirit of the founders of the Constitution of the Indian State which was, and is, avowedly secular.

The state of Gujarat and the central government of India initially blamed Pakistan for the train massacre. The heightened fears of terrorism since September 11 were exploited by local Hindu nationalist groups and the local press which printed reports of a "deadly conspiracy" against Hindus by Muslims in the state.

In the weeks that followed an estimated 2000 Muslims were killed and around 200,000 displaced.

Sexual Violence

The sexual violence perpetrated on Muslim women and young girls was unimaginable. Many women were killed after being raped and mutilated. Those who survived report that sexual violence consisted of forced nudity, mass rapes, gang rapes, mutilation, insertion of objects into bodies, cutting of breasts, slitting the stomach and reproductive organs, carving Hindu religious symbols on the body parts of women.

Majority of the survivors did not register rape complaints with the police. This is hardly surprising. Given the hostility of the police and the wrong recording of even the simpler FIRs (those related with the sequence of events and damage to property), the police were hardly going to encourage the registering of sexual crimes. Additionally, deeply internalized notions of shame and honour prevented women from registering their complaints. So while there are no official figures of the number of women subjected to sexual crimes, women's groups estimate that a minimum of 350 women must have been assaulted and raped.

Health Consequences of the Violence in Gujarat

A report of the Medico Friend Circle, a group of individuals concerned about social issues in medicine, documented the varied and multidimensional consequences of the violence in Gujarat. In addition to the obvious physical injuries inflicted by burns, arms and weapons, there was considerable mental trauma and stress, there was hunger due to curfews, isolation and hiding, and infections and epidemics due to living in inhumanly unsanitary conditions of refugee camps.

Sexual health consequences of rape among women who survived - unwanted pregnancies, STIs – must have subsequently been there, they were not picked up at that time by the fact finding teams possibly because the trauma of the rape over shadowed all else. Pregnancy outcomes were affected by sexual and other kinds of violence. Women reported premature deliveries, miscarriages and abortions. Deliveries took place in relief camps in overcrowded, unsanitary conditions because Muslim women could not access health services due to insecurity.

Apart from these direct health consequences of violence, there were the indirect and long-term health consequences. The continuing economic boycott of the Muslims, and deaths and injuries of the males, led to increasing impoverishment and therefore chronic hunger among the poorer Muslims. Because of fear of their safety, girls are being married off

early, they become mothers earlier with all the consequences of adverse maternal and child health.

Community health projects in Ahmedabad among the urban poor Muslims report that even eighteen months after the onset of violence, women are reporting menstrual irregularities and lactation failure (SANCHETNA, personal communication).

Response of the Health Care System

What was the response of the health care system in Gujarat? Did it provide first aid and humanitarian services to all injured without considering which group they belong to? Or did conscious and sub-conscious prejudices result in discrimination during service provision? Did the health care system recognize injuries and other consequences of sexual offences? Was the health care system geared to creating an enabling environment in which women could safely seek treatment for injuries due to sexual violations?

Experience of the Gujarat violence indicates that there were several lacunae in the response of the health care services. (However, while mentioning the lacunae we would also like to place on record that we also came across individuals who put themselves at risk to provide services to the injured and suffering regardless of which community they belonged to.) The following lacunae were observed:

- Medical records failed to document medical evidence of violence – death certificates and postmortem reports failed to mention injuries due to police firing or stabbing.
- Health services failed to acknowledge the seriousness of psychological trauma and did not adequately address PTSD
- There was a lack of acknowledgement of sexual violence. Medical records of dead or injured women failed to mention sexual abuse. Despite women coming to hospitals in conditions that indicated sexual assault, doctors failed to recognize this. Because of women's negative experiences at the hands of the health care providers, even in 'normal' times, and for 'normal' events (like childbirth), vulnerable sexually assaulted women did not approach health care providers for medical examinations and recording of evidence.
- While most doctors performed their duties neutrally and did not actively discriminate against any community, very few were proactive in defending the rights of their patients.
- Hospitals preferred to prematurely discharge Muslim patients rather than provide them protection and ensure their safety.

These lacunae need to be examined in the light of the obligations of the State as defined in the General Comment No. 14 of the Committee of Social, Economic and Cultural Rights and the General Recommendation 24 of Article 12 of CEDAW. The State failed to uphold its **obligation to respect the right to health** and **the obligation to protect** the rights of minority women to access health care services in the situation of engineered

violence against the Muslims. Muslim women did not feel safe to reach health care facilities. The State also failed in its **obligation to fulfil** – it did not take positive measures *'to enable and assist individuals and communities to enjoy the right to health; fulfil or provide a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means available at their disposal.'* Committee on Economic, Social and Cultural Rights. General Comment 14, E/C. 12/2000/4.

CEDAW 's General Comment No.24 says that State's **obligation to respect** rights requires state parties to refrain from obstructing action taken by women in pursuit of health goals. For example, State parties should not restrict women's access to health services. The **obligation to protect** rights relating to women's health requires state parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations. Since gender-based violence is a critical health issue for women, State parties have to

- ensure the effective enforcement of protocols and procedures to address violence against women and girls
- protective procedures for hearing complaints
- ensure adequate protection and health services including trauma treatment and counseling.

The **duty to fulfill** rights include positive measures taken to curb violations of women's rights by third parties. Budgetary, economic and other measures were required to provide sanitation and health facilities in the health camps.

Failure to uphold these obligations construes violation of article 12.

Issues that need to be addressed

The State has to specify what measures it will take in situations of violence and conflict to uphold its obligations to respect, protect and fulfil sexual and reproductive rights of women as well as their right to health care in situations of conflict. Some of our recommendations are:

1. Health care system has to be reorganized so as to become more accessible and conducive for all categories of vulnerable groups to access services in situations of conflict.
2. Health care system, forensic departments and law enforcement institutions have to interact in facilitative and gender sensitive ways.
3. There is need to rethink on the rape law, definition of rape, identity of perpetrator, medical examination and evidence to establish rape in the context of conflict situations where mass and gang rapes occur.
4. Health care delivery systems need to recognize that sexual violence is meant to not just inflict injuries but also to scar the psyche – humiliation and shame. In

addition to the physical injuries, psychological trauma has to be recognized and addressed by the health care system.

5. Health care providers need to recognize and acknowledge sexual offences and sexual injuries.
6. Health services need to be organized in refugee camps.

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Renu Khanna email: sahajbrc@icenet.co.in

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NATIONAL PUBLIC HEARING ON RIGHT TO HEALTH CARE
ORGANISED BY NHRC & JSA ON 16-17 DECEMBER 2004, NEW DELHI

NHRC Recommendations for a

National Action Plan to Operationalise the Right to Health Care

Within the broader framework of the Right to Health

Objectives of the National action plan

- **Explicit recognition of the Right to Health Care,** to be enjoyed by all citizens of India, by various concerned parties: Union and State Governments, NHRC, SHRCs and civil society and other health sector civil society platforms.
- **Delineation of essential health services and supplies** whose timely delivery would be assured as a right at various levels of the Public Health System.
- **Delineation of citizen's health rights related to the Private medical sector** including a Charter of Patients Rights.
- **Legal enshrinement of the Right to Health Care** by enacting a Public health services Act, Public health services Rules and a Clinical Establishment Regulation Act to regulate the Private medical sector.
- **Operationalisation of the Right to Health Care** by formulation of a broad timetable of activities by Union and State Governments, consisting of the essential steps required to ensure availability and accessibility of quality health services to all citizens, which would be necessary to operationalise the Right to Health care. This may include a basic set of Health Sector reform measures essential for universal and equitable access to quality health care, and guidelines regarding the budgetary provisions to be made available for effective operationalisation.
- **Initiation of mechanisms for joint monitoring** at District, State and National levels involving Health departments and civil society representatives, with specified regularity of monitoring meetings and powers to monitoring committees. In parallel with this, an institutionalised space needs to be created for regular civil society inputs towards a more consultative planning process. These should be combined with **vigilance mechanisms** to take prompt action regarding illegal charging of patients, unauthorized private practice, corruption relating to drugs and supplies etc.
- **Functional redressal mechanisms** to be put in place at District, State and National levels to address all complaints of denial of health care.

Recommendations under the action plan

Recommendations to Government of India / Union Health Ministry

- **Enactment of a National Public Health Services Act, recognizing and delineating the Health rights of citizens**, duties of the Public health system, public health obligations of private health care providers and specifying broad legal and organisational mechanisms to operationalise these rights. This act would make mandatory many of the recommendations laid down, and would make more justiciable the denial of health care arising from systemic failures, as have been witnessed during the recent public hearings.

This act would also include **special sections to recognise and legally protect the health rights of various sections of the population, which have special health needs:** Women, children, persons affected by HIV-AIDS, persons with mental health problems, persons with disability, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganised and migrant workers etc.

- **Delineation of model lists of essential health services at various levels:** village / community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens.
- **Substantial increase in Central Budgetary provisions for Public health,** to be increased to 2-3% of the GDP by 2009 as per the Common Minimum Programme.
- **Convening one or more meetings of the Central Council on Health** to evolve a consensus among various state governments towards operationalising the Right to Health Care across the country.
- Enacting a **National Clinical Establishments Regulation Act** to ensure **citizen's health rights concerning the Private medical sector** including right to emergency services, ensuring minimum standards, adherence to Standard treatment protocols and ceilings on prices of essential health services. Issuing a Health Services Price Control Order parallel to the Drug Price Control Order. Formulation of a Charter of Patients Rights.
- **Setting up a Health Services Regulatory Authority** - analogous to the Telecom regulatory authority- which broadly defines and sanctions what constitutes rational and ethical practice, and sets and monitors quality standards and prices of services. This is distinct and superior compared to the Indian Medical Council in that it is not representative of professional doctors alone – but includes representatives of legal health care providers, public health expertise, legal expertise, representatives of consumer, health and human rights groups and elected public representatives. Also this could independently monitor and intervene in an effective manner.
- Issuing **National Operational Guidelines on Essential Drugs** specifying the right of all citizens to be able to access good quality essential drugs at all levels in the public health system; promotion of generic drugs in preference to brand names; inclusion of all essential drugs under Drug Price Control Order; elimination of irrational formulations and combinations. Government of India should take steps to publish a National Drug Formulary based on the morbidity pattern of the Indian people and also on the essential drug list.
- **Measures to integrate National health programmes with the Primary Health Care system** with decentralized planning, decision-making and implementation. Focus to be shifted from bio-medical and individual based measures to social, ecological and community based measures. Such measures would include compulsory health impact assessment for all development projects; decentralized and effective surveillance and compulsory notification of prevalent diseases by all health care providers, including private practitioners.

- **Reversal of all coercive population control measures,** that are violative of basic human rights, have been shown to be less effective in stabilising population, and draw away significant resources and energies of the health system from public health priorities. In keeping with the spirit of the NPP 2000, steps need to be taken to eliminate and prevent all forms of coercive population control measures and the two-child norm, which targets the most vulnerable sections of society.
- Active participation by Union Health Ministry in a National mechanism for health services monitoring, consisting of a ***Central Health Services Monitoring and Consultative Committee*** to periodically review the implementation of health rights related to actions by the Union Government. This would also include deliberations on the underlying structural and policy issues, responsible for health rights violations. Half of the members of this Committee would be drawn from National level health sector civil society platforms. NHRC would facilitate this committee. Similarly, operationalising ***Sectoral Health Services Monitoring Committees*** dealing with specific health rights issues (Women's health, Children's health, Mental health, Right to essential drugs, Health rights related to HIV-AIDS etc.)
- The structure and functioning of the **Medical Council of India** should be immediately reviewed to make its functioning more democratic and transparent. Members from Civil Society Organisations concerned with health issues should also be included in the Medical Council.
- People's access to emergency medical care is an important facet of right to health. Based on the Report of the Expert Group constituted by NHRC (Dr. P.K.Dave Committee), short-term and long-term recommendations were sent to the Centre and to all States in May 2004. In particular, the Commission recommended:

  (i) Enunciation of a National Accident Policy;

  (ii) Establishment of a central coordinating, facilitating, monitoring and controlling committee for Emergency Medical Services (EMS) under the aegis of Ministry of Health and Family Welfare as advocated in the National Accident Policy.

  (iii) Establishment of Centralized Accident and Trauma Services in all districts of all States and various Union Territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals.

- Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to eliminate them.

- Access to Mental health care has emerged as a serious concern. The NHRC reiterates its earlier recommendations based on a Study "Quality Assurance in

Mental Health" which were sent to concerned authorities in the Centre and in States and underlines the need to take further action in this regard.

Recommendations to State Governments / State Health Ministries

- **Enactment of State Public Health Services Rules,** detailing and operationalising the National Public Health Services Act, recognizing and delineating the Health rights of citizens, duties of the Public health system and private health care providers and specifying broad legal and organisational mechanisms to operationalise these rights. This would include **delineation of lists of essential health services at all levels:** village / community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens. This would take as a base minimum the National Lists of essential services mentioned above, but would be modified in keeping with the specific health situation in each state.

  These rules would also include **special sections to recognise and protect the health rights of various sections of the population, which have special health needs:** Women, children, persons affected by HIV-AIDS, persons with mental health problems, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganised and migrant workers etc.
- Enacting **State Clinical Establishments Rules** regarding **health rights concerning the Private medical sector**, detailing the provisions made in the National Act.
- **Enactment of State Public Health Protection Acts** that define the norms for nutritional security, drinking water quality, sanitary facilities and other key determinants of health. Such acts would complement the existing acts regarding environmental protection, working conditions etc. to ensure that citizens enjoy the full range of conditions necessary for health, along with the right to accessible, good quality health services.
- **Substantial increase in State budgetary provisions for Public health** to parallel the budgetary increase at Central level, this would entail at least doubling of state health budgets in real terms by 2009.
- **Operationalising a State level health services monitoring mechanism,** consisting of a ***State Health Services Monitoring and Consultative Committee*** to periodically review the implementation of health rights, and underlying policy and structural issues in the State. Half of the members of this Committee would be drawn from State level health sector civil society platforms. Corresponding **Monitoring and Consultative Committees** with civil society involvement would be formed in all districts, and to monitor urban health services in all Class A and Class B cities.
- **Instituting a Health Rights Redressal Mechanism** at State and District levels, to enquire and take action relating to all cases of denial of health care in a time bound manner.
- **A set of public health sector reform measures** to ensure health rights through strengthening public health systems, and by making private care more accountable and equitable. The minimum aspects of a health sector reform

framework that would strengthen public health systems must be laid down as an essential precondition to securing health rights. **An illustrative list of such measures is as follows:**

1. State Governments should take steps to **decentralize the health services** by giving control to the respective Panchayati Raj Institutions(PRIs) concerning the government hospitals up to the district level. Enough funds from the plan and non plan amount should be devolved to the PRIs at various levels. The local bodies should be given the responsibility to formulate and implement health projects within the overall framework of the health policy of the state. The elected representatives of the PRIs and the officers should be given adequate training in local level health planning. Integration between the health department and local bodies should be ensured in formulating and implementing the health projects at local levels.
2. The adoption of a **State essential drug policy** that ensures full availability of essential drugs in the public health system. This would be through adoption of a graded essential drug list, transparent drug procurement and efficient drug distribution mechanisms and adequate budgetary outlay. The drug policy should also promote rational drug use in the private sector.
3. The health department should prepare a **State Drug Formulary** based on the health status of the people of the state. The drug formulary should be supplied at free of cost to all government hospitals and at subsidized rate to the private hospitals. Regular updating of the formulary should be ensured. Treatment protocols for common disease states should be prepared and made available to the members of the medical profession.
4. The adoption of a **Universal community health worker programme** with adequate provisioning and support, so as to reach out to the weakest rural and urban sections, providing basic primary care and strengthening community level mechanisms for preventive, promotive and curative care.
5. The adoption of a detailed plan with milestones, demonstrating how **essential secondary care services**, including emergency care services, which constitute a basic right but are not available today, would be made universally available.
6. The public **notification of medically underserved areas** combined with special packages administered by the local elected bodies to close these gaps in a time bound manner.
7. The adoption of an **integrated human resource development plan** to ensure adequate availability of health humanpower at all levels.
8. The adoption of transparent **non-discriminatory workforce management policies,** especially on transfers and postings, so that medical personnel are available for working in rural areas and so that specialists are prioritised for serving in secondary care facilities according to public interest.

9. The adoption of **improved vigilance mechanisms** to respond to and limit corruption, negligence and different forms of harassment within both the public and private health system.

- Ensuring the implementation of the Supreme court order regarding **food security, universalising ICDS programmes and mid day school meal programmes**, to address food insecurity and malnutrition, which are a major cause of ill-health.
- People's access to emergency medical care is an important facet of right to health. Based on the Report of the Expert Group constituted by NHRC (Dr. P.K.Dave Committee), short-term and long-term recommendations were sent to the Centre and to all States in May 2004. In particular, the Commission recommended:

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- Access to Mental health care has emerged as a serious concern. The NHRC reiterates its earlier recommendations based on a Study "Quality Assurance in Mental Health" which were sent to concerned authorities in the Centre and in States and underlines the need to take further action in this regard.

Recommendations to NHRC

- NHRC would oversee the monitoring of health rights at the National level by initiating and facilitating the ***Central Health Services Monitoring Committee***, and at regional level by appointing ***Special Rapporteurs on Health Rights*** for all regions of the country.
- Review of all laws/statutes relating to public health from a human rights perspective and to make appropriate recommendations to the Government for bringing out suitable amendments.

Recommendations to SHRCs

- SHRCs in each state would facilitate the ***State Health Rights Monitoring Committees*** and oversee the functioning of the State level health rights redressal mechanisms.

Recommendations to Jan Swasthya Abhiyan and civil society organisations

- JSA and various civil society organisations would work for the widest possible raising of awareness on health rights – 'Health Rights Literacy' among all sections of citizens of the country.

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NARMADA BACHAO ANDOLAN

- Maitri Niwas, Dhadgaon P.O, Nandurbar, Maharashtra
  Ph: 02595-220620
- 62 M.G Marg, Badwani, Madhya Pradesh - 451551
  Telefax: 07290-222464
- C/o B-13 Shivam Flats, Ellora Park, Baroda 390007,
  Gujarat. Telefax: 0265-2282232

Health Rights in Situations of Conflict and Displacement

A Brief Note Jointly prepared by
Ms. Yogini Khanolkar, Dr.Revathy Joshi and Dr. Suhas Kolhekar

The National Public Hearing on Right to Health Care, as we understand, is part of a process to understand, assess and analyze issues related to health towards creating better awareness of health rights among the people. This initiative by NHRC clearly indicates that the demand for total health is not merely a secondary issue but an important component of human rights.

WHO defines that "Health is physical, mental and social wellbeing and not merely absence of diseases". So while curative aspects are normally given more importance, any attempt at attaining full health rights should have preventive measures as the priority. Hence a deeper understanding and analysis of the causes of illness and disease is necessary.

We understand Displacement as a Physical, Emotional and Social crisis because it severely destroys the traditional health patterns and systems which have evolved out of generations of living in specific community oriented atmosphere. Due to human made displacement like Big Dams, High Ways, Mining, Military Firing Range, Privatization of coastal sea resources, Tourism, Sanctuaries, Industrial disasters like Bhopal Gas Tragedy, Communal riots or War, the affected peoples – most of them being the so called weaker sections like adivasis, dalits, women, children and minorities – finds their Right to Health Care brutally violated.

One significant example of this violation can be seen in the Narmada Valley where the health of the dam affected adivasis are deteriorating day by day, whether in the flood affected areas in the valley or in the resettlement sites. While the State policies and laws and even the Supreme Court (in its October 2000 verdict) endorses the argument that displacement improves health and livelihood means of the affected, this is not based on any detailed study per se. This view of the educated urbanized policy makers need to be challenged. **The reality is that, since health or well being is directly connected to livelihood and community relationships, forced displacement which does not provide adequate alternative resources, will lead to violation of health rights.** Providing physical resources is not enough. It is necessary to ensure that the affected groups are enabled to maintain their social and cultural life. In most situations this is not possible.

The Existing policies and laws are not sufficiently addressing the complex issue of the violation of health rights due to displacement. This may not be primarily due to a lack of effort but a problem with the perspective and the methodologies used so far. A more participatory process, with definite involvement of the displaced peoples will initiate a fresh path in the search for ensuring better health care rights to the affected populations.

VIOLATION OF RIGHT TO HEALH AND HEALTH CARE AS A CONSEQUENCE OF DISPLACEMENT IN THE NARMADA VALLEY

Many of us may remember the news clippings from Harsud (M.P.) this monsoon wherein the residents of this city, displaced by the large dam Indira Sagar were made to demolish their homes with their own hands and said to be rehabilitated in Chanera, the rehabilitation site. Few days later we also learnt that in this rehabilitation site women had no place to go to toilet. Imagine the plight of a pregnant woman. Along with the tanker supplying drinking water, there used to be an official announcement telling "*Do not use this water for drinking without boiling*" and of course availability of fuel was a problem too. Things have been worse in many more villages but often there is no access to let the world know about it.

We have been working for several years with the people displaced by Sardar Sarovar project , one of the two mega dams on the Narmada and would like to present some data and share our experiences with you all who respect the basic human rights. Even though the Governments on their computers/website shows number of project affected people (PAFs) at the dam height of 110 meters in each of the three states, namely Maharashtra, Madhya Pradesh and Gujarat as 'ZERO', there are at least 11000 PAFs still staying in the original villages, some of them having dissatisfied with and returned from the rehabilitation sites. They have been facing numerous problems but here we summarize just the few that affect their HEALTH directly. (SLIDE NO 1 and 2).

Given below are some of the Factors that affect the Health of the displaced people.

a) The loss of fertile land leading to scarcity of food, severe anemic condition of people in general and of women in particular. The children borne to such anemic mothers, if surviving are also severely anemic.
b) Malnutrition in children leading to deaths (but under-reported by the governments as the health personnel do not reach the villages facing submergence and thus not having easy access.) causes severe traumatic condition in parents, at times leading to mental sickness.
c) Fatal contamination of water because of submergence, leading to complaints of frequent stomach upset and fever and even incidences of death in children showing symptoms of gastroenteritis.
d) Stagnant back waters of the dam causing increase in mosquito borne diseases, such as Malaria.
e) Difficulties in reaching out to free flowing river leading to unhygienic conditions and increase in skin infections such as scabies.
f) Decrease in the availability of fish, the only protein source for these tribals resulting from the stagnation of the river leads to decrease in general resistance and increase in

g) Complaints of not feeling well.
h) Decrease in the availability of fruits and edible roots (rhizomes) because of destruction of the forests.
i) Submergence of forests and decomposition of trees may be adding some toxic compounds and possibly leading to complaints of stomach upset.

j) Unnatural deaths because of

- Drowning as a result of getting trapped in the sludge (silt)
- Being eaten up by crocodiles (As the crocodiles have lost their breathing places upon the big rocks in the river as a result of increased back water level , they have to come to the banks for breathing).
- Poisonous snake biting even while sleeping on cot. (Poisonous snakes from the submerged forests, having been displaced from their natural habitat, get more aggressive and attack people in the areas surrounded by water)

Status of Health Care services in these villages

Most of these villages do not have any easy access to the primary health centre. There is no health care worker paying regular visits.

There is no information about many health related programs announced by the Government such as Antyoday Yojana, Mid-day meals or even allowance available to the pregnant and lactating women.

If at all a patient reaches a rural hospital, s/he is not given proper attention .There is an inclination to send the patient to the Civil hospital which is further away and the patients' family, even though below the poverty line, is asked to make their own arrangements for transporting the patient. The hospital's vehicle or driver is not available or there is no fund for diesel.

Thus, the displaced always experience very callus and humiliating treatment from most of the staff members. All this adds to their stress. Having lost their traditional rights to Natural resources, like land, river, fish, forest minor produce and traditional medicines, they are forced to move out to city slums in very unhygienic conditions and work as labor on a day to day basis. Thus they are economically and socially in a very vulnerable situation. This may force them to get trapped into various illegal activities, addictions and sexual harassments, thus increasing the risk of being exposed to various new diseases like AIDS.

16 December 2004
Narmada Bachao Andolan

Section III: Violation of Health Rights in India

The discussions on different policies on health care and their impact on access to health care point to repeated and continued violations of Health Rights in the country. Curiously, these violations are in sharp contrast to Constitutional provisions in the country and International covenants signed by India.

The Indian Constitution incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health. Article 21 of the Constitution guarantees protection of life and personal liberty to every citizen. The Supreme Court has held that the right to live with human dignity, enshrined in Article 21, derives from the directive principles of state policy and therefore includes protection of health. Further, it has also been held that the right to health is integral to the right to life and the government has a constitutional obligation to provide health facilities.

India has also ratified a number of international covenants upholding health rights in their varied manifestations. Unfortunately, these are in sharp contrast to the widespread violations in terms of actual fulfillment of health rights – as the preceding sections bear testimony to. This massive gap between entitlements and provision makes the scale and depth of violation of health rights in India all the more striking.

In addition to the provisions of the Indian Constitution – the state of health care provision is a clear violation of which – let us also examine some the key covenants which India has ratified.

The Universal Declaration of Human Rights, Article 25 states: "*Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are entitled to special care and assistance...*"
Clearly, the state of health services and access as described earlier are evidence of violation of the Declaration.

Two covenants – the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the United Nations Convention on the Rights of the Child (CRC) – describe in detail obligations towards provision of comprehensive health services and care. Let us examine them to understand the extent of violation of health rights that we see today in the country.

International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is the most comprehensive international convention covering economic and social rights, ratified by the Government of India in 1979. This covenant includes the Right to Health, covered by article 12:
"*The states parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*"

This right has been elaborated upon and clarified by the **General Comment 14** of the UN Committee on Economic, Social and Cultural Rights, adopted in the year 2000:
"*The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation*". Recognition of the right to health or legislative implementation is absent in India, hence this obligation remains unfulfilled.

"..and to adopt a national health policy with a detailed plan for realizing the right to health".
No such plan exists in the National health policy 2002.

"States must ensure provision of health care,"
Gross deficiencies in provision of health care by the Government have been described in the previous section..

"...including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions."

"Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas."
India's high maternal mortality rate at 408 per lakh live births, poor coverage of antenatal and delivery services indicate large scale violation of this right.

"States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country."
There are large scale inequities in availability of doctors and hospital beds between urban and rural areas as shown below

The General Comment 14 also clearly specifies certain **Core obligations** of states related to the right to health:
"43 ... States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care."

"(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;"
Vulnerable groups such as rural and tribal populations suffer from denial of physical access to quality health services; one fact which exemplifies the consequence of such denial is that the tribal population, which constitutes only 8% of the total population, contributes 50% of the malarial deaths in the country. The large sections of the population living in poverty suffer from lack of financial access concerning private medical services. For example, a person from the poorest quintile of the population, despite more health problems, is **six times less** likely to access hospitalization than a person from the richest quintile.

"(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;"
All Essential drugs remain inaccessible for an estimated 80% of the population.

"(e) To ensure equitable distribution of all health facilities, goods and services;"
There is grossly inequitable distribution between urban and rural areas as described earlier.

"(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy

and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups."

There is neither such a national public health strategy, nor are we aware of any process of participatory and transparent review; nor have right to health indicators and benchmarks been developed.

The General comment 14 has clearly specified 'Violations of the obligation to fulfil' as follows:
"52. Violations of the obligation to fullfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates".
Practically all of these violations exist on a consistent and continued basis as described earlier.

Finally, the GC 14 has specified the desirability of a national legislation on Right to health:
"56. States should consider adopting a framework law to operationalise their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action"
Needless to add, no such legislation or framework exists in India.

United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child entered into force in 1990 and was ratified by India in 1992. Article 24 of CRC clearly mandates the right to health and health care for children:

Article 24

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

With 18 lakh **avoidable** child deaths taking place in India every year, it is obvious that this right remains largely unrealized

"2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:"

"(a) To diminish infant and child mortality;"
The expected decline in both IMR and CMR has not taken place during the 1990s. The current annual reduction in death rates is estimated to be 2.3 % each year, while if India intends to achieve MDGs by 2015, it should be three times the current reduction rate.

"(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;"

Gross inequities exist in access to health care for children in rural areas compared to urban areas, and for children from poor families compared to those from well off families. For example, children from the bottom income quintile suffer a **2.5 times higher infant mortality** compared to children from the top income quintile; children from lower standard of living households suffer **3.9 times higher child mortality**, compared to children from the higher standard of living households.

"(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;"

According to National Institute of Nutrition data, **92% children** in rural areas suffer from malnutrition. Only 54% of all children under age three are fully protected with immunisation. Around 6 lakh children die each year from an ordinary illness like diarrhea, almost all these deaths would have been prevented if safe drinking water and sanitary conditions were available.

"(d) To ensure appropriate pre-natal and post-natal health care for mothers;"

Only 20 percent of mothers receive all of the recommended types of antenatal care. Nearly two-thirds of births are delivered at home and 83 percent of women who give birth at home receive no postpartum care.

"(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;"

Only about 40% babies are exclusively breastfed and only 33% are given timely complementary feeds. The life saving Oral Rehydration Solution is presently administered in only 27% of cases of diarrhea in India.

"(f) To develop preventive health care, guidance for parents and family planning education and services."

The above mentioned sample facts illustrate the large scale deficiencies in preventive health care for children. As far as guidance for parents is concerned, according to the CAG report on ICDS centres, in 91 per cent of the ICDS projects, no health awareness activities were carried out. This was due to non availability of media, defective projectors and other equipment, lack of training for use of equipment and of course, general lack of time and motivation.

This overview demonstrates that violation of health rights, which have been mandated in certain international covenants ratified by the Govt. of India, is not occasional or accidental, but is universal, large scale and related to systemic issues.

Section IV: Initiatives to Remedy the Situation

It is but obvious that a large number of initiatives are required to remedy the present situation. Some immediate steps related to the *health care system* that need to be taken include:

- ***National Public Health Act*** mandating assured provision of basic health services: The Union health ministry may initiate the process by having a discussion in the Central Council on Health (including all state health ministers) and developing a consensus on the issue. Passing a 'National Public Health Act' (stipulated long back by Bhore committee-1946 and Mudaliar Committee-1961), which would specify a set of basic health services to be available to all as a right, including legal obligations of public and private health care providers, health rights of citizens, standards of care and certain proportion of public funds to be earmarked for public health. State governments to pass corresponding 'State public health services rules' within specified time.
- ***Making health care a fundamental right by suitable constitutional amendment***: The formulation of a National legislation mandating the Right to Health care, with a clearly defined ***comprehensive*** package of health care, along with authorization of the requisite budget, being made available universally within one year.
- The Government should undertake a ***review of the National Health Policy (2002)*** to foreground the Primary Health Care approach and the goal of Universal access to comprehensive health care; along with elimination of measures to promote the private medical sector and 'medical tourism'.
- Significant ***strengthening of the existing public health system with commitment to quality coverage and equity***, especially in rural areas, by assuring that all the required infrastructure, staff, equipment, medicines and other critical inputs are available, and result in delivery of all required services at the primary secondary and tertiary levels. These would be ensured based on clearly defined, publicly displayed and monitored norms. Health services need to be integrated and vertical programs must be phased out
- The ***declining trend of budgetary allocations for public health needs to be reversed***, and budgets appropriately upscaled to make optimal provision of health care in the public domain possible. At one level adopting a fiscal policy of block funding or a system of per capita allocation of resources to different levels of health care, with an emphasis on Primary Health Care will have an immediate impact in reducing rural-urban inequities by making larger resources available to rural health facilities like Primary health centres and Rural hospitals. Simultaneously, the budgetary allocation to the health sector must be increased substantially, targeting the 5% of GDP as public expenditure on health care as recommended by the WHO.
- If the public health system fails to deliver it should be treated as a legal offence, remedy for which can be sought in the courts of law. The public system must ensure all elements of care like drug prescriptions, diagnostic tests, child birth services, hospitalization care etc.
- ***Universalisation of the ICDS scheme*** should be undertaken in a time bound framework, along with the convergence of the scheme with state health services.
- There is a need for a range of policy measures to eliminate discrimination, and to provide special quality and sensitive services for women, children, elderly persons, unorganised sector workers, HIV-AIDS affected persons, disabled persons, persons with mental health problems and other vulnerable groups. Similarly, situations of conflict, displacement and migration need to be addressed with a comprehensive approach to ensure that the health rights of affected people are protected.

- Putting in place a ***National legislation to regulate the private health sector***, to adopt minimum standards, accreditation, standard treatment protocols, standardised pricing of services etc. Also a mechanism to be put in place to regulate private medical colleges.

- The government operationalise a system and set up a ***central fund for procurement of essential drugs***. Such a central fund could be utilised for procurement of a set of essential drugs in all states, to be made available through Sub-centres, PHCs and CHCs. This fund could be matched by a state essential drugs fund and transparent, rationalised procurement and distribution system at state level. The model being pursued in Tamil Nadu could possibly be examined for this purpose.
- ***Effective drug price control and promotion of rational drugs***: Steps be taken to impose price control on all drugs of the National Essential Drug List in a phased manner. This would require amendment of the DPCO (2002) and a thorough review of the 2002 Drug Policy.
- The state should introduce a new ***community-anchored health worker scheme***, and implement it in a phased manner with involvement of people's organizations and panchayati raj institutions, in both rural and urban areas, through which first contact primary care and health education can be ensured.
- All state level coercive population control policies, disincentives and orders should be removed and disproportionate financial allocation for population control activity should not be allowed to skew funding from other important public health priorities.
- Sreamlining of ***medical education to create a basic doctor*** ensuring a wider outreach and improvement of access to health care services in all areas. Regulation of the growth of capitation based medical colleges

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PEOPLE'S HEALTH CHARTER

We the people of India, stand united in our condemnation of an iniquitous global system that, under the garb of "globalisation" seeks to heap unprecedented misery and destitution on the overwhelming majority of the people on this globe. This system has systematically ravaged the economies of poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor, across the globe, are being further marginalised as they are displaced from home and hearth and alienated from their sources of livelihood as a result of the forces unleashed by this system. Standing in firm opposition to such a system we reaffirm our inalienable right to comprehensive health care that includes food security; sustainable livelihood options; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum — the right to HEALTH FOR ALL, NOW!

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of international Finance Capital. The forces of "globalization" through measures such as the structural adjustment programme are targeting our resources — built up with our labour, sweat and lives over the last fifty years — and placing them in the service of the global "market" for extraction of super-profits. The benefits of the public sector health care institutions, the public distribution system and other infrastructure – such as they were – have been taken away from us. It is the ultimate irony that we are now blamed for our plight, with the argument that it is our numbers and our propensity to multiply that is responsible for our poverty and deprivation.

We declare health as a justiciable right and demand the provision of basic health care as a fundamental constitutional right of every one of us. We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralised system of local governance vested with adequate power and responsibilities and provided with adequate finances;
- A sustainable system of agriculture based on the principle of "land to the tiller", linked to a decentralized public distribution system that ensures that no one goes hungry;
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities;
- A dignified and sustainable livelihood;
- A clean and sustainable environment;
- A drug industry geared to producing epidemiologically essential drugs at affordable cost;
- A health care system which is responsive to the people's needs and whose control is vested in peoples hands;

Further, we declare our firm opposition to:

- Agricultural policies attuned to the needs of the "market" that ignore disaggregated and equitable access to food
- Destruction of our means to livelihood and appropriation, for private profit, of our natural resource bases;
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few;
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor;
- The corporatization of medical care, state subsidies to the corporate sector in medical care, and corporate sector health insurance;
- Coercive population control and promotion of hazardous contraceptive technology;
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach;
- Institutionalization of divisive and oppressive forces in society, such as fundamentalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and

implementation. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

2. The primary medical care institutions including trained village health workers, sub-centres, and the PHCs staffed by doctors and the entire range of community health functionaries be placed under the direct administrative and financial control of the relevant level panchayat raj institutions. The overall infrastructure of the primary health care institutions be under the control of panchayati raj and gram sabhas and provision of free and accessible secondary and tertiary level care be under the control of Zilla Parishads, to be accessed primarily through referrals from PHCs. The essential components of primary care should be:

   - Village level health care based on Village Health Workers selected by the community and supported by the Gram Sabha / Panchayat and the Government health services;
   - Primary Health Centers and subcentres with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from linkages;
   - A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers;
   - Enhanced content of Primary Health Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological and preventive measures.
   - Surveillance centres at block level to monitor the local epidemiological situation and tertiary care with all speciality services, availaible in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based humanpower plan for the health sector be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend towards over-production of personnel trained in super-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. Steps be taken forthwith to close down private medical colleges charging fees higher than state colleges or taking any form of donations, and to eliminate illegal private tuition by teachers in medical colleges. At least an year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education be made mandatory, without which license to practice not be issued. Similarly, three years of rural posting after post graduation be made compulsory.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

   - ban all irrational and hazardous drugs;
   - introduce production quotas and price ceiling for essential drugs;
   - promote compulsory use of generic names;

- regulate advertisements, promotion and marketing of all medications based on ethical criteria;
- formulate guidelines for use of old and new vaccines;
- control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology;
- recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices;
- promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Research priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unetical research, especially in the area of contraceptive research, be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies to be traced forthwith and appropriately compensated. Exemplary damages to be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognised. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift to onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralisation in the decision making process, related to health care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

- integration of health impact assessment into all development projects;
- decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners;
- reorientation of measures to check STDs/AIDS through universal sex education, checking social disruption and displacement and commercialisation of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseaseslike diabetes, cancers, heart diseases, etc. to be available to all att appropriate levels of medical care.

14. Women-centered health initiatives that include:

- awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in nutrition and health-care;
- preventive and curative measures to deal with health consequences of womens' work and domestic violence;
- complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector;

- special support structures that focus on single, deserted, widowed women and commercial sex workers; gender sensitive services to deal with reproductive health including reproductive system illnesses, maternal health, abortion, and infertility;
- vigorous public campaign accompanied by legal and administrative action against female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives which include:

- a comprehensive child rights code, adequate budgetary allocation for universalisation of child care services, a expanded and revitalized ICDS programme and ensuring adequate support to working women to facilitate child care, especially breast feeding;
- comprehensive measures to prevent child abuse and sexual abuse;
- educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

- banning of hazardous technologies in industry and agriculture;
- worker centered monitoring of working conditions with the onus of ensuring a safe workplace on the management;
- reorientation of medical services for early detection of occupational disease;
- special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. Measures towards mental health that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support and community based management of mental health problems be promoted. Services for early detection and integrated management of mental health problems be integrated with Primary Health Care.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising and sale of their products to the young, and provision of services for de-addiction.

Jan Swasthya Abhiyan contact addresses

B. Ekbal, **National Convenor, JSA** Vice Chancellor University of Kerala Trivandrum Ph: 0471-306634(O) 0471- 444362(R) e-mail:	**Abhay Shukla** **JSA National Secretariat** C/o CEHAT Flat No. 3 & 4, Plot No. 126 Aman Terrace-E, Dahanukar Colony, Kothrud, Pune - 411029 Ph: 020-2545141 / 25452325 e-mail :	**Amit Sen Gupta** **Jt. Convenor, JSA** Delhi Science Forum;D-158, Lower Ground Floor,J Block, Saket, New Delhi-110017 Ph: 011-26862716/ 26524324
Amitava Guha **Jt. Convenor, JSA** FMRAI, 372/21 Russa Road East Kolkata- 700 033 Ph: 033-24242862(O) e-mail:	**Thelma Narayan** **Jt. Convenor, JSA** Community Health Cell No. 367, Srinivasa Nilaya, Jakkasandra 1st Main, Koramangala 1st Block, Bangalore-560034 Ph: 080–5531518 / 5525372 e-mail :	**T. Sundararaman** **Jt. Convenor, JSA** Director, State Health Resource Center Kalibadi, Raipur - 492001 Phone: 0771-2236104, 2236175 e-mail:
Sarojini **Member, National Secretariat** Sama, 1st Floor J-59, Saket New Delhi- 17 Ph: 011-26968972 / 26850074 e-mail:	**Vandana Prasad** **Member, National Secretariat** L- 91, Sector 25 Noida, UP , 201301 Phone: 0120- 2536578 e-mail:	
For getting in touch with the international Peoples Health Movement contact:		
Ravi Narayan **PHM Global secretariat** C/o Community Heath Cell No. 367, Srinivasa Nilaya, Jakkasandra 1st Main, Koramangala 1st Block, Bangalore-560034, Karnataka Phone: 080 - 51280009	**Mira Shiva:** Voluntary Health Association of India 40, Insitutional Area, South of Delhi, New Delhi, 110016 phone: 011-2330634(O); 6855010(R). Email: mirashiva@yahoo.com	

Yet another way of getting in touch with the PHM network is to visit its website – which has a compendium of information about PHM and the contact addresses.
The website for PHM is

L-AA-20

CONSTITUTION OF INDIA → Right of disabled persons

ARTICLE 21

COMPENSATION

— Arts. 21 and 32 — Compensation — Lunatic undertrial prisoner languishing in jail for over 30 years — *No action taken by ACMM and jail authorities — Medical treatment provided only after High Court intervened — Thus there has been complete violation of Art. 21 as also provisions of Prisons Act, CrPC and Lunacy Act — Accountability not fixed so far — Under directions of the Court the undertrial has been accommodated in the home maintained by Missionaries of Charity (Brothers) at Kancharapara (W.B.) for the time being — Considering the undertrial's present mental and physical health, direction for payment of some interim compensation to him would not be of any avail — He has no known relatives either — Therefore, as an interim measure, the Court directed that a sum of Rs two lakhs shall be paid by the State of West Bengal to the Missionaries of Charity (Brothers), Howrah, by way of donation*

(Para 6) D11/38 ➧ *R.D. Upadhyay* v. *State of A.P.*, (2001) 1 SCC 437 : AIR 2000 SC 1756 : 2000 Cri LJ 2277.

Bench Strength **3**. Coram : *Dr A.S. Anand, C.J.* and *M. Jagannadha Rao, V.N. Khare*, JJ. [Date of decision : 29-11-2000]

[Search Text : MENTAL HEALTH ACT]

Compiled by Centre For Social Justice

SERVICE LAW → Occupational rights.

MEDICAL BENEFITS

— **Reimbursement of medical expenses — Room rent paid to hospital includible** — *In absence of availability of specialised treatment of a particular heart disease in the State Hospitals of Punjab, permission given by the Director with the approval of the Medical Board to get the treatment in an approved hospital outside the State and the State Government servant concerned referred to one of such hospitals (AIIMS at New Delhi, in this case) — In such circumstances, rent room paid to the hospital by the government servant, held, reimbursable to him by the State and could not be denied on the ground of being contrary to para (vii) of Government Resolution dated 25-1-1991 as right to health is integral to the right to life and the Government is under a constitutional obligation to provide health facilities — Punjab Government Letter No. 7/7/85/5 HBV/2498 dated 25-1-1991 — Constitution of India — Article 21 — Health care — Right to health — Govt. under a constitutional obligation to provide health facilities*

The respondent, an employee of the State Government of Punjab, had a heart ailment. Since, specialised treatment for that ailment was not available in the hospitals maintained by the State Government, he was given permission by the Director and approval by the Medical Board to have treatment outside the State. His case was referred to AIIMS at New Delhi. The question was whether while reimbursing his medical expenses the room rent paid to the hospital by him was to be included therein.

The State Government pleaded against the inclusion on the ground of being contrary to para (*vii*) of its Resolution contained in letter dated 25-1-1991. Rejecting that plea and allowing the employee's appeal,

Held :

It is now settled law that right to health is integral to the right to life. Government has a constitutional obligation to provide health facilities. If the government servant has suffered an ailment which requires treatment at a specialised approved hospital and on reference whereat the government servant had undergone such treatment therein, it is but the duty of the State to bear the expenditure incurred by the government servant. Expenditure, thus, incurred requires to be reimbursed by the State to the employee. D11 38 ➧ *State of Punjab* v. *Mohinder Singh Chawla*, (1997) 2 SCC 83 : 1997 SCC (L&S) 294 : AIR 1997 SC 1225 : (1997) 1 SLR 745.

Bench Strength **2**. Coram : *K. Ramaswamy* and *G.B. Pattanaik*, JJ.

[Date of decision : 17-12-1996]

SERVICE LAW

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Bench Strength **2**. Coram : *K. Ramaswamy* and *G.B. Pattanaik*, JJ.

[Date of decision : 17-12-1996]

CONSTITUTION OF INDIA

ARTICLE 21

HEALTH CARE

— Arts. 21 and 32 — Medical aid — Denial of emergency medical aid by govt. hospitals — Compensation for — Remedial measures directed — *Govt. duty-bound to provide timely medical assistance to persons in serious/moribund condition — Medical facility cannot be denied by govt. hospitals to such patients on ground of non-availability of bed — Petitioner 2 (a member of Petitioner 1 Samiti) sustaining serious head injuries and brain haemorrhage not admitted in various State-run hospitals in city (Calcutta) because of non-availability of bed and ultimately given treatment as indoor patient in a private hospital as a result of which he incurring expenditure of Rs 17,000 — Writ petition filed by petitioner being aggrieved by the indifferent and callous attitude on the part of medical authorities of the State hospitals — Held, denial of medical assistance to the petitioner by the State hospitals amounted to violation of right to life under Art. 21 — State directed to pay Rs 25,000 to petitioner as compensation — Enquiry Committee headed by a retired Judge of High Court appointed by State Govt. to conduct enquiry and recommend remedial measures — Recommendations made by the Committee (para 10) accepted by the State Govt. and directions issued by the Govt. on that basis for dealing with the patients approaching health centres/OPDs/Emergency Departments of govt. hospitals (paras 11 to 13) — Apart from those recommendations, directions also issued by Supreme Court in order to ensure availability of proper medical facilities for dealing with emergency cases (para 15) — Other States should also take necessary steps in the light of the recommendations of the Committee, directions of the State of W.B. and further directions given by Supreme Court — State cannot avoid its constitutional obligation on ground of financial constraints*

The Constitution envisages the establishment of a welfare State at the federal level as well as at the State level. 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. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail of those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. 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 violation of his right to life guaranteed under Article 21. In the present case there was breach of the said right of Petitioner 2 guaranteed under Article 21 when he was denied treatment at the various government hospitals which were approached even though his condition was very serious at that time and

he was in need of immediate medical attention. Since the said denial of the right of the petitioner was by officers of the State, in hospitals run by the State, the State cannot avoid its responsibility for such denial of the constitutional right of the petitioner. In respect of deprivation of the constitutional rights guaranteed under Part III of the Constitution the position is well settled that adequate compensation can be awarded by the court for such violation by way of redress in proceedings under Articles 32 and 226 of the Constitution. The petitioner should, therefore, be suitably compensated for the breach of his right guaranteed under Article 21 of the Constitution. Having regard to the facts and circumstances of the case, the amount of compensation is fixed at Rs 25,000.

It is the constitutional obligation of the State to provide adequate medical services to the people to preserve human life. Whatever is necessary for this purpose has to be done. The State cannot avoid its constitutional obligation in that regard on account of financial constraints. In the matter of allocation of funds for medical services the said constitutional obligation of the State has to be kept in view. It is necessary that a time-bound plan for providing these services should be chalked out keeping in view the recommendations of the Committee as well as the requirements for ensuring availability of proper medical services in this regard as indicated by the Court and steps should be taken to implement the same. The State of West Bengal alone is a party to these proceedings. Other States, though not parties, should also take necessary steps in the light of the recommendations made by the Committee, the directions contained in the memorandum of the Government of West Bengal dated 22-8-1995 and the further directions given herein by us.

The Union of India is a party to these proceedings. Since it is the joint obligation of the Centre as well as the States to provide medical services it is expected that the Union of India would render the necessary assistance in the improvement of the medical services in the country on these lines.

As regards the Medical Officers who have been found to be responsible for the lapse resulting in denial of immediate medical aid to Petitioner 2 it is expected that the State Government will take appropriate administrative action against those officers. D11 38 ➧ *Paschim Banga Khet Mazdoor Samity* v. *State of W.B.*, (1996) 4 SCC 37. Bench Strength **2**. Coram : **S.C. Agrawal** and *G.T. Nanavati*, JJ. [Date of decision : 6-5-1996]

CONSTITUTION OF INDIA → Healthright in Const Sec

ARTICLE 32

PUBLIC INTEREST LITIGATION (PIL)

PARTICULAR INSTANCES

— Arts. 32 and 21 — PIL — Ranchi Mental Hospital — Mismanagement of — *Report submitted by Chief Judicial Magistrate, Ranchi revealing shocking and inhuman conditions in the hospital in which large number of patients kept — Proper running of hospitals and providing medical attention to every citizen is the obligation of the State and it is difficult for Supreme Court to monitor management of a hospital located far off — But State Government taking an indifferent attitude and in spite of several interim orders of the Supreme Court and assurances held out by the State, defects still not remedied — In the circumstances change in administration necessary so as to give a totally new `service to patient' orientation to the institution — In the circumstances a Committee of Management appointed by the Supreme Court with a sitting High Court Judge as its Chairman — Directions given to the Committee for proper functioning, management, funds etc. — Parties, including the Committee, at liberty to move the Court from time to time — Mental Health Act, 1987, Ss. 5, 13, 37, 39 and 77* D11 38 *Rakesh Chandra Narayan* v. *State of Bihar*, 1989 Supp (1) SCC 644 : AIR 1989 SC 348 : 1989 BLJR 13.

Bench Strength **2**. Coram : **Ranganath Misra** and *M.N. Venkatachaliah*, JJ. [Date of decision : 27-9-1988]

Rakesh Chand Narain v. State of Bihar, 1986 Supp SCC 576, referred to

MENTAL HEALTH ACT, 1987

— Ss. 3 to 8 — Suo motu action by Supreme Court — Detailed directions issued to Central and State Govts. as well as UTs regarding implementation of Act and undertaking awareness campaign with special rural focus — *Only licensed mental health care institutions to be allowed to function — Compliance report to be submitted within three months of date of Supreme Court's order — Report to state specifically that no mental patient is chained in any part of the State or UT — State/UTs having no govt.-run mental health hospital to take steps to establish the same and file affidavit informing Supreme Court within one month of steps being taken — Constitution of India — Art. 21 — Health care, Art. 21 — Mental Health* _____ D11 38

Death of 25 Chained Inmates in Asylum Fire in T.N., In re v. *Union of India*, (2002) 3 SCC 31 : AIR 2002 SC 979.

Bench Strength **3**. Coram : *M.B. Shah*, *B.N. Agrawal* and *Arijit Pasayat*, JJ. [Date of decision : 5-2-2002]

[Search Text : "MENTAL HEALTH ACT"]

CONSTITUTION OF INDIA

ARTICLE 21

HEALTH CARE

— **Arts. 21, 41 and 47 — Right to healthy life** — *Held, is the obligation of the State but Government is justified in limiting the facilities to the extent permitted by its financial resources — Hence, the decision of the appellant-State to restrict financial assistance to its employees for medical treatment, within the resources of the State, held, not violative of Art. 21 — Therefore deletion of list designated private hospitals and payment at private hospitals at specified rates fixed by Govt. not violative of Art. 21 -- Service Law — Allowances — Medical Allowance — Reimbursement of medical expenses*

The respondents in this case were aggrieved by the change in policy affected by the appellant-Government in regard to reimbursement of medical expenses to its serving and retired employees. According to previous policy promulgated in 1991, reimbursement of medical expenses charged by certain designated hospitals like, Escorts, Apollo, etc., were admissible. However, according to new policy promulgated on 13-2-1995, treatment could be had from any hospital but reimbursement of medical expenses was to be restricted ``... to the level of expenditure as per the rate fixed by the Director, Health and Family Welfare, Punjab for a similar treatment package or actual expenditure which ever is less". The new policy further laid down as follows : ``The rate for a particular treatment would be included in the advice issued by the District/State Medical Board. A Committee of technical experts shall be constituted by the Director, Health and Family Welfare, Punjab to finalise the roles of various treatment packages." There were further instructions that reimbursement of medical expenses will be according to the rates as prevalent in the All India Institute of Medical Sciences (AIIMS).

The contention of the respondent was that in *Surjit Singh case* , the Supreme Court had already upheld reimbursement for treatment at Escorts, and therefore now it would not be permissible for the appellant-State to change its policy.

Declaring the new policy as constitutionally valid,

Held :

Right of one person correlates to a duty upon another, individual, employer, Government or authority. The right of one is an obligation of another. Hence the right of a citizen to live under Article 21 casts obligation on the State. This obligation is further reinforced under Article 47, it is for the State to secure health to its citizens as its primary duty. No doubt Government is rendering this obligation by opening Government hospitals and health centres, but in order to make it meaningful, it has to be within the reach of its people, as far as possible, to reduce the queue of waiting lists, and it has to provide all facilities for which an employee looks for at another hospital. Its upkeep, maintenance and cleanliness has to be beyond aspersion. To employ the best of talents and tone up its administration to give effective

contribution. Also bring in awareness in welfare of hospital staff for their dedicated service, give them periodical medico-ethical and service-oriented training, not only at the entry point but also during the whole tenure of their service. Since it is one of the most sacrosanct and valuable rights of a citizen and equally sacrosanct sacred obligation of the State, every citizen of this welfare State looks towards the State for it to perform this obligation with top priority including by way of allocation of sufficient funds. This in turn will not only secure the right of its citizen to the best of their satisfaction but in turn will benefit the State in achieving its social, political and economical goal. For every return, there has to be investment. Investment needs resources and finances. So even to protect this sacrosanct right, finances are an inherent requirement. Harnessing such resources needs top priority.

The State can neither urge nor say that it has no obligation to provide medical facility. If that were so, it would be ex facie violative of Article 21. Under the new policy, medical facility continues to be given and now an employee is given free choice to get treatment in any private hospital in India but the amount of payment towards reimbursement is regulated. Without fixing any specific rate, the new policy refers to the obligation of paying at the rate fixed by the Director. The new policy does not leave this fixation to the sweet will of the Director but it is to be done by a committee of technical experts.

No State or country can have unlimited resources to spend on any of its projects. That is why it only approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. Provision of facilities cannot be unlimited. It has to be to the extent finances permit. If no scale or rate is fixed then in case private clinics or hospitals increase their rate to exorbitant scales, the State would be bound to reimburse the same. The principle of fixation of rate and scale under the new policy is justified and cannot be held to be violative of Article 21 or Article 47 of the Constitution.

Answer to the question whether the modification of the policy by the appellant-State by deleting its earlier decision of permitting reimbursement at the rates charged by the Escorts and other designated hospitals, is justified or not, will depend upon the facts and circumstances. The Court would not interfere with any opinion formed by the Government if it is based on relevant facts and circumstances or based on expert advice.

Any State endeavour for giving best possible health facility has direct co-relation with finances. Every State for discharging its obligation to provide some projects to its subject requires finances. Article 41 of the Constitution gives recognition to this aspect.

The appellants have explained that earlier under the 1991 policy, bulk of the budget was being taken away by a few elites for such treatment like heart ailment etc. to the detriment of a large number of other employees who suffered. Hence the facility of reimbursement of full charges at designated hospitals was withdrawn even under the old

policy. It has to be held that the appellant's decision to exclude the designated hospitals is not violative of Article 21 of the Constitution.

For the aforesaid reasons and findings, the new policy dated 13-2-1995 of the appellant-Government is upheld. It is further held that the new policy is not violative of Article 21 of the Constitution. D11 38

State of Punjab v. *Ram Lubhaya Bagga*, (1998) 4 SCC 117 : 1998 SCC (L&S) 1021 : AIR 1998 SC 1703 : 1998 Lab IC 1555 : (1998) 2 LLN 973.

Bench Strength **3**. Coram : *S.B. Majmudar*, *M. Jagannadha Rao* and **A.P. Misra**, JJ. [Date of decision : 26-2-1998]

CONSTITUTION OF INDIA

ARTICLE 21

ENVIRONMENT PROTECTION

— **Art. 21 — Use of pesticides and chemicals causing health hazard affects Art. 21** — *PIL for banning import, production, distribution, sale and use of 40 named insecticides and/or additives which are alleged to be causing health hazard and which are said to have already been banned in USA and other advanced countries — Steps already taken by Central Govt. in totally prohibiting some of the insecticides/additives and in permitting restrictive use of some other insecticides/additives — In the circumstances, a Committee of four senior officers from four different Ministries involved directed to be constituted with a view to make coordinated efforts — Use of Internet to gather the latest information suggested* D1 i 38 *Ashok (Dr)* v. *Union of India*, (1997) 5 SCC 10 : AIR 1997 SC 2298.

Bench Strength **2**. Coram : *S.C. Agrawal* and **G.B. Pattanaik**, JJ.

[Date of decision : 2-5-1997]

CONSTITUTION OF INDIA

ARTICLE 21

HEALTH CARE

— Arts. 21, 39(e) and Preamble — Right to health of a worker falls under Art. 21 — *Health does not mean mere absence of sickness but complete physical, mental and social well being — Universal Declaration of Human Rights, Arts. 22 to 25 — International Convention on Economic, Social and Cultural Rights — Labour Law — Committee on Labour Welfare, 1969, Paragraph 5.77 of Chapter 5*

Per K. Ramaswamy, J.

Right to livelihood springs from the right to life guaranteed under Art. 21. The health and strength of a worker is an integral facet of right to life. The aim of fundamental rights is to create an egalitarian society to free all citizens from coercion or restrictions by society and to make liberty available for all. Right to human dignity, development of personality, social protection, right to rest and leisure as fundamental human rights to common man mean nothing more than the status without means. To the tillers of the soil, wage earners, labourers, wood cutters, rickshaw pullers, scavengers and hut dwellers, the civil and political rights are `mere cosmetic' rights. Socio-economic and cultural rights are their means and relevant to them to realise the basic aspirations of meaningful right to life. The Universal Declaration of Human Rights, International Convention on Economic, Social and Cultural Rights recognise their needs which include right to food, clothing, housing, education, right to work, leisure, fair wages, decent working conditions, social security, right to physical or mental health, protection of their families as integral part of the right to life. Our Constitution in the Preamble and Part IV reinforces them compendiously as socio-economic justice, a bedrock to an egalitarian social order. The right to social and economic justice is thus a fundamental right.

The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensures stable manpower for economic development. Facilities of health and medical care generate devotion and dedication to give the workers' best, physically as well as mentaily, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful, economic, social and cultural life. The medical facilities are, therefore, part of social security and like gilt-edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. Health is thus a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. D11/38 *C.E.S.C. Ltd.* v. *Subhash Chandra Bose*, (1992) 1 SCC 441 : 1992 SCC (L&S) 313 : AIR 1992 SC 573 : 1992 Lab IC 332 : (1992) 1 LLJ 475 : (1992) 1 LLN 353.

Bench Strength **3**. Coram : **Ranganath Misra, C.J.** [1] and **M.M. Punchhi** [2] and **K. Ramaswamy** [3], JJ. [Date of decision : 15-11-1991]

[Search Text : " RIGHT TO HEALTH"]

occupational & environmental rights to workers

CONSTITUTION OF INDIA

ARTICLE 21

HEALTH CARE

— Arts. 21, 38, 39(e), 41, 43, 48-A, 300 and 32 & 142 — Occupational health hazards — Right to health and medical aid of workers during service and thereafter, is a fundamental right — Court can give directions in appropriate cases to State or its undertakings/ instrumentalities, company or private employer to make the right meaningful and to pay compensation to affected workmen — Workmen employed in asbestos industries affected by asbestosis and becoming prone to lung cancer and related ailments — PIL filed to enforce their fundamental right *— Held, employer obliged to provide protective measures to workmen — Asbestos industries bound by directions in ``All Safety in the Use of Asbestos'' issued by ILO — Asbestos industries further directed to maintain health record of workmen during service and after retirement, conduct their Membrane Filter Test and compulsorily insure their health coverage; Union and State Govts. directed to review the standards of permissible exposure limit and to consider monitoring of small-scale factories as well; and Inspectors of Factories directed to send the workers examined by ESI hospital for re-examination by National Institute of Occupational Health — Workers found to be suffering from occupational health hazards, entitled to compensation of Rs 1 lakh payable by the factory concerned _____ — Labour Law — Factories Act, 1948, Ss. 89 and 112*

Right to health and medical care to protect his health and vigour while in service or post-retirement is a fundamental right of a worker under Article 21, read with Articles 39(*e*), 41, 43, 48-A and all related articles and fundamental human rights to make the life of the workman meaningful and purposeful with dignity of person. The right to health of a worker is an integral facet of meaningful right to life, to have not only a meaningful existence but also robust health and vigour without which the worker would lead a life of misery. Lack of health denudes him of his livelihood. Compelling economic necessity to work in an industry exposed to health hazards due to indigence to bread-winning for himself and his dependants, should not be at the cost of the health and vigour of the workman. (Paras 25 and 24)

Facilities and opportunities, as enjoined in Article 38, should be provided to protect the health of the workman. Provision for medical test and treatment invigorates the health of the worker for higher production or efficient service. Continued treatment, while in service or after retirement is a moral, legal and constitutional concomitant duty of the employer and the State. The State, be it Union or State Government or an industry, public or private, is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live life with health and happiness. The health and strength of the worker is an integral facet of the right to life. Denial

thereof denudes the workman of the finer facets of life violating Article 21. The right to human dignity, development of personality, social protection, right to rest and leisure are fundamental human rights of a workman assured by the Charter of Human Rights, in the Preamble and Articles 38 and 39 of the Constitution. Facilities for medical care and health to prevent sickness ensures stable manpower for economic development and would generate devotion to duty and dedication to give the workers' best physically as well as mentally in the production of goods or services. Health of the worker enables him to enjoy the fruits of his labour, keeping him physically fit and mentally alert for leading a successful life, economically, socially and culturally. Medical facilities to protect the health of the workers are, therefore, the fundamental and human rights of the workmen. (Para 24)

Disease occurs wherever the exposure to the toxic or carcinogenic agent occurs regardless of the country, the type of industry, job title, job assignment or location of exposure. The disease will follow the trail of the exposure and extend the chain of carcinogenic risk beyond the workplace. It is the exposure and the nature of that exposure to asbestos that determines the risk and the diseases which subsequently result. The development of the carcinogenic risk due to asbestos or any other carcinogenic agent does not require a continuous exposure. The cancer risk does not cease when the exposure to the carcinogenic agent ceases, but rather the individual carries the increased risk for the remaining years of life. The exposure to asbestos and the resultant long tragic chain of adverse medical, legal and societal consequences, remind the employer or the producer of their legal and social responsibility not to endanger the workmen or the community or the society. They not absolved of the inherent responsibility to the exposed workmen or the society at large. They have the responsibility — legal, moral and social to provide protective measures to the workmen and to the public or all those who are exposed to the harmful consequences of their products. Mere adoption of regulations for the enforcement has no real meaning and efficacy without professional, industrial and governmental resources and legal and moral determination to implement such regulations. (Para 17)

In an appropriate case, the court would give appropriate directions to the employer, be it the State or its undertaking or private employer to make the right to life meaningful; to prevent pollution of workplace; protection of the environment; protection of the health of the workman or to preserve free and unpolluted water for the safety and heaith of the people. The authorities or even private persons or industry are bound by the directions issued by the Supreme Court under Article 32 and Article 142 of the Constitution. (Para 28)

In public law claim for compensation is a remedy available under Article 32 or Article 226 for the enforcement and protection of fundamental and human rights. The defence of sovereign immunity is inapplicable and alien to the concept of guarantee of fundamental rights. There is no question of defence being available for constitutional

remedy. It is a practical and inexpensive mode of redress available for the contravention made by the State, its servants, its instrumentalities, a company or a person in the purported exercise of their powers and enforcement of the rights claimed either under the statutes or licence issued under the statute or for the enforcement of any right or duty under the Constitution or the law. (Para 29)

The Government of India issued model Rule 123-A under the Factories Act for adoption. Under the directions issued by the Supreme Court from time to time, all the State Governments have by now amended their respective rules and adopted the same as part of it but still there are yearning gaps in their effective implementation in that behalf. It is, therefore, necessary to issue appropriate directions. In the light of the rules ``All Safety in the Use of Asbestos'' issued by the ILO, the same shall be binding on all the industries. Therefore, it is not necessary to issue any direction to the Union or State Governments to constitute a committee to convert the dry process of manufacturing into wet process but they are bound by the rules not only specifically referred to in the judgment but all the rules in that behalf in the above ILO rules. The Employees' State Insurance Act and the Workmen's Compensation Act provide for payment of mandatory compensation for the injury or death caused to the workman while in employment. Since the Act does not provide for payment of compensation after cessation of employment, it becomes necessary to protect such persons from the respective dates of cessation of their employment till date. Liquidated damages by way of compensation are accepted principles of compensation. In the light of the law above laid down and also on the doctrine of tortious liability, the respective factories or companies shall be bound to compensate the workmen for the health hazards which are the cause for the disease with which the workmen are suffering from or had suffered pending the writ petitions. Therefore, the factory or establishment shall be responsible to pay liquidated damages to the workmen concerned. (Para 30)

Accordingly, all the industries are directed (1) to maintain and keep maintaining the health record of every worker up to a minimum period of 40 years from the beginning of the employment or 15 years after retirement or cessation of the employment, whichever is later; (2) the Membrane Filter Test to detect asbestos fibre should be adopted by all the factories or establishments on a par with the Metalliferrous Mines Regulations, 1961 and Vienna Convention and rules issued thereunder; (3) all the factories whether covered by the Employees' State Insurance Act or Workmen's Compensation Act or otherwise are directed to compulsorily insure health coverage to every worker; (4) the Union and the State Governments are directed to review the standards of permissible exposure limit value of fibre/cc in tune with the international standards, reducing the permissible content as prayed in the writ petition referred to at the beginning. The review shall be continued after every 10 years and also as and when the ILO gives directions in this behalf, consistent with its recommendations or any convention; (5) the

Union and all the State Governments are directed to consider inclusion of such of those small-scale factory or factories or industries to protect health hazards of the workers engaged in the manufacture of asbestos or its ancillary products; (6) the appropriate Inspector of Factories, in particular of the State of Gujarat, is directed to send all the workers, examined by the ESI hospital concerned, for re-examination by the National Institute of Occupational Health to detect whether all or any of them are suffering from asbestosis. In case of the positive finding that all or any of them are suffering from the occupational health hazards, each such worker shall be entitled to compensation in a sum of rupees one lakh payable by the factory or industry or establishment concerned within a period of three months from the date of certification by the National Institute of Occupational Health. (Para 31) D11 38 *Consumer Education & Research Centre* v. *Union of India*, (1995) 3 SCC 42 : 1995 SCC (L&S) 604 : AIR 1995 SC 922 : (1995) 2 LLJ 768.

Bench Strength **3**. Coram : *A.M. Ahmadi, C.J.* and *M.M. Punchhi* and **K. Ramaswamy**, JJ. [Date of decision : 27-1-1995]

[Search Text : " RIGHT TO HEALTH"]

RIGHT TO HEALTH

— Right to health and medical care during service and post retirement is a fundamental right of a worker under Art. 21 r/w Arts. 39(e), 41, 43 and 48-A — *Court can give directions to State, its instrumentalities, Company or private employer to make the right meaningful and pay compensation to affected workmen — Workers of asbestos industries found to be suffering from occupational health hazards were entitled to compensation of Rs 1 lakh payable by the factory concerned* D11 38 *Consumer Education & Research Centre* v. *Union of India*, (1995) 3 SCC 42 : 1995 SCC (L&S) 604 : AIR 1995 SC 922 : (1995) 2 LLJ 768.

Bench Strength **3**. Coram : *A.M. Ahmadi, C.J.* and *M.M. Punchhi* and **K. Ramaswamy**, JJ. [Date of decision : 27-1-1995]

[Search Text : " RIGHT TO HEALTH"]

CONSTITUTION OF INDIA Environmental health rights
ARTICLE 21
ECOLOGY

— **Arts. 21 and 32 — Vehicular pollution in Delhi — Directions given in M.C. Mehta case (1998) 6 SCC 63 — Overriding effect of, over statutes** — *Having been issued to safeguard the people's right to health under Art. 21, held, the said directions override the provisions of every statute including MV Act — Moreover, emission norms fixed by MV Act for diesel vehicles, held, are in addition to and not in derogation the requirements of Environment (Protection) Act — Hence, bus operators complying with the norms fixed by MV Act, held, could not merely for that reason, bypass the directions given in M.C. Mehta case — Motor Vehicles — Motor Vehicles Act, 1988, S. 110(1)(g) — Motor Vehicles — Central Motor Vehicles Rules, 1989, Rr. 115 and 116 — Environment Protection and Pollution Control — Environment (Protection) Act, 1986, Ss. 3, 6 and 7*

(Para 8)[D11/38] *M.C. Mehta* v. *Union of India (Delhi vehicular air pollution)*, (2001) 3 SCC 756 : AIR 2001 SC 1948.

Bench Strength **3**. Coram : *Dr A.S. Anand, C.J.* and *B.N. Kirpal, V.N. Khare*, JJ. [Date of decision : 26-3-2001]

[Search Text : " RIGHT TO HEALTH"]

MEDICAL PROFESSION

MEDICAL ETHICS

— **Duty to maintain secrecy — Exception** — *Disclosure for protecting an identifiable person against health risk — Decision in Mr `X' v. Hospital `Z', (1998) 8 SCC 296 — What it decided and what it did not — Held, that decision decided only that the revealing of the appellant's HIV-positive status to the relatives of his fiancée did not violate his right in any manner — Other observations made by the Supreme Court in that case, such as those relating to the appellant's suspended right to marry, held, were uncalled for — Practice and Procedure — Obiter dicta — Observations not necessary for resolving the issue made — Status of — Constitution of India — Art. 141 — Obiter dicta, Art. 141 — Status of observations not necessary for resolving the issue — Family Law — Marriage — Suspended right to marriage — Penal Code, 1860, Ss. 269 and 270*

In *Mr `X'* v. *Hospital `Z'* , (1998) 8 SCC 296, the Supreme Court had rested its decision on the facts of that case that it was open to the hospital or the doctor concerned to reveal such information to persons related to the girl whom he intended to marry and she had a right to know about the HIV-positive status of the appellant. Therefore, there was no need for the Supreme Court to go further and declare in general as to what rights and obligations arise in such context as to right to privacy or confidentiality or whether such persons are entitled to be married or not or in the event such persons marry they would commit an offence under law or whether such right is suspended during the period of illness. Therefore, all those observations made by the Supreme Court in the said matter were unnecessary, particularly when there was no consideration of the matter after notice to all the parties concerned. (Para 6)

Therefore, it is held that the observations made by the Supreme Court in that case except to the extent of holding that the appellant's right was not affected in any manner in revealing his HIV-positive status to the relatives of his fiancée, were not called for. (Para 7) D11 38 ➡ *Mr ``X'' v. Hospital ``Z''*, (2003) 1 SCC 500.

Bench Strength **3**. Coram : **S. Rajendra Babu**, *P. Venkatarama Reddi* and *Arun Kumar*, JJ. [Date of decision : 10-12-2002]

Mr `X' v. Hospital `Z', (1998) 8 SCC 296, limited

CONSTITUTION OF INDIA

ARTICLE 21

GENERALLY

— Art. 21 — Conflict between fundamental rights of two parties — Right to privacy of one and right to healthy life of the other — Which one to prevail — *In such a case, only that right which would advance public morality or public interest, held, would be enforceable — Judges' duty towards morality, stated — Jurisprudence — Morality and the law — Judicial process — Moral aspects — Regard to by Judges*

Where there is a clash of two Fundamental Rights as in this case right to privacy of one party as part of right to life and right to lead a healthy life of another party which is also a fundamental right under Art. 21, the right which would advance the public morality or public interest, would alone be enforced through the process of court, for the reason that moral considerations cannot be kept at bay and the Judges are not expected to sit as mute structures of clay in the hall known as the courtroom, but have to be sensitive, ``in the sense that they must keep their fingers firmly upon the pulse of the accepted morality of the day".

D11 38 *Mr `X'* v. *Hospital 'Z'*, (1998) 8 SCC 296.

Bench Strength **2**. Coram : **S. Saghir Ahmad** and *B.N. Kirpal*, JJ.

[Date of decision : 21-9-1998]

But See Mr ``X'' v. Hospital ``Z'', (2003) 1 SCC 500