



Women's Right to Health

N. B. Sarojini & others

NATIONAL HUMAN RIGHTS COMMISSION

Women's Right to Health

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P r e f a c e

Dr. Justice Shivaraj V. Patil

Acting Chairperson, NHRC

For full development as human beings, exercise and enjoyment of Human Rights by all the people is necessary. Human Rights and fundamental freedoms help us to develop our intrinsic qualities, intelligence, talents and conscience to meet our material and spiritual needs. It is needless to state that without the recognition of the right to education, realization of the right to development of every human being and nation is not possible. Article 26 of the Universal Declaration of the Human Rights (1948) inter alia states that ‘education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedom. It shall promote understanding, tolerance and friendship among all nations, social or religious groups and shall further the activities of the United Nations for the maintenance of peace’. Historically, education is an instrument of development and an important factor for social change. In this view, Human Rights education is / has to be an integral part of the right to education. Of late, it is recognized as a Human Right in itself.

The knowledge of the rights and freedoms, of oneself as much as of the others, is considered as a fundamental tool to guarantee the respect of all human rights for each and every person.

On 10th December 2004, the General Assembly of the United Nations proclaimed the World Programme for Human Rights Education (2005-ongoing) to advance the implementation of human rights education programmes in all sectors. Building on the foundation laid during the United Nations Decade for Human Rights Education (1995-2004), the new initiative reflects the international community’s increasing recognition that human rights education produces far-reaching results, by promoting respect for human dignity and equality and participation in democratic decision-making.

Human Rights Education cannot merely be an intellectual exercise. It acts as a linkage between education in the classroom and developments in a society.

Study of Human Rights should be included in the curriculum or syllabus in schools and colleges making it an essential part of the learning process. India has accepted elementary education as one of the basic needs of everyone. The Constitution mandates to provide free education to all children in the age group of 6-14 years. The World Conference on 'Education for All' held in Jomtien, Thailand in 1991 pleaded universal primary education in particular on education for girls and women.

The Karnataka Women's Information and Resource Centre (KWIRC), Bangalore involved various activists, advocates and key persons associated with the movement for the rights of certain vulnerable sections of the society, for developing reference material for human rights education in universities. The dossiers prepared by the experts with commitment along with the National Human Rights Commission are presented here as reference material for university students.

The main objective of these dossiers is to inspire, motivate, cultivate curiosity, shape the opinion and enlighten the university students on issues concerning human rights.

The focus of these dossiers has been on various movements that have taken place at the grass root level rather than on individual entities. These have been written in an interactive style, rather than being narrative.

The overall content of the dossiers consists of milestones at the national and international levels, critical analysis of the situation, role of various stake holders and players, action agenda etc.

Dissemination of knowledge of human rights must aim at bringing about attitudinal change in human behaviour so that human rights for all become the spirit of the very living. The Commission hopes that the educational institutions and students pursuing human rights education and others interested in human rights will be benefited immensely by this series of books.



(Dr. Justice Shivaraj V. Patil)

24 November, 2006

A c k n o w l e d g e m e n t s

Promoting Human Rights literacy and awareness is one of the main functions of the NHRC, as per section 12(h) of the Protection of Human Rights Act, 1993. The Commission has been serving this encompassing purpose within its best means.

Since its inception, the Commission has been endeavouring to spread human right education at both school and university levels. Pursuant to Commission's efforts, the UGC introduced human rights education at the university level, which is now being imparted in over 35 Universities/Colleges across the country, besides in the National Law Schools.

It is said that the awareness of human rights is largely limited to the educated sections of society, while ideally it is necessary to create awareness about human rights at all levels. There has been a growing realization that human rights cannot be taught only from formal documents.

For the purpose of developing reference material on human rights education in Indian universities, the Commission endeavoured to request the authors along with the Karnataka Women's Information and Resource Centre, Bangalore.

Each of these dossiers that are listed below have been authored by activists and experts who are deeply involved in, or closely associated with, the relevant movement:

1. Rights of Disabled by Anuradha Mohit, Meera Pillai & Pratiti Rungta
2. The Human Rights to Housing and Land by Miloon Kothari, Sabrina Karmali and Shivani Choudhary
3. Dalit Rights by Martin Macwan
4. Rights of Home Based Workers by Shalini Sinha
5. Women's Right to Health by N. B. Sarojini and others
6. Environment and Human Rights by Ashish Kothari and Anuprita Patel
7. The New Environmentalism – The Struggle in Narmada Valley by Sanjay Sangvai.
8. Coasts, Fish Resources and Human Rights of Fish Workers by Nalini Nayak.
9. Children in India and their Rights by Dr. Savita Bhakhry

A set of nine books is now being published in the series. Two more books on 'Right to Information' and 'Gandhian struggle for Rights such as Bhoodan and Gramdhan' are intended to be published shortly.

The Commission is grateful to the authors of these dossiers.

A handwritten signature in black ink, appearing to read 'Aruna Sharma', with a stylized flourish at the end.

(Aruna Sharma)
Joint Secretary



Introduction

Societal values and norms operating within the framework of patriarchy impacts on women's rights at various levels – of family, community and state. The forces of globalisation and fundamentalism have been an addition in exacerbating women's ordeal and denying them of their rights. In India, women's lives are governed by multifaceted and nuanced realities where class, caste and religion intersect with each other in complex ways to intensify women's subordination. These vexed realities make it an imperative to analyse women's health needs within a broader socio-political and economic context.

Women's groups and civil society organisations have been relentlessly engaged in addressing and prioritising issues of women's social, political and economic rights. There are several provisions in our constitution, which also assure women these rights. Time and again, national and international conferences have been redefining/bringing to light the issues concerning women's rights. However, the sole question remains: how does one narrow down the gap between rhetoric and reality? This can probably take shape only when there is an increasing realisation and respect for rights (both among men and women) in the institutions and practices of everyday life, and also by internalising a culture that is sensitive to the needs of every human being. The most essential step in this direction would be to spread awareness and sensitise all sections of society, particularly the younger generation, about the need to recognise and develop a human rights perspective.

The campaign for women's health and health-rights in India has been primarily geared towards the demand for better health services and facilities, protests against coercive tactics that endangers women's health and their human rights, and demand for overall wellbeing of women. This document locates itself within the backdrop of these realities. Along with the struggle for justice and rights in several spheres, health-rights occupy a significant place in the lexicon of women's movement in India. This work is essentially a revisit to the long-standing debates on women's rights, the focus being specifically on women's right to health.

The **first chapter** provides an analytical review of the health situation to provide students with a larger picture of the crises that have emerged over the years, which the health activists have been trying to address. It also examines some of the policies and programmes that attempt to address health in general and women's health in particular.

The **second chapter** focuses on the situation of women's health in India and examines the factors that impinge on their right to health and well being, and locates the role of gender within these.

The **third chapter** documents the major campaigns that the women's movement undertook to ensure protection of women's health rights. A brief account of the alternative activities initiated by diverse women's networks and health groups towards comprehensive health care, and particularly women's health, has also been presented in this section.

The **fourth chapter** looks into the national and international instruments that have emerged over the years. Some of these provisions and Acts are the product of constant struggles staged by the women's and the health movements.

And finally, the **last chapter** provides action agendas, strategies which have been/can be adopted around the issue of health at different levels. It sets out the agendas for different actors – the civil society organisations and also students – to work in collaboration with each other in the effort to ensure 'Health for All!' It suggests some immediate and long-term strategies that may help in achieving health as a human right, and women's health rights in particular.

Apart from enabling the students to understand and evaluate the reality of the health situation in India, particularly of women, the dossier also seeks to provide inspiration to look beyond claims and illusions, view the situation and developments with a critical eye and act when such a need arises.

Healthcare System in India – A Critical Analysis

Right to life is considered one of the fundamental rights, and health is one of the vital indicators reflecting quality of human life. In this context, it becomes one of the primary responsibilities of the state to provide health care services to all its citizens. India, despite being a signatory to the Alma Ata Declaration of 1978, which promised 'Health for All' by 2000, is far from realising this objective. On paper, India has an excellent health care structure that has the potential to reach a large section of the population. Yet, despite this elaborate structure and the rapid advancement of medical sciences, the reality is deplorable. The percentage of population actually covered by the public health care services is reportedly a mere 30 per cent. Although programmes are being constantly reviewed and revised, the problems persist and continue to worsen.

This chapter seeks to map out the shifts, which have been taking place with the changes in the politico-economic scenario in the country. These shifts have impacts on the issues of access and availability of health services for the poor. The chapter also attempts to critically analyse some of health policies and programmes in order to examine how far the policies have been implemented to fulfil the health needs of the people, particularly women in the country.

Section 1

Evolution of Healthcare System in India

The health policies, plans, and programmes in India mostly evolved during the national movement against colonial rule. The British authorities set up a Health Survey and Development Committee, commonly known as the Bhore Committee (1946)¹ that was also greatly inspired by the aspirations of the national movement.

Some of the key recommendations of the Bhore Committee were:

- Integration of preventive and curative health services at all administrative levels;

1. The Bhore Committee was constituted by the government in 1940 to prepare a comprehensive proposal for the development of national programme of health services. They submitted the same in 1946. Several National Programmes were developed based on their recommendations.

- Development of primary health centres in two stages;
- Major change in medical education;
- Formation of district health board for each district;
- Laid emphasis on preventive health services;
- Inter-sectoral approach to health service development.

It also recommended a comprehensive proposal for development of a national programme of health service for the country.² Subsequently in 1948, the Sokhey Committee³ recommended that manpower and services be developed from the bottom upwards. The Committee represented '*a people centred and pluralistic*' model of development.⁴ However, in the post Independence era, i.e., in the 1950s and 60s, advanced research institutes, medical colleges with tertiary hospitals and primary health centres emerged, while the sub-centres at village level lagged behind. India experienced a crisis in the late 60s, when it went through widespread drought that raised concerns about the 'development model', adopted so far. The international community put the onus of this crisis on the rising population growth, which was seen to be a hindrance to India's growth and development.

Changes in the global arena

Meanwhile, countries world over were witnessing a major transition in their political and economic climates. The post second world war period was marked by liberation of many countries from hundreds of years of colonial rule, rapid industrialization, particularly in East and South East Asia, and emergence of the USA as a strong industrial power.

However, this economic growth faced a severe setback in the 70s resulting from the oil price hike in 1973. This crisis signalled the end of this era and led to two simultaneous developments. First, a worldwide economic recession and inflation which the West tried to overcome in every possible way⁵. Secondly, massive

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2. Gopalan Dr. Sarala & Shiva Dr. Mira (2000) National Profile on Women, Health and Development, VHAI, New Delhi.
 3. National Health (Sokhey) Sub-Committee (called the Sokhey Committee) and was a part of the National Planning Committee constituted by the National Congress in 1940. Its report was presented in 1948.
 4. Ritu Priya, 2005, Public Health Services in India: a historical Perspective in in Leena V. Gangolli, Ravi Duggal and Abhay Shukla (ed) Review of Health Care in India
 5. This is the period when economic restructuring happened and MNCs emerged. It started with the industrial giants diversifying production in order to capture the world market and revive the economy. While factories in the West were closing down, lots of mergers happened as the big industrialists bought in the smaller ones and expanded their base in third world countries where labour was cheap and the economy that was suffering from inflation did not have much option but to accept and invite these giants to tide over the flux.

profits were made by the Oil and Petroleum Exporting Countries (OPEC), which was invested in the international banks and monetary institutions giving these institutions the power of re-defining the economic world order.

As the slump in the economy swept the globe, the developed countries sought to expand their markets across national boundaries, with obvious targets being third world countries like India. Countries, that were themselves hit hard by the oil crisis, faced further problems as a result of unfair trade practices e.g., export of raw materials to the developed countries (the prices of which were sharply declining in the world market) and import of manufactured goods at a substantially higher price. In the face of growing crisis, the only option left to the third world countries was to take loans from the West through international financial institutions like the International Monetary Fund (IMF) and World Bank (WB), who imposed stringent conditions to safeguard their interests. This gave rise to Structural Adjustment Programmes (SAPs) – a powerful tool for economic restructuring that affected the livelihoods and health of millions of people, especially in the marginalised communities of the world.

The unfair trade agreements in the name of liberalization, coupled with the SAPs of the 1980s, had a severe impact on the economies of the developing countries. The resulting economic recession and growing dependence on loans from international financial institutions forced the governments to withdraw their support to some of the crucial entitlements and benefits that their citizens rightfully enjoyed. Health was one area that was severely affected. The public health system in the developing world deteriorated because of cuts in health budgets and reforms in health system which were tied as conditionality to loans from the financial institutions, introduction of service charges in public institutions, and the simultaneous drive for privatization.

The years following the economic reforms in the late eighties saw a sharp decline in the quality of health services in the country. Some of the major developments in this phase were:

- A growing aggression on the part of agencies like the World Bank and IMF in shaping social, economic and political priorities of the country and their consistent thrust for privatisation;
- Under various states Health Systems Development Projects, the World Bank was seen to play a significant role in re-organising the health sector in the whole country in the name of alleviating poverty. India was compelled by the international financial institutions to reduce public expenditure in health through increasing privatisation. In accordance with the conditions laid down by the WB/IMF, there was a 20 per cent

reduction in the allocation for health services in the union budget. This led to the marginalization of the public sector and the expansion of private sector. *“The World Bank promotes health care as a commercial activity with no money on treatment dictate, resulting in denial of right to health and undermining state responsibility in providing basic health care to its citizens,”* to the poor, especially women, who are the poorest of the poor⁶.

- There was an imposition of the so-called “international initiatives in health”, through a combination of development aid agencies and international organisations. The health budgets of the nation experienced huge cuts in the name of health sector reforms in the 1990s. The already under financed health services of the public sector was denounced as inefficient and too costly to be revived and concepts of private–public partnerships, user fees, etc. were introduced in primary and tertiary health care.

Impact of Reforms on Health Systems

Since the turn of the nineties, when economic reforms and structural adjustments were initiated in India, the health sector had been experiencing both direct and indirect effects of these reforms. As a direct consequence of neo-liberal policies and SAPs, the government began to retract from its commitment of providing health services and facilities to all its citizens. Real expenditures for what was once internationally acclaimed as an elaborate and well-envisioned public health structure, capable of reaching huge numbers of people, began to reduce steadily.

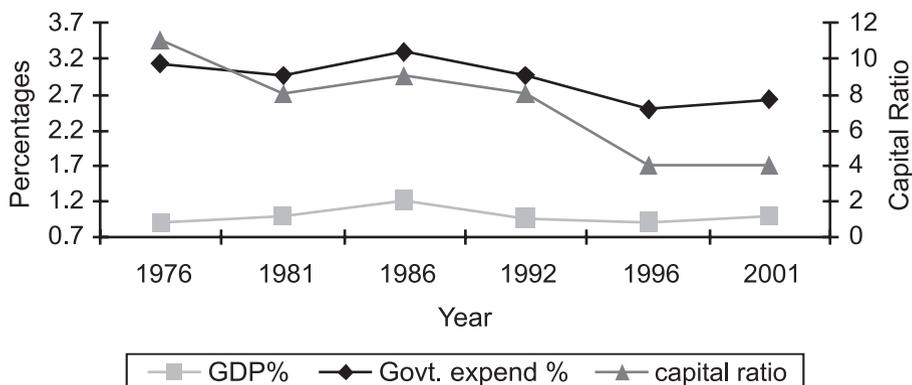
As a direct impact of reforms, the public health expenditure fell from 1.3% of Gross Domestic Product (GDP) as achieved in 1985 to 0.9% of GDP⁷. This is the lowest in the last two decades, ranking the country as the fifth lowest in the world in terms of public health expenditure.

This cut-back is reflected in – widening of disparities relating to survival and health – urban-rural as well as socio-cultural (gender, caste, class) – and slowing down of improvements in the health outcomes such as child mortality, infant mortality, etc⁸. The existing disparities also resonate the manner in which resources have been allocated within the health system. For instance, the ratio of hospital beds to population in rural areas is **fifteen times lower** than that

6. 'World Bank Funded Health Care — A Death Certificate for Poor' by Dr Vineeta Gupta

7. JSA Policy Brief 2000

8. Duggal, Ravi (2005) 'Public Health Expenditure, investment and financing under the shades of a growing private sector' in Leena V. Gangolli, Ravi Duggal and Abhay Shukla (ed) Review of Health Care in India



for urban areas. Similarly, a pregnant woman from the poorest quintile of the population is over **six times less** likely to be attended by a medically trained person during delivery. In addition, per person government spending on public health in rural areas is **seven times lower** as compared to the urban areas.

The trend of reduced public investments and expenditures in health care is forcing people to increasingly access healthcare from the private sector. However, while the dominance of the private sector on one hand, is denying access to a large section – particularly the poor, women and other marginalized communities of the society, on the other, it is skewing the balance towards urbanized, tertiary level care with profitability prevailing over equity. It is increasingly pushing the poor to take loans or sell off their assets to spend on private medical care, which is expensive and not always appropriate or rational. Further, the profit oriented corporate health care services with its urban and elite mindset has not only given rise to unethical practices in terms of irrational diagnostic and screening tests, high curative costs, etc., it has also reduced the concentration of trained medical practitioners in the public sector, especially in rural areas⁹. Both these processes have led to further impoverishment of the poor in general and women in particular.

More disturbing is the fact that this trend is in a context where the state spends less than 1% of GDP on health care and the rest is spent by people’s own resources. This translates to only 17% of total health expenditure being borne by the government an overwhelming 83% health care expenditure being private. The consequence, of this dismal allocation is a grossly inadequate public health system that is unable to meet health care demands of people and deteriorating quality of services resulting in poor health outcomes. It also makes the health sector in India one of the most privatized in the world¹⁰.

9. JSA Policy Brief 2000
 10. Ibid

The central budgetary allocation for health as a percentage of the total central budget has been stagnant at 1.3% during the eighties and nineties, while the allocation in the states have declined from 7 to 5.5% for the same period¹¹. Both central and state governments have been allocating only one-third of their expenditure on preventive and curative care. Further, out of the total curative care spending, nearly 75% is spent on secondary and tertiary sector hospitals, which are located in the urban areas. The rural areas are often ignored in the process.

Today, the presence of private sector can be felt very strongly at all levels – primary, secondary and tertiary – and in different aspects of health care. The role of private sector is no longer restricted to provisioning of services alone, but significantly seen in financing, technology, drugs, medical and paramedical education and research¹². A number of private training institutions have come up for midwives, nurses, paramedics, technicians, though not much data exists on the quality of teaching/training.

Shift from Comprehensive to Selective

Comprehensive healthcare incorporates the concept of Primary Health Care (PHC) that stresses prevention rather than cure. It believes that health is an outcome of socio-economic, political and technological advancements, and health care should involve community participation and use of technology that is acceptable, affordable by the people and appropriate to meet their needs. The Comprehensive Health Care was replaced by the idea of 'Selective Health Care' at the interest of the donor agencies. Very soon, World Health Organisation (WHO) considered it impractical and too costly to handle the complex systems involved in comprehensive care as compared to specific medical and technological interventions, and health care became restricted to cost-effective interventions.

Selective Health Care was translated into a series of **vertical programmes** that compromised the provisions of the comprehensive health services. However, the vertical programmes were not only technocratic and imposed on the masses, they also made India dependent on the North for funds, supply of vaccines and other logistic support. Hence, despite the weaknesses of these programmes, in terms of their economic, administrative and epidemiological sustainability, they were pushed through for political reasons rather than out of consideration for real needs of such programmes in the country¹³.

11. Sama, Tolakari... A New Beginning, 2005

12. Baru, Rama (2005) 'Private Health Sector in India- raising inequities' in Leena V. Gangolli, Ravi Duggal and Abhay Shukla (ed) Review of Health Care in India pp 269

13. Banerji, Debabar (2001) 'Landmarks in the Development of Health Services in India' in Imrana Qadeer, Kasturi Sen, K.R. Nayar (ed) Public Health and the Poverty of Reforms, pg 46

Increase in drug prices and effect of TRIPS

Along with budget cuts, infrastructural decline, privatisation and introduction of user charges, another significant factor responsible for the increase in health costs was the rapid liberalization of the pharmaceutical industry resulting in sharp increase in drug prices and the issue of patents. These spiralling costs have had a significant impact on access. According to the NSS surveys, the importance of 'financial reasons' for not treating illness has gone up sharply.

Price regulation in the pharmaceutical sector is an important instrument of public policy for promoting equity in access to health care. At present about 65 per cent of the Indian population lack access to essential life saving medicines despite India being recognized as a global drug manufacturer¹⁴. The Pharmaceutical Policy (PP) 2002 of the Government of India (GOI) wants to dilute drug price control by suggesting criteria for price control that will reduce the basket of price control to a bunch of irrelevant 30 or so drugs. The kinds of drugs that would be left under price control are mostly irrelevant to public health. Even the Drug Price Control Order of 1995 conspicuously omitted drugs for anaemia, diarrhoea, the majority of drugs for tuberculosis, hypertension and diabetes, and all drugs for cancer.

The Trade Related Intellectual Property Rights (TRIPS) agreement has influenced the drug pricing and policy in a negative way for India. The issue of drugs has shifted from the realm of health to the realm of trade – a situation made worse by the rise of multinational pharmaceuticals that are trying to control and own knowledge in the name of intellectual property rights¹⁵. In reality, the provisions under the TRIPS agreement undermine some of the very processes that helped India become one of the leading countries in drug manufacturing with some of the lowest prices in the world. The effect is exemplified in the attempts of the government to reformulate the pharmaceutical policy and amendment of the Indian Drug and Cosmetics Act (1948) to reduce the number of drugs under price control, and make space for clinical trials respectively in the name of liberalisation. For India it would mean wiping out of the Indian public sector, small scale sector and overpricing of a large number of essential and life saving drugs and the already vulnerable population be exposed to the unethical experimentation by the drug companies. In short, we have reached a state of 'poor health at high costs'.

14. Dabade, Gopal (2006) In Perspective 'Can the poor buy life-saving drugs?' Deccan Herald, April 2006

15. Srinivasan and Shiva (2002) 'Medicines and Health Care: Women's Perspective' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy. SAHAJ for Women & Health (WAH!)

Section 2

Availability, Accessibility and Quality to Health Care

F, a woman from a Delhi slum, was suspected of having cancer of the uterus and needed to be examined immediately. She went to an esteemed Public Hospital in South Delhi for the same. She first had to stand in a queue to get a stamp on the OPD card. By the time the doctor arrived, a large number of women were already waiting. Most of them appeared to be from a lower socio - economic category. A lot of them had come from far off places and were not familiar with the processes of the hospital, which left them at the mercy of nurses and peons who shoved them around.

With great irritation, the doctor called out names one by one and attended to them. There was no privacy at all and all sorts of questions were posed to them and they were publicly rebuked too.

F was attended to after a long hour of waiting, and she was asked to have a pap smear. However, no pap smear bottles were available in the ward. The nurse told her that there were only four bottles and they had been already distributed. F was asked to come the next day.

She left and came back the next day for the pap smear. After a long waiting, the smear was taken and the bottle needed to be deposited in another room, before which F had to stand in queue to pay Rs. 10 at the cash counter. She was asked to come back after a week for another test and after ten days for the result of the pap smear. She went back for the next test, and the doctor who was to conduct was away on an emergency surgery. She received the reports after a week and they turned to be positive. Her treatment however did not start on the day she went to collect her reports, for which she had to visit the hospital again.

The above case provides a vivid example of the poor health care system in India and the pre-existing inequality in the healthcare provisions.

Access to healthcare is becoming increasingly difficult for a growing number of people because of the continued apathy of the government to recognise health and healthcare as a national priority, along with the legitimisation of an unregulated private sector. Firstly, access to healthcare is affected by physical, financial and socio-cultural factors. Further, access to services has to be seen in terms of its coverage, availability of diagnostic facilities, medicines, surgical

care and quality. However, cost of care is an important factor that severely affects access to quality health care services. In resource-scarce countries like India, where 27% of the population lies below poverty line, cost becomes a very important issue while accessing quality.¹⁶

Geographical distance very often poses as the primary barrier to access health care. In a large country like India, people who live in remote areas, where there is either no or very poor transportation facilities, cannot even reach the nearest public health structure, and hence remain perpetually out of reach of the health system. Geographical distance becomes more crucial during the periods of epidemics, especially in the tribal areas, and contributes towards the higher mortality. It becomes more crucial for pregnant women living in remote areas to access health facilities, which results in high maternal and infant mortality.

Access of the health centres by ever-married rural women age 15-49 distance from the nearest health facility, India 1998-99						
Distance	Health PHC	Facility Sub- centre	Either PHC Sub- centre	Hospital	Dispensary/ clinic	Any health facility
Within village	13.1	33.0	36.5	9.7	28.3	47.4
<5 Km	28.4	39.7	40.8	25.0	32.4	38.9
5-9Km	29.2	16.3	15.3	25.1	17.4	9.7
10+Km	28.8	9.6	7.0	40.0	21.7	3.9
Don't know/ missing	0.5	1.4	0.3	0.2	0.2	0.2
Total %	100.0	100.0	100.0	100.0	100.0	100.0
Median distance	4.9	1.3	1.0	6.7	2.4	0.0

Source: NFHS II

Inaccessibility to health care centres, absence of health staff, deplorable sanitary conditions in the health centres and lack of drugs are a common feature in our country. There continue to exist gross disparities in the access to healthcare. This is despite the fact that as early as 1946, the Bhole Committee had

16. Ghodajkar, Prachin Kumar R., Quality of Health Care Services: Trends and Assessments in Medico Friend Circle Background Papers, 2005

recommended the guiding principle that, *“No individual should fail to secure adequate medical care because of inability to pay for it.”*¹⁷

The public hospitals do not provide the majority of medicines on one hand, and the doctors do not prescribe the medicines that the hospitals do provide on the other. The provision of low cost pharmacy, which is feasible and practical, is even denied to the patients. Patients are ultimately left to the devices of the private pharmaceutical sector that charge exorbitant prices. Access is inadequate even in the sphere of diagnostic services. In spite of having well-equipped laboratories, medical colleges support a large industry of private laboratories, often with close links to the hospital personnel. There exists a symbiotic relationship between the private and the public sector, as the private diagnostic centres fulfil the demand created by the public hospitals. This situation gets justified in the name of non-functioning and poor supply of equipments in the medical colleges.

The Primary health centres (PHCs), meant to serve the needs of the poorest and most marginalized people have the following shocking statistics:

- 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 pediatrician in 8 out of 10¹⁸.

The availability of health services in terms of infrastructure and personnel is also quite dismal. In all these years, though the government has acknowledged the requirement and presence of certain facilities in reality, there exists huge gaps. This, to some extent, explains why our health system has not been able to address the huge disease burden, especially in the rural areas.

Quality is achieved when accessible services are provided in an efficient, cost effective, acceptable manner, and when needs and expectations of patients and consumers are met¹⁹. Numerous experiences show that wherever good public

17. Sama, Tolakari... A New Beginning, 2005

18. Ibid

19. MFC Background papers 2005

Rural Health Services Infrastructure 2000-2001			
Infrastructure	Existing	Actual Required	Shortfall
Primary Health Centres (PHC) 1 per 20-30 000 population	22842	24717	8%
Sub-centres 1 per 3-5 000 population	137311	148303	7%
Community Health Centres (CHC) 1 per lakh population	3043	7415	41% First Referral Unit

Source: Quality of Health care: Public vs Private by Alpana Sagar in Background Papers for MFC Annual Meet 2006

health services are available and functional, they are definitely accessed and used by people, especially the poor. The problem generally is non-availability and poor quality of services. Patients are frequently dissatisfied with the quality of government services they receive, for reasons that include inconvenient OPD hours, high cost of services, drugs and tests, staff shortages, and lack of supplies and diagnostic techniques. Modern diagnostic techniques, such as blood sugar estimation by glucometer, pregnancy test by urinary HCG, use of nebuliser to administer a bronchodilator in acute bronchial, etc. need to be made available at the PHC level, even if it means higher costs.²⁰

Problem of accessibility is further accentuated by the lack of gender perspective in planning. The government looks at woman primarily as a child-producing machine, and the existing, inadequate health services are circumscribed within this concern. The health programme is based on the premise that maternal mortality is the cause of low sex ratio, low life expectancy and high death rates for

In Maharashtra, feedback from 36 PHC areas shows that 17% of PHCs had no public transport facility to reach the Centre at night, while 8% reported no transport at all. One in three doctors do not stay at the PHC, while the number of PHCs that did not have adequate facilities – such as water (50%), vehicle (39%), laboratory facilities (31%), no adequate medicines (86%). The number of PHCs reported, as not having any facility even for deliveries was as high as 14%, while 36% reported no gynaecological care given.

Source: Abortion Assessment Project India Report 2004 (CEHAT and Healthwatch Trust)

20. *ibid*

the female population. It believes that specific inputs to reduce deaths would make a positive impact on women's health. However, many of the causes of maternal mortality are rooted in the low social and health status of women long before they become mothers and it is this factor that is usually overlooked. The general health problems faced by women rarely get the attention they deserve.

Even within this limited concern, government programmes are badly designed and implemented. Women, especially poor women, it is believed, 'produce irresponsibly'. The medical profession's preoccupation with the reproductive function has also led to the inclusion of the family planning programmes as part of Mother and Child Health services. Yet, most women do not receive adequate ante-natal care. Though the government may claim that its focus on the reproductive age is important, some of the most common reproductive health problems of women, such as pain during menstruation, backache, infertility and reproductive tract infections, remain neglected. There is a widespread notion that reproductive tract infections are 'natural or mere baseless complaints of neurotic women'. Few women have access to gynaecological examination. The ANM or MPW are untrained to detect and treat reproductive tract infections. The dearth of women doctors in rural areas results in women continuing to suffer in silence from these ailments.

Section 3

Health Policies & Programmes in India – A critical analysis

A brief review of the government policies and programmes over the last 55 years is a reflection of how the healthcare system responds to health and particularly women's health. India has never had an explicit policy for women's health, but a range of policy decisions and measures has directly influenced women's health. This section mentions some of the policies and programmes under the National health Programmes that, to our mind, have been crucial in determining the health situation of women in India.

Since independence, several policies and programmatic interventions have been formulated to meet the health needs of people in the country. Besides, the specific policies that were initiated, the five-year plans, are a statement of the sectoral policies and programmes introduced by the Government of India. The progress of the five year plans, from the first introduced in 1951-56 to the tenth five year plan (2002-07), are indicative of the shifts in the government's priorities and commitment vis-à-vis specific health issues.

The Ministry of Health and Family Welfare (MOHFW) comprises of the Department of Health, Department of Family Welfare and the Department of Indian System of Medicine and Homeopathy.

In addition to general health services provided by MOHFW, specific health and nutritional needs of women are provided through the Integrated Child Development Services (ICDS) Programme under the Ministry of Human Resources Development and newly formed Ministry of Women and Child Development, that was only a department under the MOHFW till 2005.

Under the provision of the Constitution of India, Public health is primarily a state subject. National health programmes have been designed with flexibility to permit the state public health administration to create their own programmes according to their needs and depending on the epidemiological profile of the population. The implementation of the national health programmes carried out through the state government has decentralised public health machinery. The centre will play a coordinating role and provide technical and financial support, wherever it is felt necessary.

Below, we discuss some of the policies and programmes briefly to critically examine their effects on the health status of women.

National Health Policy (NHP)

India committed itself to universal health care in the Bhore Committee report developed way back in 1946. Subsequent to the Alma Ata commitment, the GOI passed the **National Health Policy (NHP)** in 1983. The NHP talked about comprehensive primary health care services linked to extension and health education; large scale transfer of knowledge, skills and requisite technologies to 'health volunteers'; intersectoral cooperation and better utilisation and strengthening of traditional systems of medicine²¹.

Since then, there have been marked changes in the larger climate and determinant factors relating to the health sector. The NHP 2002 is a continuation of the earlier indicated trends. The new policy deliberates on the need to improve access to health services among all social groups and in all areas, and proposes to do so by establishing new facilities in deficient areas and improving those existing. Recognizing that women and other underprivileged groups are most affected by poor access to health care, it aims at improving such groups' access to basic services. Most importantly, the central government is to give top funding

21. See NHP 2002, 1.2 www.nic.in

priority to programmes promoting women's health. The policy sets forth several time bound objectives including reduction of MMR, IMR, mortality due to TB and malaria by 2010, and zero growth of HIV/AIDS by 2007.

The new policy identifies many of the deficiencies plaguing the health care system and proposes a substantial increment in government expenditure on health care. However, in terms of its prescriptions, it represents a retreat from the fundamental concept of the NHP 1983 that was committed to the 'Health for All by 2000' through the universal provision of comprehensive primary health care services. In contrast, NHP 2002 conveniently omits the concept of comprehensive and universal health care, thus reducing primary health care to primary level care. The silence maintained on village health worker (first contact in the primary health care) and strengthening public referral services exemplify the trend²².

The policy, while on one hand is totally silent and ambiguous on the need for essential drugs, price control and standardised regimens of treatment, regulation of private medical colleges/institutions and medical research, on the other, many of its formulations pave way for greater privatisation of the system. Employing user fee in public hospitals, promoting 'health tourism' by making provisions for patients from other countries to avail domestic facilities for treatment in India, encouraging '*setting up of private insurance for expanding the scope of covering secondary and tertiary sector under private health insurance packages*', etc. mark the government's intention of legitimising further privatisation and departing from providing comprehensive, secondary and tertiary care²³. Last but not the least, health issues of women and children have been reduced to a section of rhetoric and passing references without specific prescriptions. Neither does it consider the steady decline of the female-male sex ratio over the few decades as a cause of concern²⁴, nor does it highlight any measures to prohibit sex selective abortions such as licensing and regulation of prenatal diagnostic centres. It also fails to acknowledge the problem of malnutrition, or suggest strategies and interventions to tackle the issue.

National Population Policy (NPP) 2000

In 1951, the draft outlined for the First Five-year Plan, recognised 'Population Policy' as 'essential to planning' and 'family planning' as a step towards improving

22. Jan Swasthya Abhiyan 'Policies affecting health care and violation of health rights'. Paper presented at the National Public Hearing on Right to Health Care 2004.

23. Ibid

24. Das, Abhijit (2002) 'The Current Policy Scenario in India' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy. SAHAJ for Women & Health (WAH!)

the health of the mothers and children. Women's health concerns received less attention than fertility control, and family planning became the focus. The first Family Planning Programme (FPP) was formulated in 1952. The methods propagated then were rhythm and barrier methods, like diaphragms, jellies and foam tablets. In the year 1966, Department of Family Planning was established in the Ministry of Health. The **sixties** saw a shift to Intra Uterine Devices (IUDs) and the introduction of cash incentives for doctors, motivators and the targets. The promotion of barrier methods was then stopped. In the **seventies**, the stress shifted to sterilizations, where men were targeted for vasectomies. With the declaration of Emergency in **1975**, the government declared a virtual war against the poor by way of coercive mass sterilisations. Forced sterilisation was one of the main reasons for the fall of the government. Interestingly, all subsequent governments avoided the propagation of vasectomies, and shifted their focus on women.

A statement of NPP was drafted and, in 1991, a Committee on Population was appointed which strongly recommended NPP. In the year 1993, a Committee on Population, set up by the National Development Council, proposed the formulation of a **National Population Policy**. In 1999, the draft NPP was made available, and on February 2000, the cabinet adopted the NPP²⁵.

The National Population Policy (NPP), adopted in 2000, lays out several objectives and goals to realize the long-term objective of 'stabilizing population by 2045 at a sustainable level'.

- The immediate objective is to meet the unmet need for contraception and health infrastructure;
- The medium term objective is to bring the Total Fertility Rate (TFR) to replacement levels by 2010 through intersectoral action;
- The long-term objective is to achieve a stable population, consistent with sustainable development by 2045.

The policy also states Socio-Demographic Goals to be achieved by 2010, some of which are:

- reducing IMR, MMR;
- achieving universal immunization, access to information/ counselling;
- registration of births and deaths, marriages and pregnancy;
- containing spread of infectious diseases;

25. Seminar 511, March 2002, pg 25

- promoting vigorously small family norm;
- delaying age at marriage.

Women's activists, health activists criticised the policy on many crucial grounds. First and foremost, the macro issues of income, employment, food basic health and livelihood issues do not find a mention in the NPP. Secondly, the NPP articulates stabilisation of population as the precondition for economic development. The quality of health care services including preventive and primary do not find a place in the NPP document.

Though NPP 2000 emphasises on delayed marriage, it is silent about vocational training and occupational opportunities for empowerment, which reflects that its goals are still very much limited to fertility reduction²⁶. Violence against women, men's involvement in family planning and strengthening MCH services do not get any attention in the entire policy.

Though India is a signatory with the International Conference on Population and Development (ICPD), which promotes target free approach, it continues to use disincentives as an implementation tool to achieve targets. Contravening the NPP, most states in India have formulated their own population policies, which focus on population control through two-child norm. The two-child norm has shifted the entire burden of birth control on women and further victimised women.

National Nutrition Policy (NNP), 1993

The National Nutrition Policy (1993) advocates a comprehensive inter-sectoral strategy for alleviating all the multi-faceted problems related to nutritional deficiencies, so as to achieve an optimal state of nutrition for all sections of society, but with emphasis on women and children. The strategies adopted include – screening of all pregnant women and lactating mothers for Chronic Energy Deficiency (CED); identifying women with weight below 40 kg and providing adequate ante-natal, intra-partum and neo-natal care under the RCH programme, and ensuring they receive food supplementation through the Integrated Child Development Services (ICDS) Scheme. The ICDS, launched in 1975, provides supplementary feeding to bridge the nutritional gaps that exist in respect of children below 6 years and expectant and nursing mothers. However, the ICDS programme has not been able to reach the nutritional need of children below three years.

26. Qadeer, Imrana (2002) 'Women's Health Policies and Programmes: A Critical Review' in Khanna & Gopalan (ed) Towards Comprehensive Women's Health Programmes and Policy, pg 243.

The policy however, has failed in many ways to meet the nutritional requirements of the population. Though there has been a rise in the country's food production, an ineffective distribution system has failed to benefit the masses. At the implementation level, there is a lack of co-ordination between the different departments that are supposed to provide supportive services - like safe drinking water, sanitation, day care services - and programmes that are related to women's empowerment, non-formal education and adult literacy.

Moreover, the policy thrust has been towards micronutrient supplementation rather than addressing the root causes of malnutrition. According to studies, the dismal nutritional scenario is reflected in the persistence of under nutrition in the last few decades, with a marginal reduction (only 20%) in under-nutrition. Today, India with less than 20% of the world's children, accounts for over 40% of under nourished children. Under-nutrition in pregnant women and low birth weight rate has not shown any decline.

The National Nutrition Bureau (NNB) has also been ineffective in screening nutritional disorders like CED among pregnant and lactating women, and identifying their needs. Very often, the nutritional education that is imparted is far removed from the reality of these women's lives and they fail to relate or articulate their nutritional requirements.

National Mental Health Programme (NMHP)

A National Mental Health Programme (NMHP) was launched in 1982, keeping in view the heavy burden of mental illness in the country and the inadequacy of the health system to meet the specific mental health needs. This programme aimed to shift the basis of practice from the traditional (psychiatric) services to community care.

However, in reality, the NHMP is only a footnote to the national health policy, and does not offer any (fiscal or technical) support for building community initiatives. In practice, the treatment of mental health problems is still heavily relying on the bio-medical model and is limited to the dispensing of drugs. Mental health care services are limited to those diagnosed with severe illness, where the patient is treated as a 'societal burden'. The pattern of institutional care, especially for women, reeks of neglect and paternalism and requires gender sensitive cross-referral systems²⁷.

The GOI also launched the District Mental Health Programme (DMHP) in 1996-1997 under the recommendation of the Central Council of Health and Family

27. Davar, Bhargavi (2002) 'Dilemmas of Women's Activism in Mental Health' in Khanna, Shiva and Gopalan (ed) pp 472

Welfare. The programme, initially launched in 4 states, was extended to 22 districts in 20 states by the year 2000 with a grant assistance of Rs. 22.5 lakhs each²⁸. The goal was to develop a community-based approach that has been neglected despite the programme commitment towards it. The other objectives were to impart public education in mental health to increase awareness and reduce stigma, early detection and treatment through both OPD and indoor services, and providing data from the community to the state and central levels for future planning of mental health programmes.

The programme has been criticised as giving more importance to curative services rather than preventive measures. There is also a shortage of professional manpower, and the training programmes are not adequate. Moreover, the medical care provided is still custodial in nature and requires a therapeutic approach²⁹.

Reproductive and Child Health (RCH)

The Mother and Child Health (MCH), nutrition and immunization programmes were brought under the umbrella of the Family Welfare Programme and was finally transformed into the Reproductive Child Health (RCH) programme³⁰. The national RCH programme was launched in 1997 to provide integrated health and family welfare services for women and children. The programme aimed at improving the quality, distribution and accessibility of services and to meet the health care needs of women in the reproductive ages and children more effectively.

The components included:

- prevention and management of unwanted pregnancy;
- services to promote safe motherhood and child survival;
- nutritional services for vulnerable groups;
- prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs);
- reproductive health services for adolescents;
- health, sexuality and gender information, education and counselling;
- establishment of effective referral systems;

28. <http://www.mohfw.nic.in/kk/95>

29. National Institute of Health and Family Welfare <http://www.ndc-nihfw.org/html/Programmes/NationalMentalHealth.htm>

30. Qadeer, Imrana (1999) 'Policy on Women's Health' for National Consultation towards Comprehensive Women's Health Policy and Programmes Feb 18-19.

The second phase of the programme, RCH II sought to address the inaccessibility problem of the population by re-looking at the location of sub-centres, PHCs and CHCs, working in convergence with other departments such as ICDS, Water and Sanitation, etc. It also aims at upgrading the RCH facilities at the PHC by providing for obstetric care, MTP and IUD insertion. Hiring of private anaesthetics, where none exist and referral transport facilities for poor families are some of the components of the programme.

While the RCH programme entered its second phase, a five-state social assessment of RCH I (1997-2002) revealed³¹:

- health services were not available at suitable timings for women;
- unresponsiveness of the health system to problems concerning mobile population;
- complete neglect of adolescent health needs;
- low priority accorded to treatment of gynaecological morbidities among women, even as the untreated side effects of contraceptives and post delivery complications continued to burden women;
- failure to involve men in the programme, thus rendering the RCH programme as ‘women centric’.

Despite the guidelines of the RCH programme and the existing reproductive health care services, there are certain issues that have been completely neglected and ignored by the experts. Women are unable to seek care for problems, which are not related to pregnancy and other gynaecological complications. For instance, there are no services for occupational health problems, domestic violence or abuse and mental health problems. In addition to this, the programmes deny a commitment to respond to women’s health needs throughout the life cycle and to go beyond the constricted conceptualisation of their reproductive roles as concerned only with child bearing.³²

National Rural Health Mission (NRHM)

The National Rural Health Mission (NRHM 2005) – launched in 18 states that were identified as having poor health indicators – emphasizes on comprehensive primary health care for the rural poor. The main goal of the mission is to provide

31. Sama Team (2005) ‘Reproductive Health services: The transition from policy discourse to Implementation’ in Leena V Gangoli, Ravu Duggal and Abhay Shukla (ed) Review of Health Care in India pp 166

32. Ibid

for effective health care facilities and universal access to rural population. The principle thrust areas as identified in the document are:

- Strengthening the three levels of rural health care- sub-centre, PHC and the CHC. It also states that all 'assured services' including routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes; and all support services to fulfil these should be available and strengthened at the CHC level³³.
- New health financing mechanisms for additional resource allocation and upgradation of facilities.
- Appointing ASHA (Accredited Social Health Activist) at the village level as the link worker for the rest of the rural public health system.
- Private public partnerships and regulation of private sector.

The programme document identifies all these as attempts to establish the horizontal linkages of various health programmes and provide comprehensive primary health care rather than promoting the vertical programmes, which has till now failed to provide health for all.

However, NRHM 2005 has been criticized by health activists and women's groups alike as being 'old wine in a new bottle'. Only a marginal proportion of the increased health budget has gone into the rural health system improvements under NRHM and in reality the budgets for all Family Welfare activities including the RCH II package has been clubbed together as the budget for NRHM³⁴. A consequence of such reallocation is the danger of NRHM activities being usurped by RCH programme.

The performance indicators of the ASHA and her compensation are related to RCH and there is a high possibility that this disproportionate emphasis on family planning and RCH will undermine the effectiveness of other primary health care components³⁵.

Hence, though the NRHM document reflects the renewed commitment of the government to provide comprehensive health care, it has inbuilt problems of becoming selective and abdicating the government's responsibility for healthcare provisioning.

33. Dasgupta, Rajib (2006) 'Quality Assurance in the National Rural Health Mission (NRHM): Provisions and Debates' in Background Papers for MFC Annual Meet

34. People's Rural Health Watch of JSA (2005) Action Alert on National Rural Health Mission

35. Ibid

Other Programmes

In the process of planning, a series of vertical programmes evolved towards control and eradication of communicable diseases such as TB, malaria, leprosy, etc. However, despite the vertical programmes, India is experiencing a resurgence of various communicable diseases. About 5 lakh people die from TB every year and malaria has remained at a high level of around two million cases annually.

The vertical programmes are not based on establishing a wide network of permanent health services to cater to the needs of masses in the country. Most of the programmes seem to offer simple, less effort and resource demanding option, which in no way raise concerns over the larger structural issues of poverty and inequity. The vertical programmes run through a fragmented approach, as they do not locate certain diseases within its specific context, and moreover, they are very expensive and unsustainable in the long run. The trend towards fragmentation of health programmes to vertical programmes should be reversed.

The national health programmes should be integrated in the primary health care system with decentralised planning, decision-making and implementing with the active participation of the community. Focus should be shifted from bio-medical and individual based measures to social, ecological and community based measures.³⁶ Hence, the existing policies and programmes need to be reviewed in the context of changing socio economic situation in the country.

36. PHA Charter

An Overview of Women's Health Status in India

Poverty constitutes the underlying factor for poor health status among large masses in India. The era of globalization marked by unemployment, depleting wages, rising health care costs, hazardous working and living environment has clear gender specific impacts. The patriarchal forces act in alliance with the forces of globalization to accentuate gender related subordination. Hence, one needs to go beyond the biological determinants of health and understand that women's poor health status is inextricably linked to their social and economic inequalities, which restrict their access to and control over resources.

This chapter attempts to provide an overview of women's health situation in India. In doing so, we analyze and examine the factors which make women vulnerable to mortality, communicable diseases, mental health problems, occupational health hazards and impinges on their right to health and well-being.

A critical understanding of rising mortality and morbidity rates among women in India

Women's access to health services is much less in comparison to men. The underlying reason being their lower status in the family and lack of decision-making power regarding ill health, expenditure on health care and non-availability of health care facilities prevent them from seeking medical help. Women's lack of time due to existing unequal division of labour and the socially sanctioned 'feminine' quality of 'sacrifice'. Besides, the perceptions of acceptable levels of discomfort for women and men lead to gender differences in willingness to accept that they are sick and seek care. Women wait longer than men to seek medical care for illness. This is partly due to their unwillingness to disrupt household functioning unless they become incapacitated.

Relatively high mortality rates of women are a reflection of unequal gender relations, inequalities in resource distribution, lack of access and availability of drugs and health services in our country. A look at the female to male death ratio (i.e. 0.84, for the period 1992-93) at the neo-natal stage shows that mortality rates are higher in case of males. There is a significant reversal in the picture in the post-neonatal and subsequently the 1-4 age group, where the female to male death ratios are 1.13 and 1.43 respectively. These differentials highlight the consistent gender bias inherent in seeking health care for the girl child. Many studies have clearly shown that girl children below the age of four

years displaying symptoms of pneumonia were not taken to a health provider or given any treatment at home as compared to similarly affected male children of this age group.³⁷

In India, pneumonia and anaemia constitute the major causes of death in the 0-4 age group, and tuberculosis of the lungs pose a risk in the 15-50 age group. The other causes of mortality include bronchitis and asthma, gastroenteritis, diseases of the nervous system and maternal mortality.³⁸ Poor nutritional status, coupled with lack of poor health care for girls and women underlie causes of high mortality and morbidity in India. "In India 1 out of 3 women in the age group 15-49 is undernourished as per the BMI"³⁹ (NFHS II 98-99). Studies show that access to nutrition and healthcare is skewed in favour of boys and men, which in turn, affect gender differentials in mortality. There is a definite bias in feeding nutritious food to boys and male members of the family. In northern states, it is usual for girls and women to eat less than male members. For instance, the dietary pattern indicates that in comparison to adult men, women consume approximately 1,000 fewer calories per day, far below the Recommended Dietary Allowance. Nutritional deprivation not only hinders women from reaching their full growth potential, but also results in severe and chronic anaemia.

Case study

A woman in Chidika village of Andhra Pradesh, developed pregnancy related complications. Since there was no transportation facility from that village, people had to carry her on a cot to the health centre in the nearby town. It took two hours to reach the health centre. By the time she reached the health centre, there was no staff available to attend her immediately. The woman was in critical condition and died.

The above case study illustrates the situation of health services in our country which lag behind in providing basic facilities and accessibility to women during pregnancy. India accounts for the second highest maternal mortality rate in the world⁴⁰. The figures are on a consistent rise, with National Family Health Survey (NFHS) II indicating an increase from 424 deaths per 100,000 live births in 1991 to 540 in 1997-98 and have remained stagnant till 2000⁴¹. In numbers, this translates to one woman dying every five minutes primarily from sepsis

37. NFHS 1995

38. Gopalan, Sarala and Mira Shiva (2000) National Profile on Women, Health and Development: Country Profile India, WHO

39. BMI- Body Mass Index is a reliable index of adult chronic energy deficiency

40. <http://www.infochangeindia.org/womenIbp.jsp>

41. World Health Report 2006 See <http://who.org>

infection, haemorrhage, eclampsia, obstructed labour, abortion and anaemia. With 85% of pregnant women being anaemic, blood loss due to haemorrhage in pregnancy and labour can be fatal⁴². A vicious circle of under nourishment and ill health is set in motion; poor nourished mothers give birth to low birth weight babies. Low birth weight babies have a greater risk of dying from diarrhoea and acute respiratory infections. Besides posing risks during pregnancy, anaemia increases women's susceptibility to illnesses such as tuberculosis and malaria, and reduces the energy women require for daily activities.

Lack of appropriate care during pregnancy and childbirth, and the inadequacy of services for detecting and managing complications, explains most of the maternal deaths. According to a study, 37 per cent of all pregnant women in India receive no prenatal care during their pregnancies. Moreover, women in rural areas are much less likely to receive prenatal care than women in urban areas (18 per cent and 42 per cent, respectively)⁴³. This is a cause of great concern as these deaths are preventable with improved attention to access to health care, emergency obstetric care, and proper ante-natal and postpartum care.

Apart from maternal mortality, early marriage, frequent and repeated childbearing and discrimination faced throughout the life cycle results in adverse health outcomes like RTI/STIs, uterine prolapse, etc. A district study in Maharashtra showed that reproductive problems, urinary tract infections, aches and pains and weakness made up 47% of all reported morbidity⁴⁴. Despite the Medical Termination of Pregnancy (MTP) Act in place since 1971, an estimated 4-6 million illegal abortions occur every year. While, 6-9% of these occur in adolescent girls, 16% are women between 20-34 years⁴⁵. These unsafe abortions also have negative consequences for women's health.

Section 2

Here we examine in much greater detail some of the common factors of mortality and morbidity affecting women's lives. We also make an attempt to probe into the causes behind the ill health conditions, which go beyond mere biomedical reasons. We also examine the issue of *violence against women* at multiple levels in this section, as it affects women's everyday life and health in significant ways.

42. Gopalan and Shiva (2000) National Profile on Women, Health and Development.

43. IIPS, 1995 in Sarala Gopalan and Mira Shiva National Profile on Women, Health and Development 2000 VHAI, Delhi.

44. Gopalan and Shiva (2000) National Profile on Women, Health and Development.

45. Kapilashrami, Anuj (2005) Women's health: A decade of skewed priorities, NGO Country Report.

Women and Communicable Diseases

In addition to the poor nutritional status, heavy work burden and maternal and perinatal ill-health, communicable diseases including Malaria, Tuberculosis, Encephalitis, Kala Azar, Dengue, Leprosy, etc. contribute significantly to the heavy burden of disease faced by women.

Communicable diseases remain the most common cause of death in India. Despite the arsenal of diagnostics, drugs and vaccines that have been developed during this century, medical researchers and practitioners continue to struggle against an ever-growing number of emerging infectious diseases such as HIV and hepatitis etc.⁴⁶ Structural inequalities of gender and economic resources enhance the risk of communicable diseases among poor. Although both men and women are equally exposed to communicable diseases, there are concrete evidences to show that women suffer far more than men in terms of decision making and access to treatment and services. If one considers that women constitute approximately 70% of the poor, then the interaction between poverty and gender may represent the most important risk factor to be addressed in efforts to arrest communicable diseases⁴⁷. There exist crucial linkages of communicable diseases- particularly TB and Malaria, perhaps they are so common – with issues related poverty, the environmental degradation and the change of lifestyles and food habits, etc.

Malaria - that staged resurgence in the 1980's before stabilizing at a high annual prevalence of nearly 2 million cases⁴⁸ - affects women in various ways. Repeated attacks of malaria, especially falciparum malaria in already anaemic women results in worsening of anaemia. Pregnant women with malaria are known to have a high incidence of abortion, still birth and low birth weight babies. These women have a higher risk of death.

Like Malaria, **Tuberculosis** is one of the biggest killers of women in general and of women in the reproductive age group in particular. The transition from infection to the disease and its implication is rooted not merely in the biology but in the environmental, social and material conditions of living. When women get infected, they are either sent back to their parental home for treatment or deserted. On one hand, women find it difficult to travel to distant health centres or hospitals for the diagnosis and treatment of TB, as the treatment requires regular visits to the health centres and, on the other, there is the absence of support system at home and financial help to meet the high costs of medicines.

46. Hartigan Pamela, 1999, Communicable Diseases, Gender, and Equity in Health.

47. Ibid.

48. Annual prevalence rate in 2003 as given in <http://www.globalhealthreporting.org/countries/India.asp>

The non-pulmonary TB, like genital TB is difficult to diagnose and after being diagnosed, remains untreated. Many times, this can cause infertility that has severe implication on women. The ill, treatment and ostracism meted out to a childless woman is nearly universal. 58% of **Leprosy** cases recorded in the world come from India⁴⁹. Leprosy presents itself not only as a medical disease, but is associated with immense psychological trauma and social stigma. Women inflicted with leprosy most of the time face desertion. Ironically, infliction of leprosy has been accepted as a ground for obtaining divorce that intensifies women's vulnerability.

The issue of **HIV/AIDS** presents a complex picture and has emerged as a major rights issue over the years for those infected with it. The first evidence of HIV infection in India was discovered in a female sex worker in Chennai in 1986. Since then, studies conducted all over India have shown that the infection is prevalent in a number of population groups all over the world. The NACO estimates the number of people with HIV/AIDS in India as 5.1 million in 2004.

Case study

A 25 year old woman from Davanagere was married to an auto rickshaw driver. She conceived after four years of marriage and was infected with TB. It was routine to do an HIV test for all pregnant women in the hospital. The test revealed that she was HIV positive. Her husband also underwent the test found negative. This created a tension between both the families and they completely disowned her. They left Davanagere and came to Bangalore for a living. She was two months pregnant and visited a local hospital for a check up which refused to treat her and referred her to some other hospital. By then her husband was also tested positive. Thinking that the child would be orphaned, they decided to terminate the pregnancy. The doctors at the public hospital refused and asked her to go to private clinic who demanded Rs. 5,000, which they could not afford. She went through a lot of mental strain as it was too late to terminate the pregnancy. Eventually she had a normal delivery, but lost the child⁵⁰.

The pertinent question demanding attention today is – why particular marginalised social groups more susceptible to HIV/AIDS infection? The infection in vulnerable groups brings forth economic inequality and unequal gender relations as the prime factors behind the disease. The rights of the disadvantaged people are further compromised if their HIV positive status is disclosed. People

49. Ibid

50. JSA 2004: Report on the Southern Region Public Hearing on Right to Health Care organised by JSA and NHRC,

living with HIV are stigmatised and isolated from the mainstream society. They are very often denied admissions into hospitals, schools and lose jobs on discovery of their positive status.

Case study

In Hyderabad, three HIV positive siblings were refused admission by schools since the management of the schools were against accepting HIV positive children. These schools disregarded the order of the Andhra Pradesh government, that educational institutions should not discriminate against anyone and must admit HIV positive children. The youngest of the three siblings has already succumbed to HIV and the surviving two siblings are presently being tutored by an NGO. A case with respect to the right to education of these children is pending in the Andhra Pradesh High Court.⁵¹

The recent statistics on the growing number of women affected by HIV throws light on a significant dimension of the epidemic – the spread of HIV and its links with inequitable gender relations. On one hand, there is little awareness of on issues of transmission of the infection and, on the other, women hardly have any negotiating power in sexual relationships. Added to this, the attached stigma and the reality underlying women's context, where they are socialised to hide their ailments or not seek treatment on time, keeps women out of the range of any treatment that could make a difference. Women affected by HIV/AIDS, are often disowned or dispossessed of their rights (to residence, maintenance and family property⁵². Widowed early, women are left with no social support and legal protection due of the absence of support and sustenance mechanisms outside the family. This 'feminisation' of the epidemic demands immediate attention.

Unfortunately, our health system has failed to deal with communicable diseases and their effects on women in a gender sensitive way, which results in many women being denied treatment and becoming increasingly vulnerable to ill health. The structural inequalities must be addressed to curb the growth of emerging and re-emerging diseases. Interventions in communicable diseases must be planned with cognisance of the way in which gender influences the degree to which men and women, as individuals and as population groups, have access to and control of the resources needed to protect their own families and that of community members.⁵³

51. Sama; 2005, Advancing Right to Health; the Indian Context

52. Kapilashrami, Anuj (2006) 'Women's Health: A Decade of Skewed Priorities' in From Shadows to Self- NGO Country Report 2005: Beijing +10, India Women's Watch

53. Hartigan Pamela, 1999, Communicable diseases, gender, and equity in Health

Women and Mental Health

Estimates of mental health show that about 10 million people are suffering from serious mental disorders in India. Approximately 15% of all women suffer from mental illnesses against 11% of all men⁵⁴. The social roots of women's mental health problems are overlooked owing to gender insensitivity and increasing medicalisation of mental health problems of women. Mental health care has been given very low priority and, consequently, mental health services are in an abysmal state in India.

Hospitals are poorly equipped to meet the needs of the mentally ill and often serve more of a custodial role than one of care and treatment. The infrastructural requirement in government hospitals for mental health treatment is poor. Living conditions are often abysmal, with low or non-existent standards of sanitation, and patients are often physically restrained with chains. The situation in the rural areas is worse, with erratic outpatient and outreach services and no inpatient services⁵⁵." There is also a lack of clinical psychiatrists, who can understand the socio-economic and cultural constraints and realities of the women as the major causes of mental health problems and, thereby, handle them sensitively.

Hysterectomies of Mentally Challenged Women

In 1984, a government run institution for mentally challenged girls in India came into public eye, because 17 women (ranging from 15 to 35 years of age) were brought into the district level government teaching hospital for hysterectomies. Some newspaper articles about this home had been published in the local newspapers about the abysmal facilities there.

The reason given by the state authorities (the dept. of women and child welfare) for the hysterectomies was "easy management of menstruation". They said that even though they had tried their best, the Class IV employees (cleaners, sweepers, etc.) were unable to handle the mess and thus they were sure that this was the only solution left. An eminent gynaecologist from the private sector was brought in from the metropolis to conduct the surgeries. He was going to demonstrate to the postgraduate students of surgery the new techniques of removing the uterus par-vaginally in nulliparous (not having undergone childbirth) young women.

54. Davar, Bhargavi V. (2002) 'Dilemmas of Women's Activism in Mental Health' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy. SAHAJ for Women & Health (WAH!)

55. Ibid

As the news of the impending surgeries broke out in the press, advocates from the progressive health groups went to the hospital to speak to the staff unions. The Class IV employees union unanimously supported the campaigners.⁵⁶

The case study above is an apt illustration of the complete insensitivity to women's lives and realities among the medical fraternities in the context of mental health. *Tehelka*, known for its investigative reporting, recently exposed a psychiatrist from the Agra Mental Hospital, who regularly issued false certificates to husbands wanting to relieve themselves of their wives at the cost of Rupees Ten Thousand per certificate.

The roots of many mental ailments lie in social structures and practices. Any attempt to deal with mental health holistically would automatically take into account the root causes and raise fundamental questions about social practices and norms.

The stress of work, both domestic and occupational, leaves a woman little time and space for herself. Living in hostile environments, women have no one to express or share their feelings with. Often suppressed feelings and frustrations find their own escape routes. However, the society's response to such conditions is hardly rational or sensitive. Women going through such phases are either beaten to remove the 'evil spirit', that is believed to have 'occupied the body' or, in some rare occasions, worshipped deities. People therefore resort to spiritual healing and black magic to treat mental illnesses.

In situations, where women lack autonomy, decision-making power and opportunities, they have very little control over the determinants of mental health and mental health care. In many cases they are sent to asylums by labelling women as schizophrenic patients, especially in order to discard unwanted spouse, extraction of more dowry, usurping the property of the widowed woman, etc. Many times their own parents do not want to take them back home after the treatment. Two thirds of women in mental asylums are normal women, who may be suffering from slight depression due to various emotional and physical causes.

Rights of women who have been diagnosed with mental problems, are violated, based on medical opinion and they are certified and forcibly detained. They are denied various social, political rights including the right to vote, right to enter into any kind of contract, custody of child.

56. Masum

Violence Against Women

Violence against women and girl children at the household and community levels has deep impacts on their survival, dignity, self-esteem, and overall health. Research evidences point out that globally one of the major contributors to women's mortality and morbidity is violence. Women have to confront violence in all spheres of her social life, which constantly propagates and strengthens the unequal relationship between men and women in an attempt to control women's labour, mobility, reproduction and sexuality⁵⁷.

Violence against women refers to a range of acts varying from physical abuse, psychological abuse, sexual abuse, to a host of other ways by which a woman's personal security may be seriously compromised. Women also face financial abuse, if the husband/'bread-earner' abandons the wife and children, or does not allow her access to any money by retaining all financial control. In this context, violence is one of the tools used to reinforce women's subordinate status – to control the oppressed or disempowered. This domestic violence is justified by society, if the wife is found not attending to household tasks adequately, not caring for her husband or on grounds of suspicion.⁵⁸

Contrary to popular belief, rape and sexual assault – two most common forms of violence inflicted on women – are not always crimes of passion. Neither they are always under the provocation of alcohol. Children from the age of 2 months to women of 85 are raped. According to police reports from Delhi, the rapist is most frequently not a stranger but someone from the victim's immediate family or neighbourhood.⁵⁹ Another common method used to subjugate a woman is marital rape. However, marital rape is not acknowledged by the society or the legal system as violence, since it is considered to be the conjugal right of the husband to demand sex at his will.

Instances of honour killings are also on the rise in some parts of the country, where family members kill women for transgressing the existing patriarchal social norms. Both within the family and community, widows – young and old, face particular violence in regard to practices like Sati and witch-hunting. Bihar occupies a dubious distinction of an average of 200 women being killed every year as witches⁶⁰.

57. Concept Note 10th International Women & Health Meeting (IWHM)

58. NFHS 2

59. Sama (2005) Advancing Right to Health: The Indian Context

60. Radhika Coomaraswamy explained that the lack of economic independence and security for a widow makes her particularly vulnerable to wards these atrocities. In many of these cases there is either some dispute over land with her husband's family or she had claimed other family resources.

Apart from violence in the private realm, that is, domestic/familial violence, women in our country in particular have to contend with the anti-poor policies in the name of 'development'. The steady erosion of livelihoods; alienation of indigenous people from the forests, forced migration, internal displacement of the poor; changing land use and cropping patterns to suit commercial and corporate agriculture; threats to bio-diversity and food security, are some of the processes in an array of violations in the name of development.⁶¹

The overburdening of women with roles and responsibilities, while, at the same time, reducing investment in basic infrastructure has greatly reduced women's capacities to access remunerative work and has contributed to their ill-being. Poor legislative framework to protect women's rights at the workplace [inside or outside the home], lack of recognition and unionizing of women as workers and increasing vulnerability due to loss of sustenance and survival in the period of globalization further compound matters. Trafficking of women and girl child for prostitution as well as labour/employment is another form of violence that continues to have a bearing on women's lives. Migration due to poverty, deceit in the name of marriage and jobs are the numerous ways in which women are trafficked and brought into prostitution. According to a study done by Central Social Welfare Board about 40% of trafficked women are minor.⁶² There is evidence of increasing commercial sex work among women for the survival of households, which eventually expose them to HIV infection.

Violence in many forms:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the households, pre-sex selection and sex selective abortions, female infanticide, *neglect of nutritional needs, education and medical care, early marriage*, dowry-related violence, marital rape, and other traditional practices harmful to women, non-spousal violence, and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.

61. 10 IWHM, 2005 Concept note

62. Gopalan & Shiva (2000) National Profile of Women, Health and Development pp 223-224.

Other than these, women are also victims of caste-based violence, communal violence, violence in war and conflict situations. Such violence mainly takes place in the form of rape and killing of women of one group/community by the other, since women are thought to be the carriers of honour, values and tradition of a community.

Along with familial and communal violence, women are often unprotected from State inflicted violence in diverse settings – ranging from mass sterilisation under family planning programmes, to brutal physical and sexual assault in mental hospitals and in prisons. Over time, women's bodies have been medicalised and treated as battlegrounds for unethical clinical trials, hazardous contraceptive technologies and invasive procedures with complete disregard about the effect these may have on their health. Very little or no information is provided to poor women about the risks involved and they are left without any follow up or monitoring. Many a times, sterilization is offered as a necessary condition to women asking for abortion, while no attention is paid to post-operative complaints.

The sufferings and indignation of women begins from the time she is in the womb, as is illustrated by the wide prevalence of sex preselection, sex determination tests and sex selective abortions of female

Sex ratios have witnessed an alarming decline for children in the 0-6 years of age group and stands at 927 girls for 1000 boys, even though there is a marginal improvement in the overall female ratio for the country as a whole (Census of India 2001). Between 1991 and 2001, in urban areas, the CSR declined from 935 to 903 and in rural areas from 948 to 934. This decline highlights the disturbing trend of discrimination (feeding practices, access to health care and negligence) against the girl child, unscrupulous use of medical technologies by the health 'industry' for selective elimination of foetuses and the strong son preference in society. Also, the population policies, the disincentives and the two-child norm – at variance with the NPP (2000) and the commitments made at the ICPD in Cairo – is responsible for the massive shortfall of girls in the 0-6 years age group due to Sex Selective Abortions (SSA). A recent study by the Ministry of Health also indicated the dolorous outcome of the imposition of the two-child norm for contesting elections showing that this norm had acted as an incentive for SSA.

Sex Selective abortion of female foetus is a major challenge and account for approx. 11% of unsafe abortions in India. As a result, a significant proportion of women are LOST – inside the womb, during infancy and in early years. World Bank estimates this number of 'missing' women to be about 35 million.

foetuses, which further adds to the odds that she has to struggle against in order to escape being discriminated against.

These multiple forms of gender based violence contribute to a high burden of illness and have a profound effect on women's lives. The impact may range from physical and mental health. Violence during pregnancy can lead to a range of health complications, ranging from premature labour, increased risk of miscarriages and abortions, premature labour and foetal distress. Several studies also have focused on the relationship between violence in pregnancy and low birth weight, a leading contributor to infant deaths in the developing world.⁶³

Despite its varied implications on health, violence against women has not received the public health attention it demands. Since the health care is provided in a setting which is a reflection of the larger society with its inherent prejudices and biases, the medical practice also tends to resonate and strengthen the biases. This gets reflected in the attitudes of medical professionals – predominantly male – who often see women patients as hysterical, irrational and incapable of making decisions.⁶⁴

Narsamma, a middle aged slum resident was gang raped. She was rushed to a public hospital soon after the rape occurred. She had a lump on her head, her blouse torn revealing scratch marks on her breasts. The medical officer (MO) who was approached barely looked at her and gave her paracetamol and sedatives. The next day she approached the same MO, this time accompanied by a social worker who informed the doctor about her rape. The doctor maintained that the onus of saying that she was raped is on her. This failure of the doctor to recognize the woman's state of mind and act appropriately is a characteristic of the medical establishment and its bias against women.

Often the health professionals either overlook the specific needs of victims of violence or show very little sensitivity in addressing the same. Time and space constraints and legal complications and procedures also deter doctors from addressing violence as a public health issue. The lack of support services and coordination between different systems (medical, legal, etc.) also contributes towards the continuous neglect of the problem.

63. Population Reports, Volume XXVII, Number 4, December 1999. Published by John Hopkins school of public health and CHANGE

64. Prakash, Padma, George Annie & Panalal Rupande (1993) Sexism in Medicine and Women's Rights. The Indian Journal of Social Work, Focus Issue, Patients Rights, Vol LIV, No. 2 pp 199-201 www.cehat.org/publications/pc01a11.html

While the denial and continuous neglect by the health system violates women's health rights, the medical community sometimes actively perpetuates violence on women's bodies and health through coercive sterilisations, irrational practices and unnecessary interventions such as cesarean sections, hysterectomies, routine episiotomies, etc. Women have reported rude behaviour and prejudiced attitudes of the staff while in labour, thus adding to their suffering. The hospital settings are found to be extremely depersonalized and inattentive towards women.

Women and Occupational Health

To understand the occupational aspects of health, it is necessary to have a detailed examination of women's work in terms of the actual activity undertaken, the hours of work entailed, the remuneration, if any, and the effects of all these on their nutritional status and physical as well as mental health⁶⁵. The working environment for women, both at home and at work place, affects her physical conditions. These include inadequate lighting, insanitary conditions, absence of any toilet facilities, poor airflow and ventilation, to name a few. Sexual exploitation, harassment at work place are regularly experienced by almost all sections of women in both formal and informal sectors. The most common occupational hazard for women is over-work. Over working has further grave implications on the health of women.

In rural areas, where women work as agricultural labourers, they are exposed to pesticides and chemical fertilizers that can cause diseases of the liver and nervous system, cancer, blindness or deformities. The tasks performed by women are usually those that require them to be in one position for long periods of time, which can adversely affect their reproductive health. A study in a rice-growing belt of coastal Maharashtra found that 40 per cent of all infant deaths occurred in the months of July to October. The study also found that a majority of births were either premature or stillbirths. The study attributed this to the squatting position that had to be assumed during July and August, the rice transplanting months.⁶⁶

In urban areas, where 80% of the women workforce are in unorganized sector like household industries, building construction and other petty trades, the hazardous work environment and absence of security and welfare mechanisms make women prone to serious health consequences, rape and other forms of sexual harassment.

65. Shram Shakti

66. Chronic Hunger and the Status of Women in India Carol S. Coonrod, June 1998

Carrying and lifting heavy loads often have serious health consequences for women, like menstrual disorders, prolapse of the uterus, miscarriage, and back problems, especially spinal problems.

Women who are involved in collection of industrial, hospital and household wastes suffer from intestinal and skin infections, poisoning from contact with empty chemical containers, bacterial and viral infections, hepatitis B, etc. The following chart illustrates some of the occupations and their related health implications on women.

Occupations ⁶⁷	Health Problems
<p>Manual Agricultural Workers: Postural problems; exposure to dusts and chemicals; unguarded implements; working barefoot.</p>	<p>Generalised body ache; aches in calves, hips, back, legs and shoulders; nasal catarrh; irritating coughs, irritation of the respiratory system; respiratory allergies; respiratory tract infections; tightness of chest; pneumoconiosis; cutaneous allergies; skin irritation; rashes and pruritus; mycosis; eye irritation; paddy keratitis; paronicia; fungal infection in feet; eczema; osteomyelitis of fingers; accident related health problems; Pesticide related – poisoning, intestinal respiratory and neurological disorders, nausea; vomiting, abdominal cramps, diarrhea, cough, headaches, vertigo, blurred vision, muscular twitching, convulsions; loss of reflexes; disturbance of equilibrium; jaundice; coma and ultimately death may result from respiratory arrest. Gynecological – abortions, pre mature deaths and still births; high rate of neo natal, infant and maternal mortality.</p>
<p>Quarry Workers (chrome): Exposure to high temperatures; lack of eye protection.</p>	<p>Heat strokes; severe eye problems as chips of alloys fly into the eyes.</p>

67. Shramshakti – part of the National Commission on self employed women and women in the informal sector, Chapter 6 - Occupational Health

<p>Construction workers: Heavy workload; unsafe noise levels; exposure to dusts and chemicals; accident-prone working conditions; contract labour.</p>	<p>Physical stress and strain; skeletal defects; numbness of hands and fingers; loss of hearing; stress; high blood pressure; muscular pain; intestinal problems; gastroenteritis; respiratory problems; asthma; silicosis; asbestosis; skin disease; heat cramps and sun burns; serious accident injuries, deaths; spontaneous miscarriages; high rate of infant mortality; a feeling of isolation and root-lessness</p>
<p>Ready-made Garments workers: Postural problems; heavy workload.</p>	<p>Postural problems-back, especially low back pain; eye problems; anaemia; leucorrhea; urinary tract infections.</p>
<p>Home based house workers: Exposure to dust, fumes, fuel smoke, chemicals in household products, possibility of accidents, heavy work load, drudgery, postural problems, mental tension</p>	<p>Cough and expectoration; bronchitis; emphysema; irritation of eyes, nose and throat, skin wounds, skin reactions, eye diseases, physical pain, exhaustion, anaemia, hastening of tumor, carbon monoxide toxicity; impaired foetal development; severe depression; low self-esteem.</p>

Right to Health and the Women's Movement

'The women's movement has no beginning or origin' and, that apart, one cannot compartmentalise the movement into isolated divisions and phases. But to have a comprehensive understanding, we have tried to identify some of the most significant struggles that have either been initiated by the women's movement or have found active participation and support from the women's movement, as these have had serious implications on the lives of women in one way or another. In this chapter, we have first tried to briefly trace the historical roots of the women's movement. Following this, we have pieced together certain struggles/campaigns that have had direct implication on the health and rights of women. We have then looked at a few of those initiatives that were related to the larger context of health. Finally, we have highlighted some initiatives that in the process of critiquing and challenging the prevailing approach and policies have also tried to explore alternatives.

India has quite a long history of activism for women's empowerment and rights that identified and addressed the needs of women in all spheres of economic, political and social rights. Women's movement in India has emerged as part of the Social Reform movement in the 1800s. Reformers such as Raja Ram Mohan Roy, Jyotiba Phule and Savitri Bai Phule played a pivotal role in addressing the issues of sati, child marriage, widow remarriage, and women's education. The movement encouraged women's role as doctors, social workers, teachers and scholars. The movement in its initial stage can be identified with the struggle of these women. In the early twentieth century, women's organisations forwarding their own distinct agendas emerged in several parts of India. The All India Women's Conference, established in 1924, made demands with an equal rights perspective. Women demanded equal opportunities along with men to participate in social and political spheres. They sought to reform marriage, divorce and inheritance laws, demanded education, and to be more categorical, the agenda was co-education. They wanted economic equality, and this included a right to the husband's income and pension for widows. The right to abortion was also among one of their demands. By 1955, some of the most progressive laws for women were formulated.

However, after this phase, most women in the movement were disappointed by the prevailing situation, which undermined the letter and spirit of the Hindu

Code Bill, and the movement went into a dormant phase.⁶⁸ Again, in the mid-seventies there was a revival of interest in issues related to women's status. The document 'Towards Equality' brought out in 1974 by the Committee on the Status of Women revealed that, contrary to expectations, women's position had not changed significantly since independence. Various movements raised voices in the context of women's rights in Indian society. The resurgence of the women's movement could be attributed to several temporal circumstances, which included firstly, the crisis of state and government in the 1970s going into emergency, and: the post-emergency awareness of civil rights. Secondly, the emergence and spread of women's organisations in the 1980s is one of the important factors that shaped the women's movement.

The seventies consisted of various simultaneous movements that addressed issues ranging from the creation of the Self Employed Women's Association (SEWA) and their struggle for equal wages to the Chipko movement, effort to raise the issue of women's right to land, to campaigns against price-rise in Maharashtra and

What Mathura had to endure

The heinous crime took place in March 1972 in Desai Ganj Police Station in Chandrapur district of Maharashtra. Mathura, a tribal girl of 16 years had an affair with a boy from another community. The family did not approve of the relationship and she fled with her lover, but eventually came back. Her elder brother lodged a complaint in the police station as he anticipated that she might elope with her boyfriend again. The police summoned all of them to the police station and Mathura, along with her elder brother, her boyfriend, and his mother, visited the station. After the conversation, the two policemen asked the relatives to wait outside the police station, since they wanted to question the girl alone. They took the girl in the latrine of the police station and raped her while her relatives were patiently waiting outside. When the relatives came to know of the incident they filed a complaint against the rapist. However, the Sessions Court in its judgment in 1974 released the accused. It said, since Mathura had earlier eloped with her boyfriend she must have been habituated to sex and hence cannot be raped. The case reached the Bombay High Court, where the Nagpur Bench reversed the order and sentenced both the policemen to six years of imprisonment each on the charge of rape. The appeal from the accused reached the Supreme Court, where the order was reversed in 1979. The judges held the view that since she had not raised any alarm or did not have any visible injury in her body, she must have consented to the act.

68. The Hindu Code Bill had proposed equal inheritance rights, liberalised divorce and custody rights, and prohibited polygamy. However, most of these initiatives either faced a bitter debate or were undermined.

other states. It was also the time when violence against women was taken up as a crucial issue. Towards the end of the 1970s, India witnessed the emergence of several women's groups and organisations which took up issues of rape, dowry, domestic violence, personal law, sati and campaigned for the initiation of new gender-sensitive laws and amendment of existing laws. The movement succeeded in bringing to the public certain specific issues (for instance, rape, domestic violence), which were hitherto relegated to the private sphere. The movement strategised public campaigns, demonstrations and street theatre, consciousness raising workshops, and study circles advocating legislative changes. The women's health movement has its roots in some of the crucial struggles that the women's movement waged in the 1970s and early 1980s. Some of these landmark events need specific mention in order to trace the women's health movement in the country. The Mathura Rape Case and the Supreme Court order had been one such incident in the history of women's movement.

This order created a huge controversy among the media, progressive lawyers, civil society groups and women's organizations that felt that such horrific injustice must be resisted. The incident galvanized the women's movement to seek reforms of the criminal laws concerning rape. It broached up a number of contentious issues in the legislative, legal and medical spheres. The relentless struggles of the women's movement brought in some reforms in the rape law in 1983, whereby the Bombay High Court stated that a woman constable should be present when a woman is either arrested or brought into custody. The campaign also led to visible changes in the Evidence Act, the Indian Penal Code (IPC) and the Criminal Procedure Code (CPC). It also initiated the category of 'custodial rape'.

Finally, in 1983 an amendment was made in laws pertaining to rape under which there was a provision of minimum seven years imprisonment for the one guilty of rape. Bombay High Court also stated that a woman constable should be present when a woman is either arrested or brought into custody.

An anti-dowry movement was also running parallel to this, especially in North India. Women's activism was at its peak, as they set out rallies and organised exhibitions and direct action against those who continued with the practice. Groups campaigned for legislative support to uproot the practice. In the late 1980s, the Dowry Prohibition Act of 1961 was amended, partly in response to the demands of the women's movement. One significant amendment stated that an official inquiry would be conducted if a woman (wife) died within seven years of marriage. Moreover, the husband (and co-accused) would be fined and imprisoned for seven years, if found guilty of dowry harassment.

Women's organizations all over the country also raised protests in 1978, when Shah Bano, a 62 year-old Muslim woman from Madhya Pradesh was denied her rights. Shah Bano was divorced by her husband and she approached the court for maintenance under Section 125 of the CPC, since she had no means to support herself. The High Court in its order ruled for an alimony to be paid by the husband each month. This judgment was met by hue and cry from a section of orthodox, Muslims who saw it as an encroachment of the Muslim Personal Law. The Rajiv Gandhi government gave in to the demands of the fundamentalist forces and passed the Muslim Women's Act 1986 that diluted the court's order to a large extent. It stated that the Muslim women could be paid a one-time lump sum amount (*iddat*) as maintenance.

In 1988, the issue of *Sati* came to the forefront with a case in Rajasthan, which was highlighted in the media and was taken up by women's movement.

The women's groups demanded state intervention under three clauses. First, the in-laws and the doctor who drugged her should be charged of murder and consequently punished. Second, all those related to the case who glorified the death should also be punished. Thirdly, a Special Law should be enacted to prevent the incidences of Sati and its glorification. A case was filed against 45 persons under Section 302 of IPC for the murder of Roop Kanwar. In 2004, a Special court acquitted all the 11 accused for the glorification of Sati. This shocking judgment was met by strong protests from women's organizations, human rights groups and civil liberties group in the country, who demanded that the government should file an appeal in Rajasthan High Court against the order.

How Roop Kanwar was made Sati?

In September 1987, Roop Kanwar, an 18 year-old widow from Deorala village in Sikara District of Rajasthan was burnt alive in her husband's funeral pyre as *Sati*. Her death was glorified for 13 days and funds were collected to build a *Sati* temple on the site. Women's organizations all over the country were outraged by the incident. Women's groups in Rajasthan condemned the incident and sought government action for a Central Law to prevent *Sati* and its glorification. A Joint Action Committee against *Sati* was formed and after enquiring with the neighbours, it was found that Roop Kanwar had brought in a huge amount of gold as dowry. The sudden death of her husband warranted the action from the relatives, who decided to make her a *Sati* without informing her parents. She tried to run away and hide but was dragged back and given high dosage of drugs, before she was dressed and put in the funeral pyre.

In the 1990s, women's groups expressed concerns over the unsafe environment in which women work. This was in light of the Bhanwari Devi rape case in the year 1992. Bhanwari Devi was a 41 year old dalit woman and a Sathin working for the Women's Development Programme in Rajasthan. In 1992, along with the police, she tried to stop a child marriage in her village. Bhanwari's action earned her the wrath of upper castes, and consequently in the same year she was raped by five upper caste men in the presence of her husband. Initial police investigation held her rape allegations as fake and her medical report did not confirm rape. Women's organisations and civil rights groups pressurised the government to initiate a fresh probe. This led to an investigation by the CBI and all allegations made by Bhanwari were found to be true. After a long trial, the Court acquitted the five accused of the rape charge on the ground that upper caste men would never rape a lower caste woman. This stirred a hornet's nest and women's groups, CBI and the Rajasthan government filed an appeal in the High Court to reconsider the case. It is more than a decade now and not even a single hearing has been initiated.

The Bhanwari case instigated the women's organisations to file a petition in the Supreme Court in the context of sexual harassment at the work place. The Apex Court judgment brought forth the Vishakha guidelines, according to which, the employers are responsible to provide safe working milieu to women.

The women's movement relentlessly raised its voice against the despicable violence meted out to the Muslim community that occurred in Gujarat in February 2002. The report of the International Initiative for Justice (IIJ), which undertook a fact-finding study, revealed that women suffered immense physical and sexual violence, as it was a symbolic attack to denigrate the honour of the community. The overt sexual violence against women and the explicit use of male sexuality was pointed out as being part of the political project of the Sangh Parivar, the orchestrators of the violence. The Indian government failed to address the violations and ensure justice by enforcing the recommendations put forth by women's groups, citizen's groups and human rights groups, including the recommendations of the National Human Rights Commission (NHRC).

According to the fact-finding team, members of which included women's groups, not only the legal system, but the medical system too was unresponsive towards the needs of the victims of sexual violence. Survivors had little access to counselling, no attention was paid to issues relating to consequences of the sexual violence like pregnancy, abortions and Sexually Transmitted Infections (STI) - all of which accumulated to a violation of their sexual and reproductive health and rights.

When some of these victims approached the justice system, the investigative and legal procedures furthermore victimized the women. In many cases, the police were the instigators and perpetrators of sexual violence, and in instances where rape was accompanied by murder, there was a tendency to prioritise murder. This reflected the inefficacy of the criminal justice system in dealing with incidences of communal violence involving sexual violence. The voices of the women who have been victims of sexual violence were silenced not only by the police, medical and legal system but also by the families and communities who sought to hide their 'shame'.⁶⁹

These long sustained movements drew a large number of women activists from the middle classes together with women from different segments of the society. With the experience of questioning rape, dowry and sati, it was felt important also to expand the discourse, look at women's relationship, and control over their own bodies. It is in this context that women's health, as the overall wellbeing became a central issue, which led to the emergence of women's health movement. A vivid instance is the issue of rape, and sexual violence, which brought up the nature of women's relationship with their bodies.

Women's general health and reproductive health rights were brought to the forefront through several campaigns against the introduction of hazardous contraceptives like EP drugs, Net En, Norplant, Depo-Provera, sex selective abortions and coercive population control policies of the State. Women's groups raised questions on the safety of hormonal contraceptive technologies, of the way in which clinical trials were carried out, on notions of informed consent and on general issues of women's health in the context of India's Family Welfare Programme. Furthermore, women's health activists interminably criticised the fact that women were only addressed by the health care system as reproductive beings, and their other health needs were largely ignored.

Section 1

Below, is an attempt to document the major campaigns encompassing women's health issues. However, this is not an exhaustive list of campaigns and issues that have been taken up, but it seeks to provide a glimpse into women's health movement.

69. From report of International Initiative for Justice in Gujarat addressing Sexual Violence against Women Committed by State and Non-State Actors organized by Citizen's Initiative (Ahmedabad), PUCL- Shanti Abhiyan (Vadodara), FAOW, Communalism Combat, Awaaz-E-Niswaan, Stree Sangam (Mumbai), Saheli, Jagori, Sama and Nirantar (Delhi), Organised Lesbian Alliance for Visibility and Action (OLAVA, Pune) and other women's organizations in India

HDEP Drug issue

The campaign against High Dose Estrogen-Progesterone (HDEP) occupies a significant place in the history of women's health activism. HDEP drugs were brought into the market in the 1950s for the treatment of missed menstrual periods. By the 1970s, the use of the drug became popular not only in a variety of gynaecological problems, such as menstrual irregularities, dysfunctional uterine bleeding, and dysmenorrhoea and in others, but also for pregnancy testing. EP drugs were also used for pregnancy testing, as the woman whose periods did not start after taking EP drugs, was presumed to be pregnant. The drug was increasingly misused to induce abortion. Although no pharmaceutical company has ever claimed that these drugs will induce abortion, there was enough evidence in India that these drugs were prescribed by doctors for this purpose, and were sold over the counter.⁷⁰ Evidence showed that the drug resulted in harmful side effects that included abortions, still births and abnormalities in birth. Studies also claimed that EP drugs could lead to congenital heart disease in the foetus, appearing years after birth, and they were unreliable as pregnancy tests and ineffective as treatment for missed periods. In 1982, it was estimated that about 1,80,000 women were using the drug.

A nation wide campaign was led by the All India Drug Action Network (AIDAN) along with non-governmental organisations working on health, consumer and women's rights issues. Lawyers, autonomous women's groups and individuals including doctors were also involved in the campaign.

Campaign Process in Brief

Following the campaign, the Drug Control Authority issued a ban on the drug. The ban, however, was challenged by the drug companies in the court. The women's movement, along with the drug consumer movement further strengthened the issue. When the Supreme Court, two years later, ordered the Drug Control Authority to set up a public inquiry to take the decision on the banning of the drug, women's groups and drug consumer groups were ready with the evidences of abuse and misuse of the drug in several contexts.

Although the Supreme Court directed the government to conduct a public hearing on the drug issue, the hearing was poorly organized. Announcements for the hearing were published as a routine public notice in the three cities of Delhi, Kolkata and Mumbai, where the hearing would be conducted. The government's apathetic attitude became clear when public notices were put surreptitiously and there was no attempt to contact concerned persons. For instance, notices

70. <http://www.locostindia.com>

were published on the back pages of daily newspapers along with routine advertisements and tender notices. Moreover, women who had suffered adversely were hardly in a position to undertake the burden of the technical and official formalities.

The women’s movement in association with the drug consumer movement put in a commendable effort to mobilise the women who were adversely affected by the drug. It was a long battle and after five years of continuous campaign, in 1988, the Indian Government banned the manufacture and sale of the high dose combination of EP drugs.

The urgency of addressing reproductive health issues in the women’s movement was increasingly realised. Women’s activists became aware of the political dynamics of the drug companies that targeted women for testing their products, without proper information and consent.

Campaign Against Long-acting Hormonal Contraceptives

In the bid to meet unrealistic population control targets and as part of the liberalisation policies, the Indian authorities have in the past few years relaxed drug regulations in order to expedite the introduction of long acting, invasive, hazardous hormonal contraceptives, such as the injectables (Net-en and Depo-Provera) and sub-dermal implants (Norplant) into India, that is likely to cause irreversible damage to their own and their progeny’s health. Women’s groups, health groups and human rights groups throughout the country have initiated a consistent campaign to oppose the introduction of these injectables and implants given the potential for abuse, non-completion of mandatory trials and the lack of accountability of pharmaceutical agencies.

Injectables	Commonly known as	Dosage	Manufacturing Company
Depot Medroxyprogesterone Acetate (DMPA)	Depo-Provera	150 mg every 3 months	Upjohn Co. USA (former), Presently Pfizer
Norethisterone	Net-en	200 mg every 2 months	Schering AG, Germany

Hazardous Effects of Depo-Provera and Depo-Provera

Severe side effects of Net-en and Depo-Provera are well documented, which include menstrual disorders, cessation of the monthly cycle or irregular bleeding,

general weakness, migraine headaches, and severe abdominal cramps. Depo can also lead to cancer of the breast and uterus, weight loss, loss of libido, heavy and prolonged menstrual bleedings and at times complete amenorrhoea. Moreover, studies have shown that injectable contraceptives like Depo-Provera can also lead to osteoporosis. This is again fraught with grave consequences for poor women who have low bone density due to poor nutritional status.

Clinical trials of these injectable contraceptives were being conducted by Indian Council of Medical Research (ICMR) since the mid seventies. The United States Food and Drug Agency (USFDA) banned the use of Depo for contraception. In 1975, ICMR discontinued the Depo-Provera trials, but the drug itself was not banned. There was no licensing policy and hence the drug could not be imported from other countries. A renowned gynaecologist and former Chairperson of Indian Association of fertility and sterility, Dr. C. L. Jhaveri filed a case against the Drug Controller of India and the Union of India for being refused a license to import the drug. A women's organisation (Women's Centre, Mumbai), a health network (Medico Friend Circle) in coalition with the government filed a petition against Dr. Jhaveri in 1985. They argued that the use of the drug in India's Family Planning Programme could be disastrous for women's health. Following this, Dr. Jhaveri was prohibited from importing the drug or using it on women.⁷¹

In order to assess the acceptability of Depo-Provera with a view to introduce injectable contraceptives in the National Family Welfare Programme, ICMR initiated the Phase IV (Programme Introduction) trial in 1983-84, in both urban and rural centres. A rural health centre in Patancheru, a village close to Hyderabad in Andhra Pradesh, was one of the centers where this study was conducted.

In April 1985, some members of the Stree Shakti Sanghatana (SSS), a women's group in Hyderabad, learnt of Net-en trials taking place in Patancheru Women from the poorest class were recruited for the trials. They were not informed of either its side effects or contraindications. When SSS intervened and explained the side effects and long-term implications of the drug to the women, only 5 out of 50 women remained for the trials.

Subsequently, women's groups such as SSS, Saheli, Chingari filed a writ petition in the Supreme Court against the Union of India, ICMR, Drug Controller of India (DCI) and others, asking for a stay order on the Net-En clinical trials in India. However, the government's admission at the close of the case in 2000, that mass use of Depo-Provera in the FP programme was not advisable, was a clear

71. Gandhi, Nandita and Nandita Shah (1992): *The Issues at Stake: Theory and Practice in the Contemporary Women's Movement in India*, Kali for Women, New Delhi, pp 15. Prakash, Padma (2005): *Women's Health Movement in India: A Historical Perspective*.

indication that there were potential risks associated with the injectable and that there was a need for closer monitoring and follow up. Following the public attention on unethical trials in Patancheru, Depo-Provera was placed at the backstage while clinical trials on **Norplant**, a hormonal implant, was set in motion.

Norplant is a six capsule subdermal implant containing the hormone Levenogestrol, a synthetic hormone of the progestine family. Norplant is surgically implanted under the skin of the woman's forearm. The drug is released slowly over a period of 5 years after which the capsules need to be removed.

A brief study of the women who have undergone Norplant trials in Baroda, conducted by the Forum for Women's Health, revealed the unethical and unscientific way the trials were conducted. The issue of informed consent, checking women for contraindications, follow up care and counselling was completely ignored⁷². The counselling or information that is given to her about this new method is just the following: *"These rods are of Norplant. It is a new method whose trial is going on. With a small operation, these rods will be inserted under the skin in your arm. It will work for five years and give you contraceptive protection. After five years, you have to get it removed. Come to us, we will do it whenever you want..."*⁷³ The hospitals were mainly concerned with the number of acceptors, continuation and drop out rates. Women's complaints related to heavy bleeding, amenorrhoea, etc. were not taken into consideration.

Case study

In Delhi, the Norplant trials were surreptitiously carried out without informing the women about its side effects and risks. When Shehnaz Begum enquired about the implant the doctor told her that it was a very good contraceptive that has been in use abroad and assured that there will not be any side effects. However, her experiences turned out to be completely different. She experienced continuous bleeding for four years. At the end of two years, she went back with her problem and was given an injection that stopped the bleeding for 2-3 days but it started again. She visited the doctor every 8-10 days and repeatedly asked him to remove the implant but her complaint went unnoticed. She got scared of her bleeding and fearing death due to blood loss she expressed her concerns to the doctor. She was snubbed that nobody has died of Norplant implants and she should not worry unnecessarily. However, Shehnaz Begum eventually got the implants removed from another doctor. This whole incident not only reflects the callousness and unethical practices of the doctors,

72. Lakshmi Lingam. Ed. (1998) Understanding Women's Issues: A Reader, Kali for Women, New Delhi.

73. Contraceptives: Our choices, their choices, Forum for Women's Health, 1995.

who conduct clinical trials without providing complete information and made fake promises, but also encapsulates the complete disregard of women's experiences by the medical establishment that treats women's bodies as sites of invasive experiments and violates women's right to her body and self.

(Translated from "Norplant ki kahani, Aurato ki zubaani" booklet by Stree Swasthya Manch, a compilation of experiences of women inserted with Norplant in Delhi and Vadodara)

Women's groups in Delhi, Mumbai and other cities took the initiative and protested against the introduction of Norplant. All these groups took an active role in the campaign and met regularly to discuss strategies of the campaign, compile information on these contraceptive methods and send information to other groups to involve them in the campaign. They submitted a memorandum to the Health Minister demanding the exclusion of Norplant from the National Family Welfare Programme. They also made a joint representation to the Ministry of Health concerning their opposition to the government's plan to introduce injectables and implants.

At this juncture, women's groups realized that the contentious issue of hormonal contraceptives need to be addressed comprehensively, as USFDA finally approved the use of Depo as a contraceptive method in 1992 after repeated requests by the manufacturing company Upjohn, and the DCGI approved its use by private practitioners in 1993 in India. Subsequently the Indian Government had also planned to approve the entry of Depo-Provera in the Family Welfare Programme without conducting the mandatory Phase 3 trials. Upjohn, the American multinational company, thus gained access to one of the largest markets for contraceptives without following the mandatory requirements.

Women's groups, health groups and human rights groups throughout the country have opposed the introduction of this injectable given the potential for abuse, non-completion of mandatory trials and the lack of accountability of pharmaceutical agencies. Conclusion from analysis of major studies from all over the world have compelled a call for a complete ban on injectable contraceptives, and particularly its introduction in the public (National Family Welfare Programme) sphere, because of the health hazards it poses. They also strongly protested against the government's approval of a Post Marketing Surveillance to be carried out simultaneously by the pharmaceutical company Upjohn.

In **1994**, Jagori, AIDS Awareness Group and other individuals along with some women's groups filed a case in the Supreme Court against Depo-Provera, asking to include it as a bannable drug. In the course of preparing the petition, substantial data and medical research work was studied with help from doctors

who were supportive of the campaign. After much lobbying and pressure from Sama, Saheli, AIDWA, Jagori, MFC and many other women's and health groups, the Drug Technical Advisory Board (DTAB), on the direction of the Supreme Court, passed a recommendation stating that Depo-Provera is not recommended for inclusion in the Family Welfare Programme. Right from the experience in Patancheru in Andhra Pradesh in 1985, women's groups have monitored the violations of 'informed consent' while administering contraceptives during clinical trials and research. "Unveiled Reality - A Study on Women's Experiences with Depo-Provera, an injectable contraceptive" conducted by Sama (2000) reveal that women in Delhi were administered injectable contraceptives in a Public hospital without informed consent. Vital information regarding the safety and adverse effects of the contraceptive were withheld from women, thereby depriving them of the right to make an informed choice.

More recently, in 2004, in a series of state-wise public hearings on the Right to Health initiated jointly by the National Human Rights Commission (NHRC) and Jan Swasthya Abhiyan (JSA), testimonies of women's experiences with Depo-Provera were collected and presented by Sama before the NHRC and health officials from different states. The NHRC panel was surprised that a public health establishment was administering Depo-Provera and subsequently has demanded an explanation from the officials for the same.

In 2004, a workshop in Manesar (27-29 Oct 04), was organized and co-ordinated by Parivar Seva Sanstha (a National level NGO), in collaboration with Government

Some demands from the Memorandum:

- Our position on injectables is very clear. There is enough scientific evidence to show that these are hazardous for women under any circumstances. The risks far outweigh the benefits of convenience of administration and use. Hence, we strongly oppose the move to introduce injectables at the cost of women's health;
- The public health system is particularly ill equipped to administer injectables, and NGOs and private practitioners are currently out of the ambit of practically all mechanisms of accountability. This scenario is not conducive to entry of injectables;
- We do not believe that women's 'choices' are enhanced by adding yet another hazardous contraceptive to the 'basket'. User satisfaction of a hazardous drug has to be viewed from a different lens.

of India, UNFPA and Packard Foundation through Population Foundation of India to “expand choices of contraception” by the introduction of injectables. Sama, AIDWA, Saheli and Delhi Science Forum strongly opposed the move. They mobilised many health and women’s groups across the country and submitted a Memorandum to the Health Minister.

Subsequently, the Ministry of Health and Family Welfare responded as follows: “In this connection I am to inform you that Injectable Contraceptive which was accorded marketing permission is being used in the country on the prescription of a physician since early 90s. However Government of India is not contemplating to introduce the same in the National Family Welfare Program, till the study on the effects of injectable contraceptive on Indian women’s health is completed by ICMR and the NIRRH, Mumbai and the findings are favourable. Based on the results of these studies, the Department will take a decision on the introduction of injectables under the National Family Welfare Program”. (Letter to Saheli from Dr (Mrs) MS Jayalakshmi, Deputy Commissioner (RSS), MOHFW, No.N.14013/22/2000/TO, dated 19.4.05

There were several predicaments, which the movement encountered on its way. The paramount concern was whether to go for a blanket rejection of all hormonal contraceptives or only those, which do not grant user control to women. The concern was also regarding provision of safe and effective contraceptives to those demanding contraceptives. Even women’s groups cannot be perceived as a homogenous entity with a similar stand on issues related to contraception. One strand of thought within the movement defends the use of such contraceptives like Depo. They believe that using such contraceptives like injectables and implants is the only way poor and powerless women can have control over their lives (the contraceptive is an injectable, so neither husbands nor in laws would come to know of the contraceptive method and they can escape pregnancy). So, where does the movement head for and how does it arrive at a consensus? Contrary to the above view, the widespread availability of Depo can dilute efforts to challenge the basic social and economic conditions that produce women’s powerlessness. Moreover, the drug’s side effects can never justify its use.⁷⁴

Now, let us move on to the campaign against amniocentesis, which was quite different in nature, but can be seen as a landmark in the history of women’s movement.

74. Hartmann, Betsy (1987): Reproductive Rights and Wrongs: The Global Politics of Population Control.

The Battle Against Sex-selection and Selective Abortion of Female Foetuses

Female infanticide has been an age-old practice in India. Female babies were killed by feeding them poisonous berry extracts, opium or suffocating them. A few decades back science has added a new dimension of sophistication to this practice.⁷⁵

In 1974, amniocentesis was being clinically tested in India as a technique for detecting foetal abnormalities. The survey outcome of 11,000 couples who had volunteered for the test at All India Institute of Medical Sciences (AIIMS), New Delhi, revealed that the basic motivation for this enthusiastic response had been the possibility to know the sex of the child during pregnancy. By 1975, it was quite evident that the tests were being followed by the abortion of female foetuses.⁷⁶

The tests carried out at AIIMS were stopped by 1979. There were reports from some North Indian states where medical practitioners were blatantly advertising their services. An advertisement for the amniocentesis test claimed “Better Rs 500 now than Rs 5 lakh later.”⁷⁷ There were some others, which referred to daughters as “liability to the family and a ‘threat’ to the nation’s population.”

In the year 1982, a three-point position was arrived at a meeting convened in New Delhi, wherein: firstly, an appeal was made to the government to restrict the use of amniocentesis to only teaching and medical research establishments. Secondly, the Indian Medical Council was requested to take stringent action against members involved in the practice. Thirdly, women’s organisations were to keep a vigil against the exponential growth and spread of the practice.⁷⁸

Although, the government had taken steps to restrict the practice of the test, the efforts were futile. The sex determination business had spread its roots in various pockets of India. This was the phase when the campaign against sex determination consolidated itself. In the early 1980s, the Forum against Sex-Determination and Sex-Pre-selection (FASDSP) and later on, the Doctors against Sex-Determination and Sex-Pre-selection (DASDSP), was formed. These groups in alliance addressed various issues in relation to the new reproductive technologies, undertook surveys and public awareness drives. This phase was a

75. Gandhi, Nandita and Nandita Shah (1992): *The Issues at Stake: Theory and Practice in the Contemporary Women’s Movement in India*, Kali for Women, New Delhi.

76. Indu Agnihotri and Vina Majumdar (1995): *Changing terms of Political Discourse: Women’s Movement in India, 1970s-1990s*, Economic and Political Weekly, Vol...no... pp 1869-1878

77. Gandhi, Nandita and Nandita Shah (1992): *The Issues at Stake: Theory and Practice in the Contemporary Women’s Movement in India*, Kali for Women, New Delhi.

78. Indu Agnihotri and Vina Majumdar (1995): *Changing terms of Political Discourse: Women’s Movement in India, 1970s-1990s*, Economic and Political Weekly, Vol...no... pp 1869-187

landmark in women's activism. Women's groups identified and exposed doctors who were performing these tests, addressed the public through speeches and posters, organised marches and rallies and wrote articles in the media.

In 1986, a women's group filed a petition in the Bombay High Court following the death of a woman who underwent the test in the same year. The FASDSP brought together a number of women's groups and social action groups to create public awareness on the issue. A special task force was set up to look into the issue of sex-determination and to suggest a law to ban the test in the state of Maharashtra. At the end of the eighties, the Maharashtra government finally banned the use of amniocentesis and the other pre-natal diagnostic techniques. However, this was not the end of the campaign. The campaign then demanded for a national legislation, as the sex-determination tests continued unabated in other states in India.

The centre banned all sex-determination tests in 1994, under the Pre-Natal Sex Determination Technologies (PNDT) Act. Enforced in 1996, the Act aimed to check sex selective abortion and maintain a balance in the sex ratio. The Act prohibits ultrasound tests on pregnant women without valid reasons. It was mandatory for doctors running ultrasound clinics to obtain written consent of the concerned women as well as permission of the competent authority before performing ultrasonography. Tests only to detect genetic, sex-linked or metabolic disorders, chromosomal abnormalities or certain congenital malformations by registered clinics or laboratories are permitted. According to the PNDT Act, determining the sex of the foetus is a punishable crime and doctors/relatives who encourage such a test – or even the woman herself – could be fined up to Rs 50,000 along with serving jail terms from three to five years.

Unfortunately, the Act was not free from lacunae, as it did not ban the emerging sex-pre-selection tests. Moreover, the Act had some inherent contradictions. It did not seek to criminalise the doctor under the Indian Penal Code, but let the Medical Council of India deal with violations of the Act. As a result, not a single doctor had been booked or tried under the PNDT Act of 1994. At this point, two organisations CEHAT and MASUM along with Sabu George filed a Public Interest Litigation (PIL) in February 2000 against the Union of India in the Supreme Court.⁷⁹

The PIL precipitated a massive response, mainly because in 2001 the Census revealed that the sex ratio, categorically in the 0-6 age group was dangerously skewed. In Maharashtra, which had appreciable human development indicators,

79. Gupte, Manisha (2003): A walk down a memory lane: an insiders reflections on the campaign against sex-selective abortions, Masum

the sex ratio of children below six years fell from 946 girls per 1000 boys in the 1991 census to 917 girls per 1000 boys in the 2001 census.⁸⁰

Following the PIL, the Supreme Court directed the Government of India and the states to ensure strict enforcement of the Act to stringently monitor the activities of ultrasound diagnostic clinics to prevent illegal sex selective abortion and strengthen implementation. In 2003, the PNDT Act of 1994 was revised to become the PC & PNDT (Pre-Conception and Pre-Natal Diagnostic Techniques) Act of 2003.

It is interesting to note that despite the ongoing struggle, the first conviction with a prison term took place under the Pre-natal diagnostic Techniques (Regulation and Prevention of Misuse) Act after twelve years of the enactment of the law in 2006.

A court in Faridabad, an industrial town near New Delhi, found Dr. Anil Samaniya and his Assistant guilty of carrying out tests on pregnant women at his ultrasound clinic for years. They were sentenced to two years in prison and a fine of Rs. 5,000 in Palwal, Haryana.

Dr Anil Samaniya was caught red-handed by members of the Appropriate Authority set up under the Act in every state. A four-member team along with Dr. Dahiya of JSA conducted a decoy operation and made audio and video recordings of the doctor's interaction with the customer in which he identified the sex of the foetus as female and assured the patient that it would be aborted.

After the case was filed, all private witnesses turned hostile, but the recordings made the difference as the case was heard by a lower court in Palwal. *"When we first received complaints on the phone against the doctor, we sat and strategised. We made a detailed plan,"* says RC Agarwal, civil surgeon based in Faridabad and head of Haryana's Appropriate Authority.

The amendments to the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994.

- Sex-selection: Pre and post conception methods are included.
- Ultrasound machines to be registered and records of scan to be maintained.
- Mobile ultrasound machines will be regulated.
- Constitute multi-membered State Appropriate authorities.
- Appropriate authority vested with powers of a civil court.
- Enhancement of penalties for violations of the Act

80. Ibid

He has four other complaints pending in local courts. “The most important thing is to get an early judgment. When it takes five years for a case to be decided, we get completely demoralized,” said Dr. Agarwal in an interview.

Campaign Against Anti Fertility Vaccine (AFV)

Contraceptive research in recent years is developing in the direction of immunological contraceptives. National Immunological Institute, New Delhi has been involved in the research on Anti Fertility Vaccine since 1975.

Women’s groups have challenged the development and clinical trials of Anti-fertility vaccines on various grounds. There are various issues related to the use of such vaccines, especially in developing countries like India, where health and family welfare programmes are driven by demographic objectives. So at one level, the development of the technology is a vexed issue in itself, and at another level, the geo political and social context of its use raise questions.⁸² The potential side effects of the vaccine can be seen as below:

Most of these immunological contraceptives work by using the body’s immune system to prevent pregnancy. The AFV produces antibodies, which immunise women against their own hCG hormone (Human Chronic Gonadotropin) secreted by the early blastocyte (embryo). The vaccine fools the body by modifying the structure of the body protein, so that it does not recognise it as its own and begins to produce antibodies against it. Since it is disguised to appear foreign, the fertilised egg cell is coated by antibodies which prevent it from implanting it in the woman’s uterus.”⁸¹

- The safety of the Anti-Fertility vaccines is not yet established. In the context of immunological contraceptives, it is necessary to ensure that the components of the vaccine do not have toxic effects in the user’s body.
- The immunological contraceptive works by inducing an immune response against a body component, which is protected by mechanisms of self tolerance. Auto-immune diseases can emerge when the self tolerance breaks down. Women are more frequently and severely affected by the auto-immune diseases. The other possible risks are allergies and hypersensitivity reactions.
- The immunological contraceptives do not provide any protection against

81. Ibid.

82. Target Practice: Anti-fertility Vaccine Research and Women’s Health, A Saheli Report, October 1998

HIV/AIDS and other STIs. Furthermore, the immunological contraceptive may have extremely hazardous effects on women infected with HIV, especially if they are not aware of their HIV positive status.

- The immunological contraceptives, which are long acting, and provider controlled carry a potential for abuse. The abuse is seen from the perspective of users who are mostly women. 'Informed consent' should be the prerogative underlying the trials and use of these contraceptives. However, this requirement of 'informed consent can be manoeuvred in several ways by the providers. She may not know when and exactly what contraceptives she is being administered under certain circumstances. The potential for hazard deepens in the context of top-down family planning programmes driven by the objective of population control programmes.

In June 1993, women's health activists from all over the world met in Germany for a meeting, "Vaccination against pregnancy: Researcher's Dream, Women's Nightmare?" highlighting the unethical research, inherent health risks and potential for abuse. A resolution was passed declaring that research on Anti-Fertility Vaccines should not be pursued. Following this meeting, an open letter, the "Call for a halt to Research on Anti-Fertility Vaccines" was written, directed at the main research institutes and funding agencies involved in the research.

The 'Call for a halt' petition was endorsed by a wide spectrum of groups and individuals all over India. On November 8th, 1993, about sixty women and health activists leafleted in public focussing on the inherent risks of the Anti-Fertility Vaccines and demonstrated at the office of World Health Organisation (WHO) in New Delhi, which was involved in the research.

Campaign Against Quinacrine Sterilisation in India

Quinacrine is an anti-malarial drug, used in the form of oral tablets and occasionally as an injection to treat the malarial fevers. Jaime Zipper, a Chilean scientist, first published reports in the late 1960s and early '70s about the potential use of quinacrine slurry (later developed as pellets) for chemical sterilization on women. It has gradually gained ground and promoted as an effective mode of female sterilization over the last three decades, despite the opposition by women's health activists. There are several contraindications of the method, both short and long term and reliable data is still not available. The efficacy is yet to achieve a satisfactory rate and chances of ectopic pregnancies are quite high.

The short-term complications of quinacrine sterilisation may range from pain in the lower abdomen, itching of the vagina, headaches and dizziness, infection of the pelvic cavity, effects on central nervous system. There are issues relating to its effects on the uterus in case of failure of the method. Chances of ectopic pregnancies (pregnancy occurring outside the uterus) are also higher in the event of quinacrine administration. Several issues regarding the long-term complications of the method remain unresolved. The reversibility of the method is not yet established.

In India, quinacrine sterilisations have never received any official approval and DCGI did not grant either approval or license for clinical trials, mass use, distribution, import or manufacture of Quinacrine except for oral use as an anti-malarial drug. In fact, though ICMR was permitted to conduct a limited trial for 50 women, it has initiated and abandoned the trials due to high failure rate. However, a significant section of the NGO sector and private practitioners all over the country have been carrying out illegal quinacrine sterilisations for the last twenty years, subjecting women to unethical trials and exposing them to several health risks. The women's groups and health activists in India launched a campaign against quinacrine sterilisation. They argued that it is unacceptable by any standard, and all unethical trials and use of quinacrine be immediately stopped.

Ganatantrik Mahila Samiti, a women's organisation in Kolkata protested against the use of quinacrine and was supported by a large number of women's groups. There were protests in Delhi by women's groups and other health groups. In July 1997, a Public Interest Litigation (PIL) to ban Quinacrine was filed by All India Democratic Women's Association (AIDWA) and Centre for Social Medicine and Community Health of Jawaharlal Nehru University, Delhi. In March 1998, the Supreme Court of India delivered a judgment for the banning of Quinacrine pellets for female sterilisation.⁸³

Despite the ban by the Supreme Court, a study report of 2003⁸⁴ revealed that quinacrine non-surgical sterilizations were being carried out in some parts of West Bengal without informing the women of possible side effects and they were not asked to sign any consent form or release form. Moreover, many of the providers were not qualified medical practitioners. Such findings necessitate that the campaign be strengthened and punitive measures be taken up against those who have violated the restriction, so that such malpractices could be stopped in future.

83. Saheli Report (1997) Quinacrine: Sordid Story of Chemical Sterilisation of Women

84. Mulya, Shree Singh, Navsharan & Dasgupta Rajashri (2003) 'Quinacrine Non-Surgical Sterilization in West Bengal- what we have learned from the ground'- a draft report (unpublished)

Challenging Population Control Policies and Two-child Norm

During the last 15 years, population control in India has moved away from a tightly connected system of policies imposed by the central government. Instead, individual states have devised population policies of their own and have relied on targets and coercion as the mechanism to achieve 'population control'. About ten states, namely Madhya Pradesh, Rajasthan, Uttar Pradesh, Haryana, Himachal Pradesh, Orissa, Chattisgarh, Gujarat, Maharashtra and Andhra Pradesh came up with State Population Policies, which deter parents of two children from having a third. These policies employ disturbing new incentives and disincentives and tread on the rights and health of the people, especially those having a marginal existence in the society – poor, Dalits, tribals, and women. The State Population Policies (SPP) of the referred states comprised features such as:

- Disentitlement of the third child to ration under public distribution system;
- Parent to be penalized in their jobs, if they hold a government job;
- Withdrawal of a range of welfare programs;
- Bar people from contesting elections and also removing them from existing posts in the Panchayat Raj Institutions after the birth of the third child;
- Introduce long acting hormonal contraceptives in the Family Welfare Programmes.

Women's organizations in Delhi played a critical role in initiating a public debate on the whole issue of population control from 1993 onwards. But with the SPP coming in place in 10 States, they argued that these coercive policies are both anti-women and anti-poor and are against the Cairo Declaration⁸⁵ and NPP principles. A consistent campaign against population control policies and two child norm was taken up by Sama, AIDWA, CWDS, Saheli, Delhi Science Forum, Medico friend Circle, Jan Swasthya Abhiyan, CSSM-JNU, Health watch UP-Bihar, Forum for Women's Health and many other women and health groups along with individual researchers and academicians. The movement gained momentum through debates, studies, seminars, press conferences and public tribunals.

A memorandum to the National Human Rights Commission (NHRC) was submitted on 2002, as the campaign group felt that the measures mentioned in SPP of

85. The International Conference on Population and Development was held in Cairo in the year 1994. The declaration condemned coercive population policies and favoured a population policy based on reproductive health and rights of women. India was one of the signatories' among 179 countries that ratified the declaration.

these States violate human rights of people and should not be included in the population policy. The memorandum requested the NHRC to direct the states to comply with the directives and not to use population policies to deny basic rights.

After receiving the memorandum, the NHRC issued notices to the state governments. The states were asked to explain the questionable provisions in their population control policies.

A study on the implications of State Population Policy on the Local Self-Governance [Panchayat Raj Institutions (PRIs)] by Sama and MP BGVS showed that the two-child norm disproportionately impacts adivasis, dalits, especially women and in general the poor. Nearly 50% of the 128 respondents were dalits and adivasis (SCs and STs), of which almost 40% were women, most being non-literate, landless and from the lowest category of average monthly household income.

A large number of **younger men and women** in the reproductive age group are adversely affected by this norm. The study highlighted, for example, an emerging trend whereby older women/mothers/mothers-in-law replaced vacated posts of daughters/daughters-in-law.

The study also revealed that the norm has far reaching implications for women. **Forced abortions**, giving up a child for **adoption**, **desertion** and **abandonment of women and children** were used as strategies to prevent disqualification and continue as representatives.

Another study of the implications of the two child norm by Mahila Chetna Manch in Orissa, Haryana, Madhya Pradesh and Rajasthan highlighted that implementation of the norm had led to an **increase** in the number of pre-natal sex determination tests that resulted in the abortion of female foetuses. A study by the organisation SUTRA in Himachal Pradesh shows that the districts with the highest juvenile sex ratio have the highest disqualifications, while those with the lowest sex ratio show no or very few disqualifications.

A People's Tribunal organized by HRLN, Sama, JSA, Health watch UP Bihar and Hunger Project held at Delhi, nearly 70 women from 15 states such as Uttar Pradesh, Rajasthan, Himachal Pradesh, Madhya Pradesh, Haryana, Tamil Nadu, Gujarat and Bihar assembled in Delhi to depose before a Public Tribunal. On the pretext of promoting small family, as many as 4,000 men and women from the states of Rajasthan, Madhya Pradesh, Chattisgarh and Haryana have been disqualified from various Panchayat positions on the grounds of infringement of the two-child norm.

After a long campaign, publication of reports and findings⁸⁶ on the ill effect of such policies especially on women and advocacy with the parliamentarians, the states of Himachal Pradesh and Madhya Pradesh have finally revoked the two-child norm in May and November 2005, respectively.

The women's movement thus had played a crucial role in systematically campaigning against hazardous contraceptives, coercive population policies and sex selective abortion. However, there had not been systematic engagement of the movement with **Assisted Reproductive Technologies**⁸⁷ making our understanding of these technologies and their implication on women inadequate. It is important to understand the context in which these technologies are used, uses/abuses to which they are put to and the implications that these have on women's health and lives. This is because, where at one level there is unavailability of necessary medical technologies, at the other level there is over medicalization. What becomes fundamental for the women's movement is to question the social stigma associated with infertility. But simultaneously also to deglamourise these technologies by bringing in the real picture of low success rate, side effects of the hormonal drugs that are used in the treatment and anguish of women undergoing treatment. Given the pace at which these technologies are invading lives of women, these issues cannot be left unattended by the ongoing women's movement of the country.

Section 2

While recounting the history of the women's health movement, we felt it may be interesting to view these developments in the context of a larger health campaign that had been going on in India through the same period.

Campaigning for a Rational Drug Policy

Both health groups and consumer groups have been campaigning for a rational drug policy based on the principle of essential drugs. In the absence of rational drug use by the prescribers and the consumers, it is obvious that a rational drug policy alone would not be able to benefit the public. The major demands of the rational drug campaigners has been withdrawal of hazardous and irrational drugs, control of drug prices, proper screening of therapeutic efficacy of a

86. Studies by SUTRA in Himachal Pradesh and Sama-Resource Group for Women and Health in Madhya Pradesh on impact of Two Child Norm

87. Assisted Reproductive Technologies is a group of reproductive technologies, which assist conception and pregnancy. The category of technologies used for assisting reproduction range from simple methods like artificial insemination to methods such as in-vitro fertilization (IVF).

particular combination of medicine, and protection of the population against potential misuse.⁸⁸

Looking for new markets and higher profits, multinational pharmaceutical companies were pressurising third world governments to liberalise their drug policies that were otherwise protective of the interests of the national pharma companies as well as those of the consumers. In reaction to the Indian government's drug policy that was solely interested in creating and maintaining a stronghold of the international pharmaceutical sector, a network called The All India Drug Action Network (AIDAN) was established in 1982. AIDAN argued that the exorbitant drug prices were leading to further inaccessibility of essential and rational drugs for the marginalized sections. It also critiqued the irrational drug use by doctors and the increasing drug dumping - the phenomena by which drugs banned in Western/developed countries are marketed in poor countries like India (For instance, Novalgin, a common pain killer manufactured by Hoechst, was banned in West Germany, but freely available - even without prescription - and indiscriminately used in India).

The campaign for a rational drug policy has also been fighting for the availability of essential drugs at affordable prices and for the withdrawal of irrational and dangerous drug combinations. It is also lobbying for the use of generic names of drugs, since the manufacturers sell the same drug under different brand names and charge exceptionally high rates to make profits. For example, Paracetamol is sold by different companies under different brand names like Crocin, Calpol, etc. These tablets are priced as 80-90 paise per tablet, whereas the actual manufacturing cost of a paracetamol is about 15 paise per tablet.

In 1983, LOCOST was established by a majority of the activists who were a part of the larger rational drug campaign. LOCOST has been successful in demystifying the production process and demonstrated that drugs can be manufactured and sold well below current market prices. In retaliation to the prices charged by national and international pharmaceuticals, that are generally beyond this citizen's reach, the project has evolved about 80 low cost generic drugs.

In 1986, an all-India seminar on National Drug policy was organized in Delhi by the Delhi Science Forum and Federation of Medical Representatives Associations of India (FMRAI), among many other organizations. The seminar addressed issues of inadequate supply of essential drugs, proliferation of non-essential drugs and irrational pharmaceutical products, hazardous implications of drugs,

88. Shiva, Mira (1986) 'Essential Drugs - Concept, need and implementation' in Amit Sen Gupta (ed) *Drug Industry and the Indian People*, DSF & FMRAI

issues related to pharmaceutical industries, pricing and profitability, and the question of self-reliance in developing countries. This dialogue between several national organizations, scientific institutions, international organizations, women's groups and people from various sections of the civil society, set a significant tone to forward the national policy on drugs in India.

The rational drug campaign is currently pressing the government for a price regime. It has critiqued the Pharmaceutical Policy 2004 for withdrawal of price regulatory mechanisms. Under the new policy, the number of drugs under price control has been reduced to 74 drugs as compared to the earlier 347 drugs that enjoyed protection under the Pharmaceutical Policy of 1979. It argued that this would lead to further inaccessibility and impoverishment of the masses.

LOCOST, Jan Swasthya Sahyog (JSS), AIDAN and the Medico Friend Circle (MFC) have filed a series of supportive affidavits in the Supreme Court in 2003. These groups have questioned the rationale behind the criteria for drug price control in the Pharmaceutical Policy 2002. (PP 02): "It is our submission that the policy will increase the price of medicines and therefore have a long-term effect, for the worse, on the health of people, especially poor people."

The Bhopal Gas Tragedy – A Sustained Campaign

The Bhopal disaster (December 3rd, 1984) was caused by the accidental release of 40 tonnes of Methyl Isocyanate (MIC), a dangerous and toxic gas, from a pesticide plant of the Union Carbide India Ltd. The factory was located in the heart of Bhopal and the gas leak ended up killing almost 20,000 people. According to government estimates, a population of 2,50,000 was instantly poisoned by the gas leak. The effects of the contamination are felt and seen even today, after almost two decades.

While certain health consequences were common to both women and men, women additionally suffered from health problems that were specific to them. The gas will continue to affect generations of women. Among women who were pregnant at the time of the disaster, 43% suffered spontaneous abortions. In the years that followed, the spontaneous abortion rate remained four to ten times worse than the national Indian average. Only 50% of pre-adolescent girls, who were exposed to the gas, had normal menstrual cycles. It is now coming to light that even girls who were exposed in infancy and were in their mother's wombs are experiencing 'menstrual chaos'.

MFC was the first to carry out an epidemiological study of the Bhopal gas tragedy and did a pregnancy outcome study in Bhopal nine months after exposure to

the toxic gas. The study found that women who were pregnant at that time of gas exposure suffered from spontaneous abortions, still births, diminished foetal movements, and menstrual disorders. Another study by MFC uncovered large differences between more and less exposed neighbourhoods in their frequencies of menstrual problems, such as shortening of cycle, excess bleeding during menstruation, vaginal discharges, etc.

A study report, 'Surviving Bhopal: Toxic Present, Toxic Future', in 2001, by Srishti, a Delhi-based environmental NGO highlights the fact that *"not only the soil, but also the groundwater, vegetables and even breast milk is contaminated to various degrees by heavy metals like nickel, chromium, mercury and lead, Volatile Organic Compounds (VOCs) like dichlorobenzene and halo-organics like dichloromethane and chloroform cause a serious health threat not only to those currently exposed but also to future generations"*.⁸⁹

A study by Sambhavna Trust in 2003 clearly showed that children conceived and born after the disaster to exposed parents were significantly different from children of the same age who were born to unexposed parents. The children born to exposed parents were shorter, thinner, lighter, and had smaller heads.

Survivor organisations and concerned groups constantly campaigned for the justice to the survivors of the gas tragedy. The Survivors' organisations launched the *padayatra* (march) in February-March 2006 from Bhopal to Delhi, to ensure that the Indian authorities agree for their demands.

The focus of the *padayatra* was also on health and specifically on health care effect on next generation, mental health, medical research, women's health, and alternative health care for survivors, etc. Six persons, including three survivors of the Bhopal gas disaster, were on an indefinite fast at the end of their march to Delhi in March 2006. The indefinite fast was called off after six days when the Prime Minister agreed to a time-bound plan for the delivery of safe drinking water to communities affected by contamination of water, scientific assessment of the depth and spread

Some of the demands:

Set up a National Commission on Bhopal;

Provide Safe Drinking Water;

Prosecute Union Carbide and Anderson;

Make Dow Clean Up and Pay;

Blacklist Dow and Union Carbide
Declare December 3rd as a National Day of Mourning for Victims of Industrial Disasters and Pollution;

Creation of a Memorial to the Disaster.

89. Lakshmi Murthy, Bhopal: Tragedy Without End

of toxic contamination in and around the Union Carbide factory in Bhopal, and funds to address all health issues related to contamination.

Movement Against Ordinance Amending the Patent ACT, 1970

JSA⁹⁰ along with other health groups and progressive movements took strong exception to the Ordinance amending the Patent Act, 1970. The Central Government promulgated this ordinance on 26th December 2004. In this ordinance, the Government disregarded public interest and appeared unwilling to make use of even the limited safeguards available in the TRIPS (Trade Related Aspects of Intellectual Property Rights) agreement, which could have mitigated the ill effects of this agreement. JSA felt that the provisions of the Patent Amendment Ordinance contradict the National Common Minimum Programme that promised to take all steps to ensure availability of life saving drugs at reasonable prices, and that the ordinance, if implemented as such, shall seriously affect the Constitutional Right to Health and Life of the Indian people.

JSA, along with other people's movements, expressed the concern that India, through the Ordinance, will trade away its rights to protect the public health of people who need access to low-cost, quality medicines. The constituent organisations of JSA presented a critique of the Patent Ordinance by publishing pamphlets, organising seminars, meetings, etc. JSA organisers lobbied with the members of parliament and signatures were collected on a letter addressed to the Prime Minister expressing all these concerns. It was because of the effective intervention of people's movements and organisations that the government had to modify the Ordinance in such a way that some of the demands made by various organisations, including JSA, were conceded when the final Act was passed.

National Campaign for Healthcare as a Fundamental Right

In an effort to establish the right to basic healthcare as a fundamental (Constitutional) right, JSA aimed to build a national social consensus on the issue. As a part of the process to establish health rights, a series of Regional Public Hearings on Right to Health Care were organised by JSA in collaboration with the NHRC in various parts of country.

To ensure that the State takes the public hearings seriously, JSA groups in various states started a process of documenting cases of denial of healthcare.

90. Jan Swasthya Abhiyan (JSA) the Indian regional circle of PHM, is a coalition of 20 National networks and more than 1000 organizations from all over the country working in the field of health, science, women's issues and development. Details on the emergence of JSA and PHM (People's Health Movement) have been dealt later in the chapter.

Information was collected with the help of a specific protocol, and cases where denial of health services has led to the loss of life, physical damage or severe financial loss to patients were brought into the forefront. These case studies depicted the real status of the primary health care services in the country.

A series of Regional Public Hearings were organised in different pockets of the country, where the documented case studies on denial of health care were presented.

Western	Southern	Northern	Eastern	North-eastern
Bhopal in July 2004	Chennai in August 2004	Lucknow in September 2004	Ranchi in October 2004	Guwahati in November 2004

These major regional hearings, each attended by hundreds of delegates was followed by a culminating event, i.e., the National Public Hearing on Right to Health Care organised by JSA and NHRC on 16-17 December 2004 at New Delhi. Subsequently, a National Action Plan was released by the NHRC with inputs from JSA towards operationalising the right to health care within the Indian context. The state units of JSA demanded implementation of the NHRC ‘National Action Plan’⁹¹ on Right to Health Care on World Health Day, 2005.

One of JSA’s main tasks now is to pressurise government not only to implement the NHRC Action Plan, but also to work towards a comprehensive legislation that will guarantee the right to health care to all citizens of India.

Monitoring NRHM: A People’s Rural Health Watch

Several members of JSA were involved in the Task Groups of the National Rural Health Mission in an attempt to make the NRHM more effective and sensitive to the needs of the disadvantaged people and communities. There have been some concrete recommendations from the JSA to this end. However, the Mission is fraught with limitations. JSA raised a large number of concerns relating to the conceptualisation, design and implementation of the Mission. In this context, JSA has planned to take up an ongoing activity to monitor and influence the Mission in a pro-people direction through the formation of a ‘People’s Rural Health Watch’.

This process was initiated in May 2005 and is expected to do the following:

- Monitoring of the actual implementation at state level, through surveys of health facilities, systems and reviews;

91. For details on National Action Plan refer annexure II.

- Analysis of available documents regarding NRHM including task group recommendations, funding sources and financial allocations, etc.;
- Distribution of a NRHM Action Alert Kit that would put reflect JSA's position on the NRHM, and guide local groups and organisations on how they can possibly engage with and monitor the implementation of the NRHM.

Section 3

The development model being pursued by our country is clearly benefiting a handful, while marginalising a huge bulk of its population. Various groups concerned with this inequitable and unjust model have engaged with the search for alternatives, and in the process have given birth to intense social movements, important interventions at various levels of the society, and innovative processes and experiments.

In this section, we would like to touch upon the search of health groups, social movements, networks and women's groups for alternatives in the area of health and their attempt to work towards a comprehensive health care model, particularly in the area of women's health.

Medico Friend Circle - MFC

Medico Friend Circle (a non funded network primarily of doctors and social activists engaged with health) was formed in 1974 from the growing dissatisfaction with the public health situation and an urgent need for a 'medical paradigm shift'. Initially focusing on rural health care, MFC has expanded its sphere of concern to different issues in the Indian health care system. Over the years, it has been engaged in issues of access to health services, widening gap between the urban rich and the rural poor, the role of doctors in society, misuse of drugs by doctors, alternative medical education, irrational use of medical technology, hazardous injectable contraceptives, problems of under-nutrition, bias against women in medical care, resurgence of communicable disease like TB, child survival, unethical fertility control practices and much more.

In the early 90s, the Primary Health Cell and Women's Health Cell were formed in response to the specific interests and needs of MFC members and for indepth discussion on these issues.

MFC undertook an investigation on the public health services in the riot-torn Gujarat in 2002 and published a report titled "Carnage in Gujarat - a Public

Health crisis". In the light of the investigation, it filed a case against Dr. Pravin Togadia of the Vishwa Hindu Parishad with the Medical Council of India for violating the duties of a doctor.

MFC has a grounded approach, be it in the field of medicine or other social concerns like communalism and fundamentalism that affect the lives of people. It offers a forum for dialogue/debate and sharing of experiences with the aim of realising the goals outlined above and for taking up issues of common concern for action.

Decentralisation of Health – An Effort by Mine Workers of Dalli Rajhara

The Chhattisgarh Mines Shramik Sangh (CMSS), an independent trade union of iron mine workers of Durg district of Chhattisgarh. The workers demanded for fair wages and safe working conditions with basic facilities. The struggle subsequently expanded to include primary education and health. The mine workers initiated a health programme after the death of a woman worker during childbirth. A need was felt for an appropriate health care facility that was accessible to the workers and the Shaheed Hospital began taking shape. The hospital was built from the contributions of the mine workers. A small group of doctors sympathetic to the movement engaged full time with the hospital. Some of the mine workers volunteered to be the health workers who, while continuing to work in the mines, devoted time to the hospital. Some of the workers were not educated and some had very little formal education. Initially they were apprehensive about their capabilities, but with time, they became highly skilled at nursing, operation theatre work, and management functions of the hospital. Today the hospital has 80 beds, with a lab and an X-ray machine. The mine workers with the support of CMSS made the project a success.⁹²

Low Cost Standard Therapeutics - LOCOST

LOCOST was founded in 1983 as an important alternative source of medicines for the poor to access drugs at affordable prices. It is a public, non-profit charitable trust registered in Baroda in Gujarat that has demonstrated that standard rational drugs can be manufactured and sold at a much affordable price, thereby dispelling the myth of high priced drugs as the only effective ones. In retaliation to the prices charged by national and international pharmaceuticals that are generally beyond this citizen's reach, the project has evolved about 80 low cost generic drugs. LOCOST has been supplying drugs to over 100 civil society organizations, NGOs and social action groups for the past

92. People's Health Care. Initiative in Chhattisgarh district Binayak Sen

23 years, who in turn make them available to the poor. This has helped groups and individuals to circumvent the virtual monopoly of drug manufacturers. Currently functioning in Gujarat, Maharashtra and Karnataka, it has also been involved in advocacy for a people oriented drug policy and rational therapeutics, envisaging further threat to poor consumers in the central government's plan to decontrol the prices of the current list of scheduled drugs as part of its overall liberalization programme.

Federation of Medical and Sales Representatives' Associations of India (FMRAI)

This national federation of medical and sales representatives has 47,000 members, most of which are from pharmaceutical industry. The federation has nearly 300 centres covering all important cities in all the states. The federation deals with service and working conditions of the members with nearly 200 pharmaceutical companies.

The federation, apart from trade union issues, deals with the issues related to medicines and health rights of the people. FMRAI since 1978 has campaigned for a rational pharmaceutical policy. FMRAI vigorously campaigned against Super 301 imposed by USA and later took up a campaign of popularisation of patent issues among the public. It is the only federation, which initiated a country wide, strike against the Patents Amendment Bill of 1998. FMRAI has formed separate cells in the states for redressal of the problems of the women medical representatives. Nearly 10% of the members are women.

Search for Alternatives – a Shodhini Experience

The women's movement has played a crucial role in critiquing the hegemony of western medical science. It initiated a self-help approach and demanded for non-discriminatory, women friendly health care services irrespective of caste, class and religion. Dissatisfied with modern health care services, some women's groups held a national consultation in October 1987 in SRED, Tamil Nadu where 50 women's health activists from both rural and urban areas gathered to discuss the state of women's health. A member of the Geneva Women's Health Collective that had begun to explore non-allopathic alternatives was also present at this meeting.

In the course of the discussions, it was obvious that while there were a number of similar remedies and cures being used in different parts of the country, much was dying out with the passing on of older women. There was an urgent need to document and record this knowledge, which has been passed down from woman

to woman over generations. A small group, Action Research on Alternative Medicines and Women's Health was formed that brought together a number of field based organisations to collect, collate, test and document information on traditional medicine under 'Shodhini'. It attempted to discover meaningful alternatives in health that would respond to women's health needs in India, especially the needs of socio-economically marginalised women. A woman-oriented approach aimed at evolving a simple, natural and cost-effective health care system, it also aimed at increasing women's control over their own bodies by understanding its rhythms and power, and looking after their own health needs by training local women in simple gynaecology through self help. Another objective was also to empower women healers by reclaiming and validating their traditional knowledge and enhancing status.

The research finding was compiled into a book 'Touch Me, Touch-me-not' in 1997 and was translated into many Indian languages.

Appropriate Technology for Health – Jan Swasthya Sahayog (JSS)

There has been rapid development of technology in the last few years but it has eluded the public health system, specifically women's health. Among the health workers in the village level there is no or poor access to technology who has to deal with common women's health problem on a daily basis. To make some of these technologies available and accessible, Jan Swasthya Sahyog (JSS) a voluntary, non-profit, registered society founded by a group of health professionals in Bilaspur district of Chhattisgarh, JSS is involved in research activities to develop and validate low-cost health care and diagnostic technology, including appropriate solutions to common health problems, and also making them available for all marginalized groups. JSS has evolved simple but accurate technologies that are acceptable and cheap and hence can be used in low resource settings. Other than developing simple tools like thermometers and Blood Pressure instruments, patient friendly teaching stethoscope, in regard to women's reproductive health there is a reproductive health test battery for diagnosis of urinary and vaginal infections, pregnancy, pre-eclampsia; safe delivery kits, tests for anaemia and also developed herbal remedies. The efforts are an answer to the high technology driven private health care sector and rapid withdrawal of the public health system that is increasingly undermining the health of the poor.

Sadaphuli – Barefoot Gynaecologists of MASUM

The health activists explored alternative avenues for addressing women's health needs through the formation of self-help groups. One such successful experiment

is *Sadaphuli*, a Self-help group for Women's Health by *Mahila Sarvangin Uttkarsh Mandal* (MASUM), a community based women's organisation in Pune district of Maharashtra. It was recognized that socio-cultural barriers and taboos inhibited women from expressing any problem even remotely associated with reproduction and sexuality. These problems were often neglected or left untreated. Most women were shy and afraid to talk to or be examined by male doctors present at the local primary health centres or the rural hospitals.

In response, MASUM initiated the **Feminist Health Centre (FHC)** and **village based health centres** known as the Sadaphuli Kendras (*Sadaphuli* literally meaning ever blossoming flower – *vinca rosea*) in 1994 & 1995 respectively. The women's health programme here is built on the self help principle, which aims to empower women with knowledge of their own bodies and addresses unequal relationship between the provider and receiver because of the possession of knowledge and skills with the provider, by sharing information. It recognises the emotional, social and environmental factors that affect health and works towards addressing these issues.

The community based health workers (called the *Sadaphulis*) have been trained to conduct breast examinations as well as speculum and bi-manual examinations for detection of reproductive tract infection and other gynaecological problems. In addition to this, at the Feminist Health Centre, pap smear test are conducted to detect cervical cancer. High-risk pregnancies are identified and necessary precautions are suggested. Reproductive tract complications and infections are also identified and women are encouraged to initiate a dialogue with their partners about sexual health.⁹³

Counseling of Women Victims of Violence in a Public Hospital: the DILAASA Project

With an aim to sensitise the public health system to gender and violence issues and to develop a health-based response to domestic violence. CEHAT and the Public Health Department of the Brihanmumbai Municipal Corporation (BMC) have established Dilaasa at K.B.Bhabha Hospital, Bandra (West), Mumbai. Dilaasa means 'Reassurance' and seeks to provide social and psychological support to women survivors of domestic violence. Dilaasa believes that every woman has a right to a safe home, right to a life without violence; there is no excuse for domestic violence. Through collaboration with Majlis and Lawyers Collective, legal aid is provided to women. There is provision for temporary shelter for a short period at two shelters in the city. The hospital also provides 24-hour shelter under medical observation.

93. Bandewar Sunita paramedics in mr practice: a feasibility evaluation & www.masum.org

Training is one of the ongoing activities of the centre. The hospital staff is being sensitised to gender issues so that they are able to screen women survivors of domestic violence and refer them to the centre.⁹⁴

Jan Swasthya Abhiyan (JSA)

JSA emerged as the campaign platform from the People's Health Assembly process in India in December 2000. Jan Swasthya Abhiyan is a coalition of 20 National networks and more than 1,000 organizations from all over the country working in the field of health, science, women's issues and development. Since early 2000, the activities of JSA in India are being carried out at the local, state and national levels. Some of JSA's key areas of activities are:

- initiating 'Watch Groups' to monitor and advocate health situations, implementation of programmes and policies;
- analysis and critique of health and related policies;
- campaigning for right to health care as fundamental right;
- organising public dialogues, conventions, seminars, workshops and peoples tribunals on right to health and health determinants;
- development of information sheets, alerts, booklets on health issues, policies, programmes on health issues;
- advocacy for strengthening the public health system;
- advocating regulation of the private health sector;
- critiquing the National Health Policy and advocating pro-people changes in the health sector.⁹⁵

Gender mainstreaming in medical education – An initiative of Achutha Menon Centre for Health Science Studies (AMCHSS), Trivandrum

Concerned at the gender differences in the provision of health care and the lack of training to medical students in gender issues, the Achutha Menon Centre for Health Science Studies (AMCHSS), Thiruvananthapuram, initiated a project to mainstream gender issues in medical education.

The first strategy in this project is to train medical and nursing educators in short courses and support them as 'agents of change' in their institutions. The

94. Efforts that Worked – A few Case Studies, Advancing Right to Health: The Indian Context by Sama-Resource Group for Women and Health.

95. Excerpt from Report of the National Workshop on Right to Health Care: September 5, 2003 & National Public Consultation on Health Care as Human Right: September 6, 2003

second strategy is to do a baseline survey in medical institutions to collect and analyse sex-disaggregated data. A gender-based review of textbooks in several disciplines of medicine was initiated. It brought together both women's health activists and medical professionals to conduct a critical review of standard texts.

The third step involves advocacy with the Medical Council/Nursing Council of India, vice chancellors, deans of medical universities/institutions and professional bodies such as the Indian Medical Association (IMA) to facilitate change.⁹⁶

Other than the range of alternative, initiatives women's groups and health activists have tried to incorporate health rights in the mainstream policies and programmes through the use of domestic laws/provisions, at times also taking recourse to international instruments that we will now be dealt in the next chapter.

96. Bhan, Anant article in IJME

National and International Remedies for Women's Right to Health

This section tries to acquaint the students with the national and international provisions that guarantee women's right to health. It introduces the Constitutional provisions, policies, laws in the Indian context and international instruments, treaties, conventions that can be applied in this context to safeguard and promote women's right to health. It also provides information on India's position vis-à-vis the International Conventions.

This section attempts to improve the students' understanding about how the 'concept' of women's right to health can be translated into very concrete 'rights' that are justiciable. It is important to note, however, that understanding women's right to health demands clarity about right to health in general and dimensions of gender and discrimination that additionally impact women's health.

Section 1

The Concept of Right to Health

The right to health has clear links to many other rights. The realisation of the Right to Health requires the fulfillment of several interconnected rights of a range of determinants, such as food, education, environment, housing, working conditions, poverty, health care and so on.

Unless all these determinants are also addressed, it is not possible to ensure the right to health. The denial or enjoyment of the rights mentioned above can impact a person's ability to achieve the highest attainable standard of health, and conversely, the health status determines the enjoyment of other rights, i.e. a person who is not 'healthy' may not be able to participate fully and actively in economic, social or political activities in society.

Thus, when the State violates one specific right, its interconnectedness to various other rights results in a chain of violations, each of which individually stands as a right, and has its own set of norms and obligations on the state⁹⁷. For example, The Right to Health is interdependent on the Right to Food. In Article

97. Sama-Women's Group for Gender and Health (2005) *Advancing Right to Health: The Indian Context, Beyond the Circle*.

24(2) (c) of the Convention on the Rights of the Child (CRC)⁹⁸ and Article 12(2) of Convention on the Elimination of Discrimination against Women (CEDAW)⁹⁹, the right to food is considered part of the right to health of both women and children. Therefore, when considering the Right to Health, the above-mentioned Articles should also be taken into account. This is true of all other rights connected to the determinants of health – environment, exclusion, prohibition on the basis of sex, caste, class, education, etc.

Similarly Article 21 of the Constitution of India guarantees the Right to Life of every citizen, and imposes the duty to protect this right upon the state. The Supreme Court of India has previously stated that the right to life includes the right to live with dignity and all that goes along with it, including the right to food. For example, in response to the writ petition on the ‘Right to Food’ by the People’s Union for Civil Liberties (PUCL), Rajasthan, in 2001, the Supreme Court judged that the state governments are indeed violating Article 21 of the Constitution of India. The Court’s judgment in its very essence recognises the justiciability of the Right to Food, and the protection of this right under the Constitution. The Supreme Court affirmed that where people are unable to feed themselves adequately, governments have an obligation to provide for them, ensuring at the very least that they are not exposed to malnourishment, starvation and other related problems¹⁰⁰.

In the context of women, therefore, right to health would imply that women’s right to all the determinants be fulfilled. In order to do that the State and all its institutions must analyse and understand the reasons and factors that deny women their rights and try to create the necessary conditions to ensure that these rights are fulfilled.

National Remedies

The Constitution of India

The Constitution of India does not explicitly recognise health as a Fundamental Right. However, it recognises the right to life, equality, and freedom of speech, expression and opportunity and to seek judicial redress for enforcement of these rights as fundamental rights. Right to Health is

98. Children’s Convention (adopted 1989; entered into force 1990): Convention setting forth a full spectrum of civil, cultural, economic, social, and political rights for children, <http://www1.umn.edu/humanrts>

99. Women’s Convention (adopted 1979; entered into force 1981): The first legally binding international document prohibiting discrimination against women and obligating governments to take affirmative steps to advance the equality of women, <http://www1.umn.edu/humanrts>

100. www.hrschool.org

included in Article 47 of the Directive Principles of State Policy. These constitutional provisions must be interpreted expansively to understand and ensure women's right to health.

The **Preamble** to the Constitution highlights some of the core values and principles that guide the Constitution of India. Although the preamble is not regarded as a part of the Constitution and is not enforceable in a court of law, the Constitution is interpreted in the light of the preamble and in a majority of decisions the Supreme Court of India has held that the objectives of justice, liberty, equality and fraternity stated in the preamble constitute the basic structure of the Constitution. The Preamble directs the state to initiate measures to establish justice, equality, ensure dignity, etc. which have a direct bearing on women's health.

The following *Fundamental Rights* contained in Part III of the Constitution are related to women's right to health and health care.

Right to Equality and Freedom (Articles 14 –17 and 19) ensure the right to equality before the law and equal protection of the law, prohibition of discrimination on the basis of sex, caste, religion, race or place of birth, equal opportunity in matters of employment and abolition of untouchability. However, the right to equality does not take away the right of the State to initiate affirmative action or provide special provisions for women and marginalized communities (especially women from scheduled castes and tribes). In the context of health, any form of discrimination, be it gender or practice of untouchability, has severe implications for health, preventing or limiting access to basic needs and opportunities that impact health and access to health care. For example, women are traditionally responsible for fetching water. Depending on the distance of the source of water, the location, the woman's age, caste, health status and various other conditions at home impact her access to water, which in turn affects her health and the health of others in her family.

***Right to Protection of Life and Personal Liberty (Article 21)* ensures that no person shall be deprived of his / her life or personal liberty, except according to the procedure established by law. While the provision of health services is essential to ensure good health, there are several others factors that influence a person's health. The Supreme Court first recognised this in *Bandhua Mukti Morcha vs. Union of India*, a case concerning the living and working conditions of stone quarry workers in Haryana (near Delhi) and whether these living and working conditions deprived them of their right to life. "The court held that humane working conditions were essential to the pursuit of the Right to Life. It lay down that workers should be provided**

with medical facilities, clean drinking water and sanitation facilities so that they may live with human dignity”¹⁰¹.

Right against exploitation (Articles 23-24) secures a person or persons against prohibition of traffic in human beings and forced labour, employment of children in factories, mine, or in any other hazardous employment¹⁰².

The Directive Principles of State Policy (DPSP)

As mentioned earlier, the reference to Right to Health in the Indian Constitution is contained in Article 47, which is consigned to the Directive Principles of State Policy (DPSP) section. With regard to health and health care, Article 47 states that it is *the Duty of the State to raise the level of nutrition and the standard of living and to improve public health*¹⁰³.

Another principle is that the *state must strive to secure social order for the promotion of welfare of the people by securing and protecting as effectively, as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life.*

The State shall, in particular, strive to minimise the inequalities in income, and endeavour to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations¹⁰⁴.

The State must try to ensure that its policies are based on people’s (men and women equally) right to an adequate means of livelihood; ensure equitable distribution of wealth and prevent the concentration of wealth and means of production; equal remuneration regardless of sex; ensure that the existing system do not abuse the health and strength of men and women, and children and that they are not pushed by economic necessity to work in occupations that is detrimental to their age¹⁰⁵.

The State should try to

- **provide opportunities and facilities to children to develop in a healthy manner, in the absence of exploitation¹⁰⁶.**

101. www.cehat.org/rthc

102. This information is downloaded from the website of Ministry of Law and Justice (Legislative Department)

103. This information is downloaded from the website of Ministry of Law and Justice (Legislative Department)

104. Article 38, i & ii

105. Article 39

106. Ibid

- **make effective, within the limits of its economic capacity and development, provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, etc.**¹⁰⁷
- **provide just and humane conditions of work and maternity relief, secure wages by ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities, including participation in the management of organisations**¹⁰⁸.
- **protect marginalised groups like Scheduled Castes and Tribes against exploitation and ensure that their right to justice is protected**¹⁰⁹.
- **endeavour to protect and improve the environment and safeguard forests and wild life**¹¹⁰.

Article 37 of the Constitution however states that Directive Principles “*shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws*”.

In 1973, the Supreme Court of India made a landmark judgment that is pertinent to realisation of the Right to Health in India. In the case *Keshavananda Bharati vs. the State of Kerala*, also popularly referred to as the Fundamental Rights Case, the Court recognised that the directive principles should enjoy the same status as ‘traditional’ fundamental rights¹¹¹.

International Conventions

The Right to Health is recognised by several International Conventions. In the context of Women’s Right to Health, discrimination on the basis of sex is prohibited in the Universal Declaration of Human Rights and in Article 2 of the two most significant International Covenants¹¹²—on Civil and Political Rights and on Economic, Social and Cultural Rights.

The Women’s Convention or CEDAW is the UN treaty that clearly brings together civil, political and economic, social and cultural rights. In addition, since its

107. Articles 41

108. Articles 43, 43 A

109. Articles 46

110. Article 48A

111. S. Muralidhar, ‘Justiciability of Economic and Social Rights – The Indian Experience’ in Circle of Rights (IHRIP & Forum Asia 2000)

112. Binding agreement between states; used synonymously with Convention and Treaty

inception, the committee established under CEDAW has issued a number of General Recommendations (GR) that elaborate on the articles of the Convention. The one that is most critical to health is the GR 24 that elaborates Article 12 of the Convention¹¹³.

Convention on the Elimination of Discrimination Against Women (CEDAW), 1965

CEDAW's Article 12 establishes the obligation to adopt adequate measures to guarantee women access to health and medical care, with no discrimination whatsoever, including access to family planning services. It also establishes the commitment to guarantee adequate maternal and child health care¹¹⁴.

Article 12 (1) states that governments shall take all appropriate measures to eliminate discrimination against women in the field of health care to ensure, access to health-care services, including those related to family planning. Article 12 (2) 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 Parties¹¹⁵ are encouraged to address the issue of women's health throughout the woman's lifespan. The articles of the convention are applicable to women, including girls and adolescents.

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.

The CEDAW Committee, in its (Twentieth session, 1999) elaborated a general recommendation (24) on Women and Health on Article 12 of the Convention¹¹⁶.

Recommendations for State action according to the GR 24 on Article 12 of CEDAW

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

113. Circle of Rights: Economic, Social and Cultural Rights - A Training Resource, IHRIP & Forum Asia, 2000.

114. Ibid.

115. Those countries that have Ratified a Covenant or a Convention and are thereby bound to conform to its provisions, <http://www1.umn.edu/humanrts>.

116. www.umn.edu/humanrts

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.

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.

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.

Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.

The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966

Article 12 (1) of the ICESCR¹¹⁷ recommends that States Parties recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12 (2) of the Covenant lays down several steps that should be taken by the States Parties to achieve the full realisation of this right.

The Committee on ESC Rights in 2000 significantly clarified and elaborated the content through a General Comment (CESCR General Comment 14: The Right to Highest Attainable Standard of Health).

Child Rights Convention (CRC), 1989

Articles 23 and 24 of the CRC recognise the right to health for all children and identify several steps for its realisation. Article 23¹¹⁸ ensures the rights of a mentally or physically disabled child to dignity; to enjoy a 'full and decent life'; to special care and encourages the promotion of self-reliance so that the child may actively participate in the community.

117. Sama-Resource Group for Women and Health (2005) Advancing Right to Health: The Indian Context Beyond the Circle Project

118. <http://www.ohchr.org>

According to Article 24¹¹⁹, States Parties must recognise 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. They should ensure that no child is deprived of his or her right of access to such health care services. States Parties shall pursue full implementation of this right and in particular, shall take appropriate measures to reduce infant and child mortality, ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care, combat disease and malnutrition, including within the framework of primary health care, through application of readily available technology and through the provision of adequate nutritious food and clean drinking water, taking into consideration the dangers and risks of environmental pollution.”*

Article 24 also ensures appropriate pre-natal health care for mothers, ensures access to information particularly of parents and children, access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents. States Parties will promote and encourage international co-operatives with a view to achieving progressively the full realisation of the right recognised in the present Article, in keeping with particular needs of developing countries.

Other Instruments that guarantee Right to Health are:

- The International Convention on the Elimination of All Forms of Racial Discrimination;
- The Convention relating to the Status of Refugees;
- The International Convention on the Protection of the Rights of All Migrant Workers and members of Their Families;
- The Declaration on the Protection of Women and Children in Emergency and Armed Conflict;
- The Standard Minimum Rules for the Treatment of Prisoners;
- The Declaration on the Rights of Mentally Retarded Persons;
- The Declaration on the Rights of Disabled Persons;
- The Declaration on the Rights of AIDS Patients¹²⁰.

119. Sama-Resource Group for Women and Health (2005) Advancing Right to Health: The Indian Context, Beyond the Circle Project.

120. International Human Rights Internship Program (IHRIP) and Forum Asia, Circle of Rights, Module 14, <http://www1.umn.edu>

International Covenants/Conventions/Treaties ratified¹²¹/acceded¹²²/signed¹²³ by India

India was admitted to the UN on 30th October 1945. The following table indicates the main instruments ratified/signed/acceded to. However, India has also made some declarations and reservations to some of the articles in some of the treaties that have not been detailed here. As is shown in the table below, India has ratified the Women’s Convention but has not acted on the Optional Protocol¹²⁴ of CEDAW.

Instruments	Ratified	Signed	Acceded	No Action
International Covenant on Civil and Political Rights			April 10, 1979	
Optional Protocol to the International Covenant on Civil and Political Rights				×
Second Optional Protocol to the International Covenant on Civil and Political Rights				×
International Covenant on Economic, Social and Cultural Rights			April 10, 1979	
Convention on the Elimination of All Forms of Discrimination against Women	July 9, 1993			

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- 121. The ratification of a treaty is the expression of acceptance of the obligation of the treaty. For example, a government may sign a treaty and announce its ratification once it has modified its law to bring them in conformity with the treaty. When a state ratifies a treaty, it becomes state party to the treaty, Human Rights Praxis, D.J. Ravindran.
 - 122. A state is said to accede to a treaty when it becomes party to a treaty that has already come into force. For example, if a state were to now ratify the covenant on civil and political rights, it will be said to have acceded to that treaty.
 - 123. The signing of a treaty is an expression of the intention to ratify a treaty. A treaty maybe signed by the duly accredited representative of a State expressing his/her government’s intention to ratify it. The treaty is later ratified according to the procedures stipulated under the national law. For example, in some countries a treaty can be ratified only by parliament as opposed to executive action, Human Rights Praxis, D.J. Ravindran.
 - 124. Protocol is a treaty which modifies another treaty (e.g., adding additional procedures or substantive provisions), <http://www1.umn.edu/humanrts>

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women				x
Convention on the Rights of the Child			December 11, 1992	
Optional Protocol to the Convention on the Rights of the Child on the involvement of Children in armed conflict	x			
International Convention on the Elimination of All Forms of Racial Discrimination	x			
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and Child pornography	x			
Convention on the Prevention and Punishment on the Crime on Genocide	August 27, 1959			
Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment		October 8, 1997		
Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of others	January 9, 1953			

India is **not a signatory** to many other international conventions or mechanisms like the Convention on the Status of Refugees, the Protocol relating to the status of refugees, the UN Code of Conduct for Law Enforcement Officials, the

UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, the UN Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions that form the basic tenets of customary international law¹²⁵.

Declarations

The Universal Declaration of Human Rights (UDHR) 1948

Article 25 (1) of UDHR affirms that everyone has a right to a standard of living adequate for the health of himself and 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.

Declaration of Alma-Ata on Primary Health Care, 1978

Governments at Alma-Ata reiterated Health for All by 2000 and committed to ensuring comprehensive, primary health care. This Declaration is not binding on governments but it reiterated the commitment of the governments/states towards achieving the right to health.

The Declaration highlighted that:

- Health is a fundamental right and its realisation requires the action of many other social and economic sectors. The current gross inequality in health status is politically, socially and economically unacceptable.
- People have a right and duty to participate individually and collectively in the planning and implementation of their health care.
- Primary Health Care includes in the least, health education, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunisation against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs.

Helsinki Declaration¹²⁶

The Declaration developed by the World Medical Association, lays down ethical Principles to provide guidelines to doctors and other participants in medical

125. <http://www.hrdc.net/sahrdc/>

126. Adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964, amended by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and the 35th World Medical Assembly, Venice, Italy, October 1983.

research involving human subjects, including research on identifiable human material or identifiable data. It emphasises that the ‘knowledge and conscience’ of doctors and other participants in such research must protect the life and dignity and promote and safeguard the health and rights of the people. It states that the well being of the person (s) involved in such research should take precedence over the interests of science and society¹²⁷.

One of the basic principles of the Declaration is “In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject’s freely given informed consent preferably in writing”¹²⁸.

International (United Nations) Conferences

The Right to health has been included in several International Instruments, as seen above. Apart from these Instruments which maybe binding on States Parties who have signed, ratified them, the Right to health is also elaborated in the:

- The International Conference on Population and Development Programme of Action (The ICPD Programme of Action, 1994);
- The Fourth World Conference on Women – Platform for Action (The FWCW Platform, 1995);
- The World Conference for Human Rights (WCHR) 1993;
- Vienna Declaration and Programme of Action of 1993;
- These Declarations and Programmes of Action are not binding on member states, but play the role of guiding principles. In preparing the General recommendations on health, relevant programmes of action adopted at United Nations world conferences and, in particular, those of the Conferences on health mentioned above are also taken into account.

The International Conference on Population and Development Programme of Action (The ICPD Programme of Action) 1994

Principle 1 Everyone has the right to life, liberty and security of person.

Paragraph 7.3 ...[Reproductive rights] also includes [couples and individuals] right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

127. <http://www.wma.net>

128. Sama-Resource Group for Women and Health (2005) Advancing Right to Health: The Indian Context, Beyond the Circle Project.

Paragraph 7.17: Government at all levels are urged to institute systems of monitoring and evaluation of user centered services with a view to detecting, preventing and controlling abuses by family-planning managers and providers ... To this end, Governments should secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision.

Paragraph 8.34: Governments should develop policies and guidelines to protect the individual rights of persons infected with HIV and their families. Services to detect HIV infections should be strengthened, making sure that they ensure confidentiality.

Paragraph 7.45: Recognising the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted infections and sexual abuse.

Principle 8: Everyone has right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion.

The Fourth World Conference on Women - Platform for Action (The FWCW Platform) 1995

Paragraph 89: Women have the right to the enjoyment of the highest attainable standard of physical and mental health. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Paragraph 92: Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men.

Paragraph 96: The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

Paragraph 106: Governments [should] ... (g) Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent; encourage the development, implementation and dissemination of codes of medical ethics as well as ethical principles that govern other health professionals.

Paragraph 108: Governments [should]...(c) Encourage all sectors of society ... to develop compassionate and supportive, non-discriminatory HIV/AIDS-related policies and practices that protect the rights of infected individuals.

The World Conference on Human Rights (WCHR) 1993

Paragraph 41: The World Conference on Human Rights recognises the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life-span...The World Conference on Human Rights 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.

Vienna Declaration and Programme of Action

(Adopted by the World Conference on Human Rights on 25 June 1993)

The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in the political, civil, economic, social and cultural life, at the national, regional and international levels, and eradication of all forms of discrimination on grounds of sex are priority objectives of the international community.

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. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support. 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. The World Conference urges governments, institutions, inter-governmental and non-governmental organisations to intensify their efforts for the protection and promotion of human rights of women and the girl-child¹²⁹.

129. Sama-Resource Group for Women and Health (2005) *Advancing Right to Health: The Indian Context, Beyond the Circle*.

Section 2

Processes, Remedies in our Constitution and in International Conventions to ensure that women's right to health is respected, protected and fulfilled

The Indian Constitution as well as the International Conventions provide some remedies for this purpose. The declarations and programme of action adopted by the UN World Conferences also provide recommendations to States to develop National Action Plans (NAPs) as part of their commitment to ensure human rights, gender justice and social development.

The **Constitution ensures the right to Remedies** for enforcement of rights¹³⁰, through the *Supreme Court or the lower courts for enforcement of rights along with the right to equal justice. The right to remedies includes the right to free legal aid by initiating suitable legislation, by accessing schemes or in any other way, to ensure that opportunities for securing justice are not denied to any citizen because of economic or other disabilities*¹³¹.

The Supreme Court of India (or High Court according to Article 226) has the power to issue directions or orders or writs, for the enforcement of any of the rights.

A system of Public Interest Litigation (PILs) meant for enforcement of fundamental and other legal rights of the people who are poor, weak, less familiar with the legal redressal system or otherwise in a disadvantageous position due to their social or economic background has been initiated and applied since three decades¹³². A PIL facilitates easy access to the court by consciously simplifying the legal procedures involved. In the case of PILs, the issue is of primary importance and it is not necessary that only a person or persons whose rights have been violated can or should initiate the PIL.

The court explained the philosophy underlying PIL in the *Bandhua Mukti Morcha vs. Union of India* (1984). In this case the Supreme Court looked into a matter concerning release of bonded labour raised by an organization dedicated to the cause of release of bonded labour. "Where a person or class of persons to whom legal injury is caused by reason of violation of a fundamental right is unable to approach the court of judicial redress on account of poverty or disability or socially or economically disadvantaged position, any member of the public acting ...(*in good faith*) can move the court for relief under Article 32 and under Article 226, so that the fundamental rights may be meaningful not only for the rich and the well to do who have the means to approach the court but

130. Article 32

131. Article 39 A

132. <http://supremecourtindia.nic.in>

also for the large masses of people who are living a life of want and destitution and who are by reason of lack of awareness, assertiveness and resources unable to seek judicial redress.”

International Guarantees for Women’s Right to Health

According to International Treaties the State is obliged to:

Respect: The Obligation to Respect requires the State ‘not to do’ certain things in order to guarantee women’s right to health. For example, the State must not conduct unethical trials on women, must not commit violence against women.

Protect: The obligation to protect requires the state to take action. The State should take necessary action to prevent third parties from interfering with women’s right to health. For example, the state must ensure that a woman is not prevented from accessing health facilities by her family; states should prevent violence against women by their husbands/partners, the health providers, etc.

Fulfill and Promote: The obligation to fulfill and promote requires the State to adopt appropriate legislative, administrative, financial (budgetary), judicial, promotional and other measures so that women’s right to health is attained/realised. For example, state has to provide necessary interventions to address violence against women, provide necessary resources as well as policies/legal guarantees to ensure that she can access health care¹³³.

The General Recommendation 24 of CEDAW **further elaborates the obligation of the state:**

- (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

133. Gupte Manisha, 2004 ‘Women’s Right to Health Care: Reiterating State Obligation’-Background document of the presentation at the National Public Hearing on Right to Health Care (Jan Sunwai)

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 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 services¹³⁴.

The Committee on Economic, Social and Cultural Rights (CESCR), in its General Comment 9, has established categorically that the central obligation in relation to the Covenant is for States Parties to give effect to the rights recognised therein. By requiring Governments to do so "by all appropriate means", the Covenant adopts a broad and flexible approach, which enables the particularities of the legal and administrative systems of each State, as well as other relevant considerations, to be taken into account. But this flexibility coexists with the obligation upon each State party to use all the means at its disposal to give effect to the rights recognised in the Covenant. In this respect, the fundamental requirements of international human rights law must be borne in mind. Thus the Covenant norms must be recognised in appropriate ways within the domestic legal order, appropriate means of redress, or remedies, must be available to any aggrieved individual or group, and appropriate means of ensuring governmental accountability must be put in place¹³⁵.

Some Positive Experiences

Legal recourse or going to the courts is just one strategy for ensuring that our rights are not violated and if violated to reclaim them and prevent further violations. Moreover, our courts and the judiciary are not very accessible to the poor and disadvantaged, especially women. Hence, it is important to assess the risks and benefits of pursuing legal recourse, which definitely can be a part of the education and mobilization process but may not always be the only or the best strategy.

In spite of a very dismal picture of our legal system, the Supreme Court of India has made some landmark judgments that are pertinent to realisation of right to health, and create important precedence in ensuring women's right to health.

In the *Paschim Banga Khet Samity vs. State of West Bengal, 1996*, the petitioner(s) aggrieved by the indifferent and callous attitude on the part of the medical authorities at the various State run hospitals in Kolkata in providing treatment for the serious injuries sustained by the petitioner following a train accident, filed this writ petition.

134. [http:// www1.umn.edu-humanrts-gencomm-generl24](http://www1.umn.edu-humanrts-gencomm-generl24)

135. Op cit

The Supreme Court held that that 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. Therefore, the failure of a government run health centre to provide timely treatment, is violative of a person's right to life. Further, the Court ordered that Primary health care centres be equipped to deal with medical emergencies. It has also been held in this judgment that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation¹³⁶.

"The Constitution envisages the establishment of a welfare state...Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in this respect and discharges this obligation by running hospitals and health centres."

In line with its general approach of frequently offering comprehensive remedies that go beyond merely providing redress for the victim and also laying down the necessary policy and administrative steps to be taken by the state in the wider public interest, the Court not only ordered compensation but also directed the type of facilities that the state government had to provide. This included hospitals and emergency provision (ambulances and communications) by formulating a blueprint for primary health care with particular reference to treatment of patients under an emergency as part of the state's public health obligation under Article 47. Furthermore, the Court ruled that its orders should apply to other states, together with the national government, and that they should be sent a copy of the judgment¹³⁷.

In *Parmanand Katara vs. Union of India, 1989*, a Division Bench of the Supreme Court admitted an application filed under Article 32 by a practising advocate along with a new item entitled: "Law Helps the Injured to Die" published in The Hindustan Times, New Delhi, as a public interest litigation. The petitioner, through this public interest litigation, had highlighted the difficulties faced by the injured persons in getting medical treatment urgently required to save their lives, in view of the refusal by many doctors and hospitals on the ground that such cases are medico-legal cases. In that case, the petitioner narrated the

136. www.cehat.org/rthc

137. Byrne, Iain (2005) Making the Right to Health a Reality: Legal Strategies for Effective Implementation, Commonwealth Law Officer, Interights Visiting Fellow, Human Rights Centre, Essex University)

unfortunate incident of a person dying due to the non-availability of immediate medical treatment. “The Court extensively dealt with the professional ethics of the medical profession and issued a number of directions to ensure that an injured person is instantaneously given medical aid, notwithstanding the formalities to be followed under the procedural criminal law. The Court declared that the right to medical treatment is a Fundamental Right of the people under Article 21 of the Constitution. The Court issued directions to the Union of India, Medical Council of India, and Indian Medical Association etc. to give wide publicity to the Court’s directions in this regard”¹³⁸. “The Supreme Court regarding obligation of state to provide emergency medical treatment, said that whether the patient was innocent or criminal, it was the obligation of those in charge of community health to preserve the life of the patient”¹³⁹.

Conclusion

While some rights have been accepted as fundamental by both the international conventions as well the Indian laws, the ‘Right to Health’ has yet to be acknowledged as a fundamental right in India. Women’s groups, health and human rights activists in the country have been campaigning for several years for Health to be recognised as a constitutional guarantee. In this ongoing struggle, women along with these groups and activists have played a critical role in the process of formulating their health rights – in deciding what their rights should be, the content of these rights and the processes by which these rights can be claimed. These processes have also witnessed application of existing international conventions to hold the State accountable for violating these rights.

The understanding and scope of women’s Right to Health is constantly evolving as women participate more actively in these processes, causing changes in attitudes towards women and their health, bringing about change in the way laws are formulated and interpreted.

Combined efforts are required now, more than ever, to demand and ensure the recognition of Right to Health as a fundamental right.

138. Justice A. S. Anand, in M.C. Bhandari Memorial Lecture Public Interest Litigation as Aid to Protection of Human Rights, www.ebc-india.com

139 Justice Anand (2003) Inaugural Address, National Consultation on Health Care as a Human Right, Jan Swasthya Abhiyan and NHRC

Strategies and Actions

This chapter tries to elaborate the strategies that need to be initiated by different actors with the objective of achieving women's right to health. Although there can be innumerable actors in this struggle, this chapter limits itself to actions that Civil Society Organisations/People's Health Movements/Women's movements and Students have initiated. Given below are some examples of concrete action that have been taken up by Civil Society Organisations, People's Health Movements, Women's Movement and Students.

Forming networks and coalitions to strengthen campaigns by bringing large numbers of individuals, organisations together on a particular issue/concern. One such example is the Medico Friend Circle, an all-India network of individuals from diverse backgrounds, who have come together to address the health situation in the country.

Gathering information, feedback from community including women to gather first hand information and accurate/true report of the situation. This kind of documentation has been a useful mechanism for campaigns.

Organising Fact finding visits to affected areas and communities. For example, a fact finding mission to Gujarat after the carnage, was organised by the Medico Friend Circle (MFC) to assess the functioning of health care services and to examine the extent to which the affected community, particularly women, were able to access these services. Documentation of violations played a critical role in monitoring and highlighting the accountability of the State and other Institutions.

Organising People's Tribunals (Jan Sunwais) to facilitate expression of peoples' grievances and experiences of violations, which they may find difficult to voice in any other forum. This has been a very useful way to create an interface between the people, the State and other relevant actors. For example, several tribunals were organised, in which the survivors of the Bhopal Gas Tragedy presented the reality of their situation – its impact on their health, corruption in disbursement of compensation and several other issues. Prayas, an NGO in Rajasthan, also documented cases of violations of women's right to health care and organised a series of public hearings in collaboration with the National Commission for Women and the State Women's Commission in different districts across the State.

Compilation and analysis of data has been an important tool to substantiate opinions and strengthen debates towards making necessary revisions, amendments, etc.

Critiquing policies, programmes, and related documents with the objective of making them comprehensive and gender sensitive.

For example, the National Family Health Survey data (2000) showed that among women in the reproductive age group of 15-44 years, deaths occurring due to communicable diseases were more than double the number of deaths due to pregnancy and child birth. This analysis was used to advocate for the need to prioritise and provide facilities and services for communicable diseases¹⁴⁰.

Information about the child sex ratio in the age group of 0-6 years from the census report (2001) was analysed to substantiate the fact that there was a decrease in the ratio of girls to boys from 1981 to 2001. This analysis helped to create pressure on the Judiciary, resulting in the Supreme Court directive to the States to furnish details about this.

Carrying out Action Research and studies to gather information and evidence to substantiate facts about relevant issues and initiate advocacy efforts. For example, Sama carried out a study on the 'Interrelationship between gender and malaria among the rural poor in Jharkhand'. The findings of this study were used to highlight the abysmal state of health services in the region and provide substantial data for the campaign for the improvement of public health services.

Dissemination of information to raise awareness and consciousness about women's right to health among women, communities, organisations, medical institutions, judiciary, media, State and others.

Organising people's assemblies, meetings, workshops, seminars, and lectures.

Developing information booklets, pamphlets, flyers, fact sheets, etc. For example, booklets on health were developed and published by Jan Swasthya Abhiyan before the People's Health Assembly at Dhaka in 2000. These were extremely useful in raising public awareness and mobilizing people around health issues.

Engaging the Media to write/raise debates on social issues through organizing press conferences and issuing press releases.

140. Mohan Rao, EPW, Dec. 2, 2000.

Sensitising the judiciary, media, parliamentarians, health functionaries and others.

For example, an innovative Gender & Judges programme was initiated by Sakshi, an NGO working in Delhi, on sexual violence and women's rights. This gender sensitisation programme for the Judiciary aimed to introduce gender perspective in the legal system, which is heavily biased against women.

Providing recommendations and suggestions to improve the existing policies, guidelines, programmes, plans, through participation in meetings and task groups.

Representatives of health movements and other organisations *participated in task groups towards identifying gaps and improving the policy draft* of the National Rural Health Mission.

Women's groups *reviewed the guidelines* of the Indian Council of Medical Research (ICMR) on clinical research and provided gender sensitive inputs to prevent unethical clinical trials in the future.

Initiating Community Monitoring processes to monitor the implementation of policies and programmes. For example, Citizens Against Pre Elimination of Daughters (CAPED), a network of NGOs in Delhi, was initiated to monitor and ensure the implementation of the PC&PNDT Act (2003).

Lobbying with the government/policy-makers and other institutions to seek political and legislative changes

Presenting Petitions and Memorandums

For example, the memorandum on the impact of the State Population Policies (two-child norm) was submitted in (2002) to the National Human Rights Commission (NHRC) to draw attention to the issue.

Organising Signature Campaigns to build support. For example, the 'Million Voices Campaign' was initiated by sexual rights groups for repealing Section 377 of the Indian Penal Code.

Organising Protests, Rallies, Demonstrations to create pressure and advocate for a cause. For example, a rally was organised in Delhi by Jan Swasthya Abhiyan in 2004, to draw attention of the public towards health as a human right and to lobby for the recognition of the Right to Health care as a fundamental right.

Using Legislation to achieve justice, to ensure protection and promotion of rights. For example, a PIL was filed by the Centre for Enquiry into Health and Allied Themes (CEHAT), Mahila Sarvangeen Utkarsh Mandal (MASUM), and Dr. Sabu George in 2000, to pressurise the central and state governments to set up appropriate structures to ensure the proper implementation of the PNMT Act and to also include sex pre-selection techniques in the Act. Because of this PIL, the existing PNMT Act was amended and changed to the PC & PNMT Act in 2003.

Involvement of Students

The involvement of students in various initiatives taken up by Civil Society Organisations, People's Health Movements and Women's Movement, has been critical. From the early days of the women's movement, students have been an integral part of it through their involvement in the *Mathura* rape case and anti dowry campaigns. Their participation in the larger social campaigns like the *Narmada Bachao Andolan* or the Campaign for Justice in Bhopal has been instrumental in making them mass based. Students have also been vocal against communalism and resurging fundamentalist forces – whether it be Sikh riots in Delhi, or the Babri Masjid demolition in Ayodhya, or the more recent Gujarat carnage. Students from various universities and colleges have been actively involved in relief camps engaging in counselling, documentation and recording of violations. The participation of students has provided the strength and energy to carry out sustained campaigns and struggles.

Apart from being involved in these movements and campaigns for larger social causes, students have also launched specific initiatives to address these issues and bring about change in their own educational institutions. In doing this, they have used multiple strategies like rallies, demonstrations, e-petitions, lectures, workshops, street theatre, etc. A few such students' initiatives have been illustrated below:

- 'We for Bhopal' a remarkable initiative was started in 2003 by a group of English students from Hindu College of Delhi University. This is a forum of students/youth supporters fighting for justice for the Bhopal Gas survivors, with the motto that "Bhopal can happen anywhere, until and unless we become aware citizens". The forum seeks to break the "illusion of urban metropolis' existence" that makes the youth blind to issues, which they think, do not affect them directly. It also encourages innovative actions to bring about changes. The aim is not only to criticise bureaucracy but to also make inroads into the system by placing demands and recommendations. Another objective is to reach out to other students and encourage them to express their opinions in public in order to influence the decision-makers. Some of the specific initiatives that the

group has taken up are: i) sending petitions for securing justice; ii) organising meetings, demonstrations and candle light vigils to keep the protest alive; iii) organizing concerts for fundraising; iv) sending of fact finding films and reports to concerned authorities. The group constantly engages in discussions and protests on anti-poor policies and notion of progress that marginalises the poor and tries to raise awareness of the student community on these issues¹⁴¹.

- The Gender Sensitisation Committee Against Sexual Harassment (GSCASH) was initiated in 1999 in Jawaharlal Nehru University, New Delhi, for the prevention and deterrence of sexual harassment in the University. The students were instrumental in formulating the policies and composition of the body. In the ten members committee, there are two independent student representatives apart from a Students' Union representative. The independent members are elected by the student community. They play a significant role in raising awareness and debates on the issues of sexual harassment, intimidation or exploitation and in upholding principles of equality and dignity¹⁴².
- An Anti Coke and Pepsi campaign was launched by students of Jadavpur University, Kolkata along with the University staff and administration in 2003. This was prompted by the scandal over pesticide residue in Coke and Pepsi bottles in India and contributed to a ban on buying and selling of Coke and Pepsi in the University campus. A novel and popular experiment as part of the protest was the launching of a cola substitute. It was called 'Cola-Hal' (which means 'creating a noisy disruption' in *Bangla*). It was produced in the university and sold through the student and staff canteens¹⁴³.
- Students of universities all over Tamil Nadu engaged in massive relief operations after the Tsunami hit the coast in 2004. The students carried out relief work in the urban and rural areas. Truckloads of rice and other food items, emergency supplies, medicines and clothes were collected and sent to the coastal areas.
- Anjuman, the Jawaharlal Nehru University students' queer collective was started in 2003. It is a forum for all people willing to question the place of gender and sexuality in their own lives and society to express themselves. Anjuman has been organizing discussions, debates, film screenings to create awareness and generate support for issues of sexuality¹⁴⁴.

141. <http://www.thesouthasian.org/archives/>

142. <http://www.jnu.ac.in/GsCash/GsCash.asp>

143. <http://www.colombiasolidarity.org.uk>

144. anjuman_jnu.blogspot.com

- Students of Kolkata University organised and participated in a massive ‘Anti Iraq war rally’ in Kolkata in 2003. Subsequently the students handed over a unanimous resolution against war to the officers of the American Centre. They also launched a website of the students against war (<http://www.sawindia.org>) with the objective of networking, building alliances and continuing similar action¹⁴⁵.

Civil Society Organisations, People’s Health Movements, Women’s Movement and Students have contributed significantly to bring about social change. Given the present context, such combined actions are becoming essential tools to combat larger global forces and safeguard the interests of vulnerable groups and communities. The role that the students play is critical as they bring in new ideas, enthusiasm and energies to the movements. The initiatives taken by students in their own contexts or as part of larger movements have immense potential to carry the struggles forward.

145. www.cpiml.org

Check Your Progress

1. Critically analysis the various health polices and programmes in India particularly with reference to Women's Health.
2. Give an overview of the status of Women Health in India.
3. Discuss the evolution of Women's right to Health Movement.
4. Write a short note on the following:
 - a. Population Control Policies.
 - b. Campaign for Rational Drug Policy
5. Enumerate International Instrument and National Laws concerning Right to Health of Women with relevant case laws.
6. Discuss the role of NGO's and of National Human Rights Commission on right to health.
7. Critically analysis the impact of reforms on the health system in India.
8. Discuss the evolution of health care system in India.

National Health Programmes initiated by the Government of India

Year	National Health Programmes
1945	Drugs and Cosmetics Act 1940 and Drugs and Cosmetics Rules,
1948	Employees State Insurance Act
1952	National Family Planning Programme
1953	National Malaria Eradication Programme
1955	National Filaria Control Programme
1956	National Leprosy Control Programme
1961	The Maternity Benefit Act
1962	National Small Pox Eradication Programme
1962	National TB Control Programme
1962	National Goitre Control Programme
1963	National Trachoma Control Programme
1965	Indian Medical Council Act 1933
1970	The Contract Labour (Regulation and Adoption) Act
1971	The Medical Termination of Pregnancy Act 1971, revised in 1975, amended in 2002
1975	The Integrated Child Development Services Scheme
1976	National Blindness Control Programme
1975 - 1976	National Cancer Control Programme, revised in 2004
1977	Family Welfare Programme
1978	Expanded Programme of Immunisation
	National Iodine Deficiency Disorder (IDD) Control Programme
	National Diabetes Control Programme

1978	National Diarrhoeal Disease Control Programme
1982	National Mental Health Programme
1983	National Leprosy Eradication Programme
1983	National Programme for Guinea Worm Eradication
1987	National AIDS Control Programme
1987	The Mental Health Act
1993	Revised National TB Control Programme
1993	National Nutrition Policy
1995	Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act
1997	Reproductive and Child Health Programme
1999	Standards for Male and Female Sterilisation
2001	National Policy for the Empowerment of Women
2002	National Population Policy
2002	National AIDS Control and Prevention Policy
2002	National Blood Policy
2002	National Health Policy
2002	National Common Minimum Programme
2003	Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) or PC & PNDT Act
2004	The Draft National Rural Employment Guarantee Act
2005	Food Safety and Standards Bill
2005	The Right to Information Act
2005	The Communal Violence (Prevention, Control and Rehabilitation of Victims) Bill
2005	The HIV/AIDS Bill
2005 – 2012	National Rural Health Mission (NRHM)

Compiled by Sama - Resource Group for Women & Health

National Action Plan to operationalise the Right to Health Care within the broader framework of the Right to Health

(Recommendations for this NAP evolved at the National Public Hearing on Right to Health Care, organised by NHRC & JSA on 16-17 December 2004, at New Delhi.)

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 Government, 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 the 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 committee. Parallel to 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, unauthorised 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 to the Government of India/Union Health Ministry

- **Enactment of a National Public Health Services Act recognising 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 populations 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 service at various levels**: village/community, subcentre, 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 citizens' 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 consumers, 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 decentralised 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.
- decentralised 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:
 - enunciation of a National Accident Policy.
 - 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.
 - establishment of Centralised 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 Government/State Health Ministries

- **Enactment of State Public Health Services Rules** detailing and operationalising the National Public Health Services Act, recognising 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-center, PHC, CHC, Subdivisional 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 budget 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 within a specified time frame.
- **Public Health Sector Reform measures** to ensure health rights through strengthening public health systems, and making private care more accountable and equitable. The minimum aspects of a health sector reform

framework that would strengthen public rights. **An illustrative list of such measures is as follows:**

- State Governments should take steps to **decentralise the health services** by giving control to the respective Panchyati 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.
- 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.
- 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 free of cost to all government hospitals and at subsidised rates to the private hospitals. Regular updating of the formulary should be ensured. Treatment protocols for common diseases should be prepared and made available to the members of the medical profession.
- **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.
- 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.
- 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.

- The adoption of an integrated human resource development plan to ensure adequate availability of health, human power at all levels.
- 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 the specialists are prioritised for serving in secondary care facilities according to public interest.
- 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, universalizing ICDS programmes and mid day school meal programmes, to address food insecurity and malnutrition, which are a major cause of ill-health.

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 Organisation, and by a government that functions under the dictates of international Finance Capital. The forces of ‘globalisation’ 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 decentralised 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 corporatisation 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.
- Institutionalisation 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:

- 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 decentralised planning, decision-making and implementation. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

- 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 Centres and subcentres with adequate staff and supplies which provide quality curative services at the PHC 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 specialty services, available in every district.
 - A comprehensive medical care programme financed by the government to the extent of at least 5 per cent of our GNP, of which at least half be disbursed to Panchayati Raj Institutions (PRIs) 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.

- 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.
- A comprehensive need-based human power 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-specialties. 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 a 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.
- 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.
- 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.
- 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 unethical 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.
 - 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 the onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception.

- 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.
- 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.
- 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. Decentralised 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 STIs, HIV /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.
- Facilities for early detection and treatment of non-communicable diseases like diabetes, cancers, heart diseases, etc. to be available to all at appropriate levels of medical care.
- 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 women's work and domestic violence.
 - Complete maternity benefits and childcare facilities to be provided in all occupations employing women, be they in the organised or unorganised 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 foeticide, infanticide and sex pre-selection.

- Child centered health initiatives, which include:
 - A comprehensive child rights code, adequate budgetary allocation for universalisation of childcare services, an expanded and revitalised ICDS programme and ensuring adequate support to working women to facilitate childcare, 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.
- 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.
- Measures towards mental health that promotes 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.
- 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.
- Measures to promote the health of physically and mentally disadvantaged by focusing 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.
- 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.

Glossary

1. AFV : Anti Fertility Vaccine
2. AIDAN : All India Drug Action Network
3. AIDWA : All India Democratic Women's Association
4. ANM : Auxiliary Nurse Midwife
5. ASHA : Accredited Social Health Activist
6. BMI : Body Mass Index
7. CED : Chronic Energy Deficiency
8. CEDAW : Convention on the Elimination of all forms of Discrimination against Women
9. CHC : Community Health Centre
10. CMD : Common Mental Disorder
11. CRC : Convention on the Rights of the Child
12. CSSM JNU : Centre for Social Medicine, Jawaharlal Nehru University
13. CSSM : Child Survival and Safe Motherhood
14. CWDS : Centre for Women's Development Studies
15. DMHP : District Mental Health Programmes
16. DMPA : Depot Medroxyprogesterone Acetate also known as Depo Provera
17. EmOC : Emergency Obstetric Care
18. EP : Estrogen Progesterone
19. FPP : Family Planning Programme
20. FWCW : Fourth World Conference on Women
21. FWP : Family Welfare Programme
22. GDP : Gross Domestic Product
23. GR : General Recommendations

- 24. HDEP : High Dose Estrogen-Progesterone
- 25. HRLN : Human Rights and Law Network
- 26. ICDS : Integrated Child Development Services
- 27. ICESCR : The International Covenant on Economic, Social and Cultural Rights
- 28. ICMR : Indian Council for Medical Research
- 29. ICPD : International Conference on Population and Development
- 30. IIJ : International Initiative for Justice
- 31. IUDs : Intra Uterine Devices
- 32. JSA : Jan Swasthya Abhiyan
- 33. JSS : Jan Swasthya Sahyog
- 34. MCH : Maternal and Child Health
- 35. MFC : Medico Friend Circle
- 36. MMR : Maternal Mortality Rate
- 37. MNC : Multinational Corporations
- 38. MOHFW : Ministry of Health and Family Welfare
- 39. MTP : Medical Termination of Pregnancy
- 40. NACPP : National Aids Control and Prevention Policy
- 41. NAP : National Action Plan
- 42. Net En : Norethisterone Enanthate
- 43. NFHS : National Family Health Survey
- 44. NHP : National Health Policy
- 45. NHRC : National Human Rights Commission
- 46. NMHP : National Mental Health Programme
- 47. NNAPP : National Nutritional and Anaemia Prophylaxis Programme
- 48. NNP : National Nutritional Policy
- 49. NPC : National Planning Committee
- 50. NPEW : National Policy on Empowerment of Women

- 51. NPP : National Population Policy
- 52. NRHM : National Rural Health Mission
- 53. OPEC : Oil and Petroleum Exporting Countries
- 54. PC & PNDT Act : Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (2003)
- 55. PHC : Primary Health Care
- 56. PIL : Public Interest Litigation
- 57. PP : Pharmaceutical Policy
- 58. PUCL : People's Union for Civil Liberties
- 59. RCH : Reproductive and Child Health
- 60. RTI : Reproductive Tract Infection
- 61. SAPs: : Structural Adjustment Programmes
- 62. SMD : Severe Mental Disorder
- 63. SSS : Stree Shakti Sangathana
- 64. STI : Sexually Transmitted Infections
- 65. TBA : Traditional Birth Attendants
- 66. TRIPs : Trade Related Intellectual Property Rights
- 67. UDHR : Universal Declaration of Human Rights
- 68. UNDP : United Nations Development Programme
- 69. UNFPA : United Nations Population Fund
- 70. UPA : United Progressive Alliance
- 71. WHO : World Health Organisation

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The dossier has been prepared by Sama - Resource Group for Women and Health, a Delhi-based women's group, which primarily works on health issues and issues related to women, especially from marginalised communities.

Sama is an active member of Jan Swasthya Abhiyan (Indian Chapter of People's Health Movement), and is part of the National Coordination Committee (NCC) of National Autonomous Women's Conference.



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