POLICY BRIEF

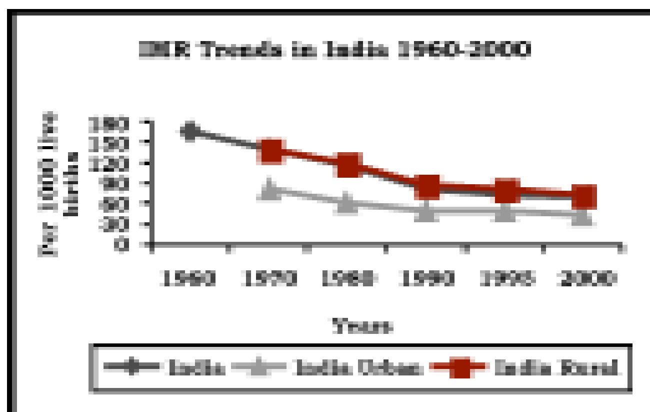
Save Public Health - Ensure Health for All NOW!
Make Health Care a Fundamental Right!

One of the best ways to judge the well being of the people of any nation is by examining the standards of health that ordinary people have attained. Healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but also essential prerequisites for social and economic development. Hence it is high time that **people's health is given priority as a national political issue.** The current health policies need to be seriously examined so that new policies can be implemented in the framework of quality health care for all as a basic right. The following sections first take a look at the hard realities of people's health in India today, and examine some of the maladies of recent health policies. Next the availability of various resources, which could be utilised for an improved health care system is discussed, finally followed by certain recommendations to strengthen and reorient the health system to ensure quality health care for all. We hope these **recommendations will be incorporated by political parties in their election manifestos** for the upcoming general election as a demonstration of their commitment to public health. Jan Swasthya Abhiyan, a national platform working for people's health, looks forward to such a commitment from all political forces in the country.

How can India's health be shining when ...

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years.[1] We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births.[2] More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and 80s, has slowed down in the 1990s, (See graph below)

- **130,000 mothers die during childbirth every year**. The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today.[1] In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births.[3]



- **Three completely avoidable child deaths occur every minute**. If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala,[1] then **18 lakh deaths of under-five children could be avoided every year**. The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through better child health care and supplemental feeding programs.[2] The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected.[4]

- **About 5 lakh people die from tuberculosis every year**[18], and this number is almost unchanged since Independence![19] 20 lakh new cases are added each year, to the burgeoning number of TB patients presently estimated at around 1.40 crore[2] Indians !

- India is experiencing a **resurgence of various communicable diseases** including Malaria, Encephalitis, Kala azar, Dengue and Leptospirosis. The number of cases of **Malaria has remained at a high level of around 2 million cases annually** since the mid eighties. By the year 2001, the worrying fact has emerged that **nearly half of the cases are of Falciparum malaria,** which can cause the deadly cerebral malaria. The outbreak of **Dengue** in India in 1996-97, saw 16,517 cases

and claimed 545 lives[8]. Environmental and social dislocations combined with weakening public health systems have contributed to this resurgence.

- Diarrhea, dysentery, acute respiratory infections and asthma continue to take their toll because we are unable to improve environmental health conditions. **Around 6 lakh children die each year from an ordinary illness like diarrhoea.** While diarrhea itself could be largely prevented by universal provision of safe drinking water and sanitary conditions, these deaths can be prevented by timely administration of oral rehydration solution, which is presently administered in only 27% of cases[3].

- Cancer claims over 3 lakh lives per year and **tobacco related cancers** contribute to 50% of the overall cancer burden, which means that such deaths might be prevented by tobacco control measures[2].

- Estimates of mental health show about 10 million people suffering from serious mental illness, 20-30 million having neuroses and 0.5 to 1 percent of all children having mental retardation[2]. **One Indian commits suicide every 5 minutes[5]!**

As a nation, today there is a need to look closely at the deep problems in the health system, rather than making exaggerated claims. There is a need to recognize the growing health inequities, and urgently implement basic changes in the health system.

With political will and people's involvement, ensuring good quality health care for every Indian is possible!

The growing inequities in health and health care are unjust !

The Constitution of India guarantees the 'Right to Life' to **all** citizens. However, the disparities relating to survival and health, between the well off and the poor, the urban residents and rural people, the adivasis and dalits and others, and between men and women are extremely glaring.

- The Infant Mortality Rate in the poorest 20% of the population is **2.5 times higher** than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family[3].

- A child in the 'Low standard of living' economic group is **almost four times** more likely to die in childhood than a child in the better off 'High standard of living' group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups[3].

- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The **female to male ratios** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001[16]. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls)[3].

- Dalit Women are one and a half times more likely to suffer the consequences of chronic malnutrition (stunted height) as compared to women from other castes. Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.

- A person from the poorest quintile of the population, despite more health problems, is **six times less** likely to access hospitalization than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required.

- The delivery of a mother, from the poorest quintile of the population is **over six times** less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population. An adivasi mother is half as likely to be delivered by a medically trained person[3].

- The ratio of hospital beds to population in rural areas is **fifteen times** lower than that for urban areas[14].

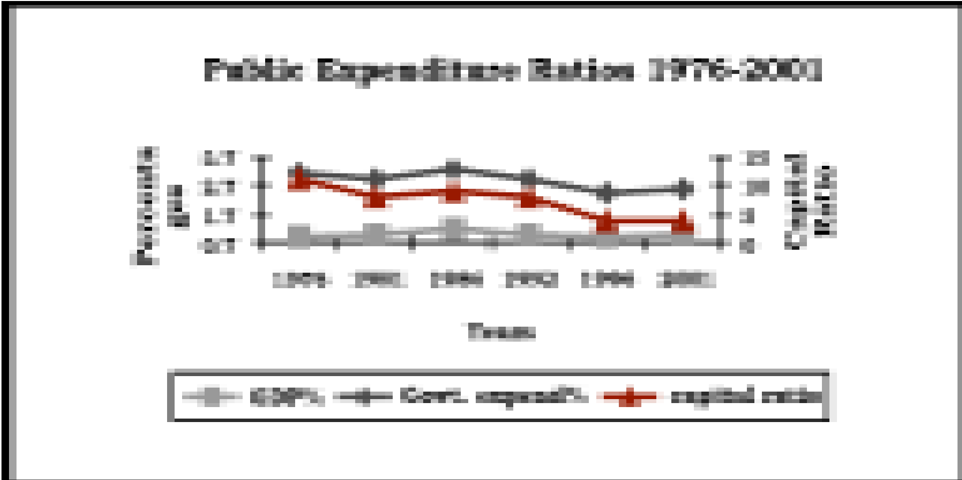
- The ratio of doctors to population in rural areas is **almost six times lower** than the availability of doctors for the urban population[14].

- Per person, Government spending on public health is **seven times lower in rural areas**, compared to Government health spending for urban areas.

These **health and health care inequities are increasing**, and are deeply unjust -- a just health system would ensure that all citizens, irrespective of social background or gender, would get basic quality health care in times of need.

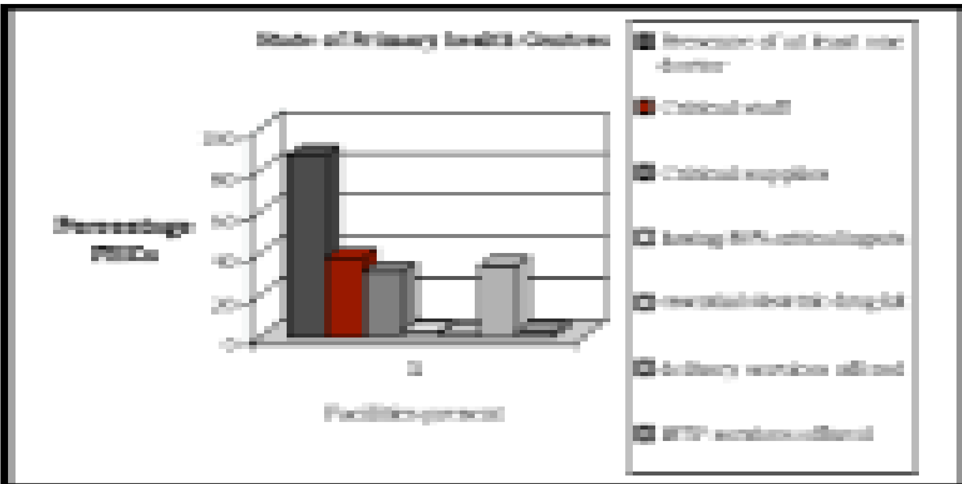
Public health being weakened, people's health being undermined

The NDA Government has recently claimed that one of its signal achievements has been the allocation of 6% of GDP to Health care. In reality, the government spends just 0.9 % of the GDP on Health care and the rest is spent by people from their own resources. Thus only 17% of all health expenditure in this country is borne by the government — this makes the Indian public health system grossly inadequate to meet healthcare demands of its people, and makes the health sector the **most privatised in the world.** Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia[6]). The W.H.O. standard for expenditure on public health is 5% of the GDP. The average spending today by Less Developed Countries is 2.8 % of GDP, but India presently spends only 0.9% of its GDP on public health, which is merely one-third of the less developed countries' average[6] !



The consequence of this dismally low allocation, which stands at the lowest levels in the last two decades, (in contrast to 1.3% of GDP achieved in 1985), is deteriorating quality of public health services. For example, Primary health centers (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 center would find no obstetrician in 7 out of 10 centers, and no pediatrician in 8 out of 10!



Source: 7

Private health care and essential drugs are increasingly unaffordable !

The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban biased, tertiary level health services with profitability overriding equity, and rationality of care often taking a back seat.

- A growing proportion of Indians cannot afford health care when they fall ill. National surveys show that the number of people who could not seek medical care because of lack of money increased significantly between 1986 and 1995[15]. The proportion of such persons **unable to afford health care almost doubled**, increasing from 10 to 21 % in urban areas, and growing from 15 to 24% in rural areas in this decade[15].
- **Forty percent** of hospitalised people are forced to borrow money or sell assets to cover expenses[15].
- **Over 2 crores of Indians are pushed below the poverty line** every year because of the catastrophic effect of out of pocket spending on health care[20]!
- Irrational medical procedures are on the rise. According to just one study in a community in Chennai, **45% of all deliveries were performed by Cesarean operations,** whereas the WHO has recommended that not more than 10-15% of deliveries would require Cesarean operations[17].
- Due to **irrational prescribing**, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs[21]!
- The pharmaceutical industry is rapidly growing…yet only 20% of the population can access all essential drugs that they require. There is a proliferation of brand names with over 70,000 brands marketed in India, but the 2002 Drug policy recommends that only 25 drugs be kept under price control[13]. As a result, many drugs are being sold at 200 to 500 percent profit margin, and essential drugs have become unaffordable for the majority of the Indian population.

Health policy developments since the 1990s have critically weakened the health system

The effectiveness of the public health system and access to quality health care, especially for the poor has worsened since the decade of the 1990s, due to a variety of policy developments, at both national and state levels:

- Stagnant public health budgets and decreasing Government expenditure on capital investment for public health facilities.
- Introduction of user fees at various levels of public health facilities.
- Freezing of new recruitments and inadequate budgets for supplies and maintenance in the public health system.
- Contracting out health services or privatisation of health facilities.
- Encouragement of growth of private secondary and tertiary hospitals through tax waivers, reduced import duties, subsidized land etc. which have led to a further expansion of the unregulated private medical sector.
- Promotion of 'Health tourism' for foreign visitors, while basic health services remain inaccessible for a large proportion of the Indian population.
- Conducting occasional, expensive and largely ineffective 'Health melas' instead of upgrading the public health system as a sustainable solution.
- Deregulation of the pharmaceutical industry, lax price controls on drugs — the list of drugs under price control being proposed to be reduced to 25 drugs (compared to 343 drugs under price control in 1979.)
- Many bulk drug manufacturing units have closed down due to liberalized import and dumping as a result of the implementation of the WTO agreement and autonomous economic liberalization policies. Due to reduction of customs duty and increase of excise duty, imported drugs will become cheaper while local drugs will become more expensive.

Is this inevitable ? Can only developed countries manage good health care for their people ?

Indians need not accept poor health as their inevitable fate! Many other developing countries, which have given a high priority to people's health, have achieved much better health outcomes compared to India. As a country, we spend a higher proportion of the GDP on health care compared to these countries – but an overwhelming percentage of this (83%) is private expenditure. As a result we have a weak public health system with poor health outcomes forcing families to spend a lot on private medical care, which is expensive, and not always appropriate, leaving us with **'poor health at high cost'!** Here is how some other Asian countries are doing in comparison with India...

Health Outcomes in Relation to Health Expenditures in some Asian countries[10]

	Total Health Expenditure as % of GDP	Public Health Expenditure as % of total	Under 5 Mortality	Life Expectancy	
				Male	Female
India	**5.2**	**17**	**95**	**59.6**	**61.2**
Sri Lanka	3.0	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9

Does India have the resources to provide health care for all ?

As a country, Indians spend more on health care than most other developing countries, but this is mostly out-of-pocket spending. Health care facilities have grown substantially, but these are mostly in the private sector. The system is producing more and more healthcare professionals, but we lose them to the private sector, or to western countries. To give some idea of the available health care resources in India –

- Compared to 11,174 hospitals in 1991 (57% private), the number grew to 18,218 (75% private) in 2000[14]. In 2000, the country had 12.5 lakh doctors and 8 lakh nurses! At the national level, there is one allopathic doctor for every 1800 people, or one doctor from systems including ISM and homeopathy for 800 people. This means there are more doctors than the required estimate of one doctor for 1500 population[2].
- Approximately 15,000 new graduate doctors and 5,000 postgraduate doctors are produced every year and one-fifth of them leave the country for greener pastures[14].
- We have an annual pharmaceutical production of about 260 billion rupees[22], and we export a large proportion of these drugs - Sadly, while our exports grow, 80% of our people do not have access to all the drugs they require.

In short, we have substantial health care resources, but because of the privatised, unregulated and inequitable nature of the health care system, it is unable to ensure good quality health care for a majority of citizens. Rather than producing more doctors or setting up more private hospitals, what we need is a reorganisation of the health system, with substantial strengthening of public health, greatly enhanced public expenditure, regulation of the private medical sector and an overall planned approach to make health care resources available to all.

What can be done as immediate steps ?

The objective should be to **make Health care a Fundamental right and an operational entitlement**. This would require a National Public Health Act, which mandates right to basic healthcare services to all citizens through a system of universal access to healthcare. The Indian Constitution through its directive principles provides the basis for the Right to health care, and the Indian state has ratified the International Covenant of Economic, Social and Cultural Rights which makes it obligatory on its part to comply with Article 12 that mandates right to healthcare. Universal access to healthcare is well established in a number of countries including not only developed countries like Canada and United Kingdom, but also developing countries such as Cuba, Brazil, Costa Rica and Thailand. There is no reason why this cannot be made a reality in India. Hence we need to set in motion processes, which will take us towards the goal of universal access to health care, in a Rights-based framework and with equity.

Some immediate steps related to the health care system that need to be taken include:

- Making healthcare a fundamental right by suitable constitutional amendment. The formulation of a National legislation mandating the Right to Health care, with a clearly defined comprehensive package of health care, along with authorization of the requisite budget, being made available universally within one year.
- Significant strengthening of the existing public health system, especially in rural areas, by assuring that all the required infrastructure, staff, equipment, medicines and other critical inputs are available, and result in delivery of all required services. These would be ensured based on clearly defined, publicly displayed and monitored norms.
- The declining trend of budgetary allocations for public health needs to be reversed, and budgets appropriately up–scaled to make optimal provision of health care in the public domain possible. At one level adopting a fiscal policy of block funding or a system of per capita allocation of resources to different levels of health care, with an emphasis on Primary Health Care will have an immediate impact in reducing rural-urban inequities by making larger resources available to rural health facilities like Primary health centers and Rural hospitals. Simultaneously, the budgetary allocation to the health sector must be increased substantially, targeting the 5% of GDP as public expenditure on health care as recommended by the WHO.
- If the public health system fails to deliver it should be treated as a legal offence, remedy for which can be sought in the courts of law. The public system must ensure all elements of care like drug prescriptions, diagnostic tests, child birth services, hospitalization care etc. One way to ensure this could be that in exceptional situations, where patients who do not receive these services from the public facility they may be referred to seek them from alternate facilities, which are registered with the state agency. Such registered and regulated facilities would honour such referrals, for which the state would reimburse them at a mutually agreed rate. This would maintain pressure on the public health system to provide all elements of care, and would ensure that the patient is not deprived of essential care at time of need.
- Various vulnerable and marginalised sections of the population have special health needs. There is a need for a range of policy measures to eliminate discrimination, and to provide special quality and sensitive services for women, children, elderly persons, unorganised sector workers, HIV-AIDS affected persons, disabled persons, persons with mental health problems and other vulnerable groups. Similarly, situations of conflict, displacement and migration need to be addressed with a comprehensive approach to ensure that the health rights of affected people are protected. The **People's Health Charter** deals with issues related to such special sections of the population, and can provide a basis for formulation of appropriate policy initiatives, in consultation with organisations representing these social segments.
- Putting in place a National legislation to regulate the private health sector, to adopt minimum standards, accreditation, standard treatment protocols, standardised pricing of services etc.
- Adopting a rational and essential medications-based drug policy. All States must have an essential drugs and consumables list and all the drugs and consumables on this list must be under price control. Further all state governments must adopt procurement and distribution

policies similar to what has been done by the Tamilnadu State Medical Services Corporation and hence ensure that essential drugs in the list are actually available in every facility.

- The state should introduce a new community-anchored health worker scheme, and implement it in a phased manner with involvement of people's organizations and panchayati raj institutions, in both rural and urban areas, through which first contact primary care and health education can be ensured.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas.
- All state level coercive population control policies, disincentives and orders should be revoked. Disproportionate financial allocation for population control activity should not be allowed to skew funding from other important public health priorities.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas. Effective regulation of the growth of capitation based medical colleges.

Conclusion

The persistence of unacceptably large numbers of avoidable deaths, resurgence of communicable diseases, declining quality of public health services and unaffordable, often inappropriate private medical care need not remain the lot of over a billion ordinary Indians. Recent policy changes of privatisation, declining public health budgets and pro-drug industry measures need to be replaced by strong public health initiatives, with the active involvement of communities and civil society organisations.

By and large, India today possesses the humanpower, infrastructure, national financial resources and appropriate health care know-how to ensure quality health care for all its citizens. What is needed is a major restructuring and strengthening of the health system. This involves two major ingredients: popular mobilisation for operationalising the Right to Health Care, and the political will to implement policy changes necessary to transform the health system. Jan Swasthya Abhiyan is today involved in the former task, by reaching out to people across the country, enabling them to mobilise for their just health rights. It calls upon political parties, which recognise people's right to healthy lives, to address the latter task, and to perform their historic duty by establishing and operationalising the Right to Health care as a Fundamental right.

This document focuses on the need for strengthening of the health care system, and certain immediate steps required for this. However, improvement of people's health requires equally importantly, provision of other necessary **facilities and conditions required for a healthy life**, such as safe drinking water, sanitation, food security, healthy housing, basic education and a safe environment. The **People's Health Charter** has dealt with these issues, and may be taken as a guideline to develop effective policies and improve people's living standard in order to achieve better health.

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Indian 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, as well as the sections of poor in the rich nations, 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 and demand for comprehensive health care that includes food security; sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum - the right to **Health For All, Now!**

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of International Finance Capital. The forces '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 comprehensive 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 decentralized system of local governance vested with adequate power and responsibilities, provided with adequate finances and responsibility for local level planning.
- A sustainable system of agriculture based on the principle of land to the tiller – both men and women – equitable distribution of land and water, linked to a decentralized public distribution system that ensures that no one goes hungry
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities
- A dignified and sustainable livelihood
- A clean and sustainable environment
- A drug industry geared to producing epidemiological essential drugs at affordable cost
- A health care system which is gender sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market defined concept of health care.

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 and appropriation of bio-diversity.
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor
- The corporatization and commericialization 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 which are directed primarily at the poor and women
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach
- Institutionalization of divisive and oppressive forces in society, such as communalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation with the active participation of the community. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

2. The primary health care institutions including trained village health workers, sub-centers, and the PHCs staffed by doctors and the entire range of community health functionaries including the ICDS workers, be placed under the direct administrative and financial control of the relevant level Panchayati Raj institutions. The overall infrastructure of the primary health care institutions be under the control of Panchayats 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 which are given regulatory powers and adequate resource support

- Primary Health Centers and sub-centers with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from referral linkages
- A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers under the control of local self government such as ward committees and municipalities.
- 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 centers at block level to monitor the local epidemiological situation and tertiary care with all speciality services, available in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based 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-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. No commodification of medical education. Steps 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.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self-reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

    - Ban all irrational and hazardous drugs. Set up effective mechanisms to control the introduction of new drugs and formulations as well as periodic review of currently approved drugs.
    - Introduce production quotas & price ceiling for essential drugs
    - Promote compulsory use of generic names
    - Regulate advertisements, promotion and marketing of all medications based on ethical criteria
    - Formulate guidelines for use of old and new vaccines
    - Control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology
    - Recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices
    - Promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Research priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All 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.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognized. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift to onus of contraception away from women and ensure at least equal emphasis on men’s responsibility for contraception. Facilities for safe abortions be provided right from the primary health center level.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralization in the decision making process, related to health care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

    - Integration of health impact assessment into all development projects
    - Decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners
    - Reorientation of measures to check STDs/AIDS through universal sex education, promoting responsible safe sex practices, questioning forced disruption and displacement and the culture of commodification of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseases like diabetes, cancers, heart diseases, etc. to be available to all at appropriate levels of medical care.

14. Women-centered health initiatives that include:

    - Awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in upbringing and life conditions within and outside the family; preventive and curative measures to deal with health consequences of women's work and violence against women
    - Complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector
    - Special support structures that focus on single, deserted, widowed women and minority women which will include religious, ethnic and women with a different sexual orientation and commercial sex workers; gender sensitive services to deal with all the health problems of women including reproductive health, maternal health, abortion, and infertility
    - Vigorous public campaign accompanied by legal and administrative action against sex selective abortions including female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives that include:

    - A comprehensive child rights code, adequate budgetary allocation for universalisation of child care services
    - An expanded & revitalized ICDS programme. Ensuring adequate support to working women to facilitate child care, especially breast feeding
    - Comprehensive measures to prevent child abuse, sexual abuse and child prostitution
    - Educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory quality elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

    - Banning of hazardous technologies in industry and agriculture
    - Worker centered monitoring of working conditions with the onus of ensuring a safe and secure workplace on the management
    - Reorienting medical services for early detection of occupational disease
    - Special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. The approach to mental health problems should take into account the social structure in India which makes certain sections like women more vulnerable to mental health problems. Mental Health Measures that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support & community based management of mental health problems be promoted. Services for early detection & integrated management of mental health problems be integrated with Primary Health Care and the rights of the mentally ill and the mentally challenged persons to be safe guarded.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly. Services that cater to the special needs of people in transit, the homeless, migratory workers and temporary settlement dwellers.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising, sponsorship and sale of their products to the young, and provision of services for de-addiction.

Constituents of the JAN SWASTHYA ABHIYAN

The Jan Swasthya Abhiyan at the national level is the coalition of the networks of voluntary organizations and peoples movements involved in healthcare delivery and health policy, who made themselves a part of the Peoples Health Assembly campaign in India in the year 2000, and have continued to participate in this process. These national networks have numerous constituent organisations, which implies that a few hundred organizations are involved directly in the national process. Beyond these networks, several hundred other organizations have been involved at state, district and block level activities across the country. The networks that constitute the National Coordination Committee of Jan Swasthya Abhiyan are:

1. All India Peoples Science Network
2. All India Democratic Women's Association
3. All India Drug Action Network
4. Asian Community Health Action Network
5. Bharat Gyan Vigyan Samiti
6. Catholic Health Association of India (CHAI)
7. Christian Medical Association of India (CMAI)
8. Federation of Medical Representatives and Sales Associations of India (FMRAI)
9. Forum for Creche and Child Care Services (FORCES)
10. Joint Women's Programme
11. Medico Friends Circle (MFC)
12. National Alliance of People's Movements (NAPM)
13. National Alliance of Women's Organisations (NAWO)
14. National Federation of Indian Women (NFIW)
15. Ramakrishna Mission
16. Voluntary Health Association of India (VHAI)
17. Association for Indian Development, India (AID-India)
18. Breastfeeding Promotion Network of India (BFPNI) National Resource Groups:
19. Centre for Enquiry into Health and Allied Themes (CEHAT)
20. Centre for Social Medicine and Community Health, Jawaharlal Nehru University
21. Community Health Cell (CHC)

The representatives of all the above organisations constitute the National Coordination Committee of JSA, which is the national decision making body of the coalition. N.H. Antia is the Chairperson and D. Banerjee is the Vice-Chairperson of JSA. National organisers of JSA include B. Ekbal as Convenor, Abhay Shukla, Amit Sengupta, Amitava Guha, Thelma Narayan and T. Sundararaman as Joint convenors, with Vandana Prasad and N.B.Sarojini as National secretariat members.

Jan Swasthya Abhiyan presently has state units or contacts in the following states: **Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal.**

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