

A photograph of a man with a beard, wearing a white kurta and dhoti, sitting on concrete steps in front of a building. The building has a metal gate and a blue-painted section. The scene is outdoors with trees and sunlight filtering through the leaves.

**Peoples Health
Manifesto - 2009**

**Health for All
NOW!**

A Call to all Political Parties

**Jan Swasthya
Abhiyan**

March, 2009

Published by B.Ekbal, on behalf of Jan Swasthya Abhiyan, and Printed at Progressive Printers, 21 Jhilmil Colony, Shahdara, Delhi.

Jan Swasthya Abhiyan

National Secretariat:

Contact Person: Dr Ajay Kumar Khare

Madhya Pradesh Vigyan Sabha

Village Sagonikala, Post Kolua Khurd, Raisen Road, Bhopal (MP)

email: ajaykharebpl@gmail.com

Phone: 09425004269

Also for correspondence:

Delhi:

Sama- Resource Group for Women and Health

B-45 2nd Floor, Main Road Shivalik, Malviya Nagar,, New Delhi-110017

Phone : 011-65637632/26692730; email: sama.womenshealth@gmail.com

Delhi Science Forum

D-158, LGF, Saket, New Delhi - 110 017

Phones: 011-26524323/ 26524324, email: ctddsfs@vsnl.com

Pune:

SATHI-CEHAT

3 & 4, Aman E Terrace, Dahanukar Colony, Kothrud,, Pune - 411029

Phone: 020-25451413, 25452325, email: cehatpun@vsnl.com

Health for All NOW! A Call to all Political Parties

While the country, by many accounts, is poised to take its rightful place as a leader in the community of nations, the stark reality that faces a majority of the Indian people cannot be ignored. A recurring and distressing face of this reality is the unacceptable state of ill-health of our people. The Jan Swasthya Abhiyan, a national platform working for people's health, believes that healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but also essential accompaniments of social and economic development. Such an understanding would, in turn, require that ***people's health is given priority as a national political issue***. The current health policies and their implementation need to be seriously examined so that new policies can be implemented in the framework of quality health care for all and access to basic determinants of health 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. This is followed by core recommendations to strengthen and reorient the health system so as 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, looks forward to such a commitment from all political forces in the country.

Health for All: A Mirage?

For countless millions in the country, the slogan of Health for All, continues to be a mere slogan. India has the dubious distinction of being one of the worst performers in its ability to secure access to health. Allocation for health has been extremely low by global standards, resulting in a large majority of people having to access the private sector. Even the meagre allocation for health has not been optimally utilised, resulting in extremely poor quality of services provided by the public sector. Thus, to a very large extent, health services and health care in India tends to respond to the existing 'market demand'. The vast health needs of the majority of the people do not figure as part of this "demand" for there is neither the awareness nor the organization nor their participation in the making of these decisions.

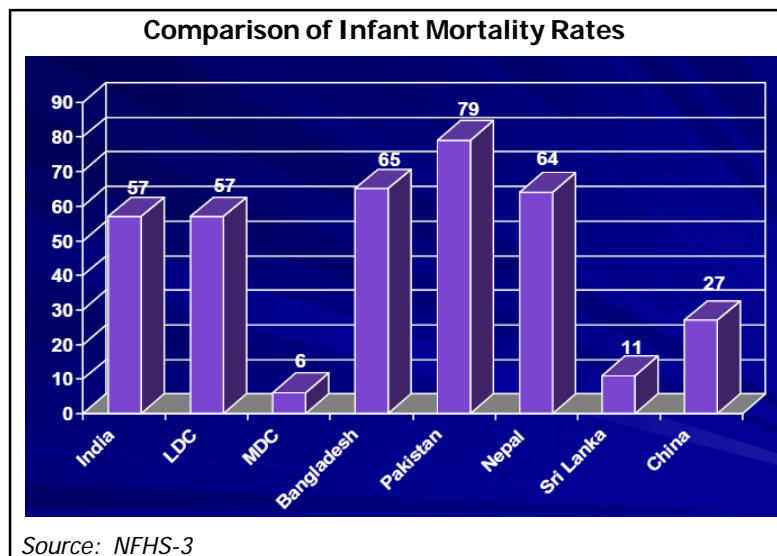
Further, the impact of an urban elitist bias in medical education as well as in medical services has detracted from the ability of the Indian Government in providing Health care to the poor as well as those in rural India. Continued emigration of doctors, rush for super specialties, development of corporate hospitals and polyclinics, and an incredibly large and near universal trend to irrational use of drugs and technology are all trends that are a consequence of this bias. As a result, the major disease-load of

the population has continued to be unacceptably high and, in recent years, many health indicators have started stagnating after the downward trends seen earlier.

Child Health: The Continuing Tragedy of Broken Promises

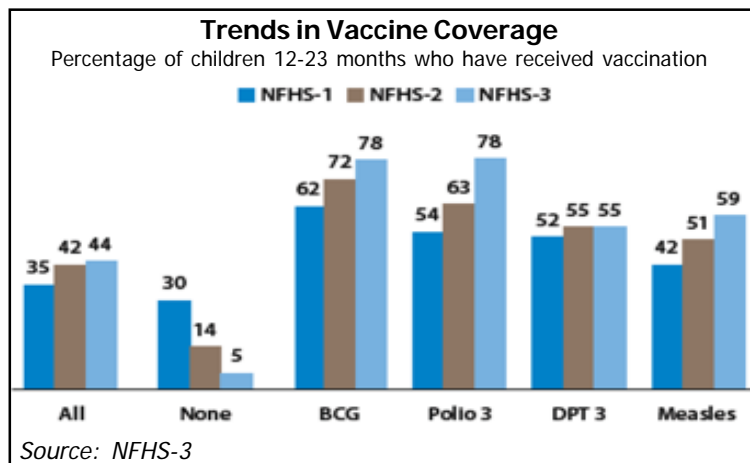
The State of the health of a country's children holds a mirror to the health of its entire population. Many parameters related to child health in the country are similar, if not worse, than those in Least Developed Countries (LDCs). It is widely assumed that India shall fall well short of the UN Millennium Development goals (MDGs) set for 2015, that are related to child health.

Mortality Rates: More than 1 in 18 children die within the first year of life, and 1 in 13 die before reaching the age of five. The NFHS-3 (data from 0-4 years back) reports an Infant Mortality rate of 57 (i.e. 57 children out of 1000 die before reaching the age of one year). This is a decrease from an IMR of 72 reported in the NFHS-2 (data from 5-9 years back). The Under5 Child Mortality rate (deaths before the age of five per 1000 children) reported in NFHS-3 is 74, down from a Child Mortality rate of 92 reported by the NFHS-2. However these figures continue to be unacceptably high. The Child mortality rate is still much higher than the Millennium Development Goal (MDG) target of bringing Under5 Mortality Rate below 42 in 2015. ***The IMR in India is equal to the average of all Least Developed Countries (LDCs), two and half times that of China, and eight to ten times higher than rates achieved in developed countries.*** Even these distressingly high figures hide inequities in the system. Infant mortality in rural areas is 50 percent higher than in

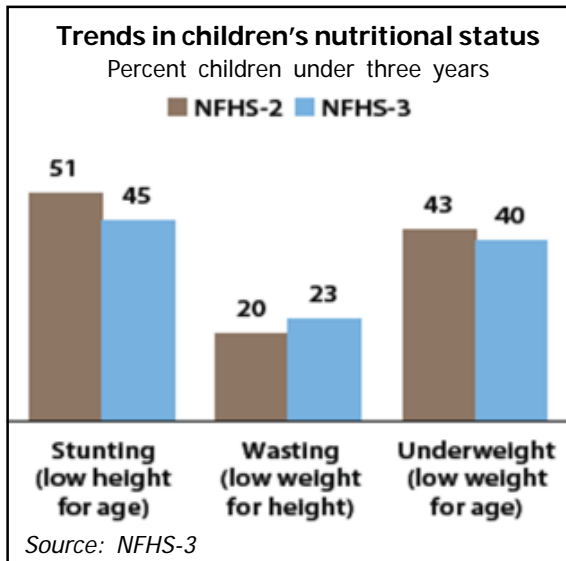


urban areas. Children from dalit and adivasi communities are at greater risk of dying than other children¹. There are also large inter-state differences that need to be urgently addressed in order to reduce huge existing inequalities in health..

Faltering immunization programme: A large majority of the deaths among children we talk about earlier are unnecessary. We do have the tools to prevent many if not most of these deaths. One such tool is the availability of vaccines that can protect children against some life threatening conditions. Yet there has been **very little improvement in the full vaccination coverage in the last five years** – as seen by the data between NFHS-2 (42%) and NFHS-3 (44%). Vaccination coverage has actually worsened substantially in some states, such as Andhra Pradesh, Gujarat, Maharashtra, Punjab, and Tamil Nadu². It needs to be understood that inability to ensure full immunization coverage is also an indication of weakness of the public health system. Also of concern are trends – such as recently reported from Tamilnadu – where the locus of immunisation is sought to be shifted away from near local habitations in the sub-centres to more distant and less easily accessible PHCs. The flagship programme on immunization – the Pulse Polio Programme – has faltered and we are far from reaching the promised goal of a polio free India. There are reasons to conclude that the programme, while not having delivered on its promise, has also been responsible for drawing away attention and resources from the routine immunization programmes. The polio-eradication programme was designed to reduce the incidence of lameness in children, as polio is the most important cause of preventable lameness in children. But in reality the incidence of limb-paralysis in children has increased after the Polio Eradication Initiative. Data available³ shows that the number of cases of Acute Flaccid Paralysis (AFP) in children increased from 3,047 in 1997 to 31,973 in 2006!



Childhood Malnutrition: India today is in danger of being termed as the *hunger capital of the world*. Almost half of children under age five are stunted, or too short for their age, which indicates that they have

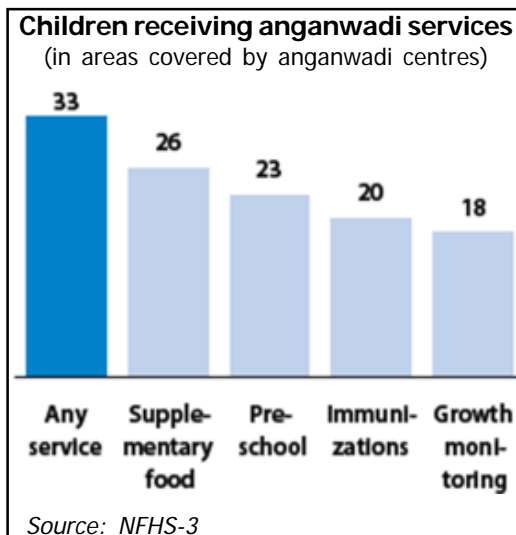


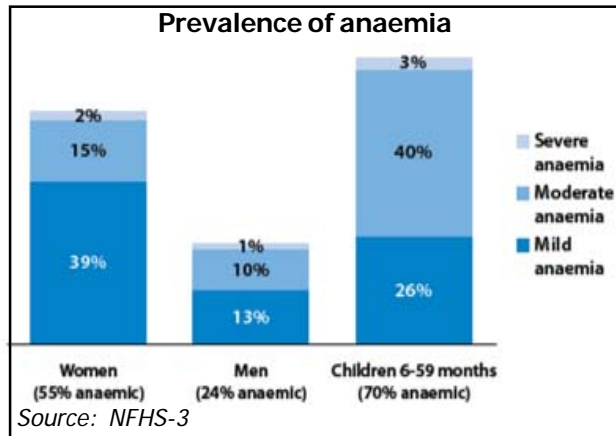
been undernourished for some time. Twenty percent are indicates both chronic and acute undernutrition. More than half of children under age five are underweight in Madhya Pradesh, Jharkhand, and Bihar. These figures are some of the highest in the world, and about double the levels of under-nutrition among children seen in the poorest regions of the

world, such as Sub-Saharan Africa.

Children's nutritional status in India has stagnated in the last five years. Children under age three (the age group for which nutritional status data are available in NFHS-2) are less likely to be too short for their age today than they were seven years ago, which means chronic undernutrition is less widespread, but they are more likely to be too thin for their height, which means *acute undernutrition may actually have increased in recent years*.

The country's major programme aimed at promoting child health and nutrition – the Integrated Child Develop-





ment Service (ICDS) – continues to be plagued by problems of poor outreach and delivery. Among the 81 percent of children under six who are in areas covered by an *anganwadi*

centre, only one-third receive services of some kind from the centre and only 26% of children under 6 and preschool received any supplementary nutrition from an *anganwadi* centre. Thus, in the entire country, **only 20% of the children receive supplementary food from ICDS centres**. Even within this, in many areas, caste discrimination continues to be a barrier in expanding to vulnerable populations.

Undernutrition is clearly not limited to children. 55% of women and 24% of men are also anemic, thus showing that large sections of the Indian population is deprived of access to adequate and balanced nutrition. The data on prevalence of chronic malnutrition in later years is also an indication that childhood undernutrition translates into chronic malnutrition and stunting during adult life – especially among women.

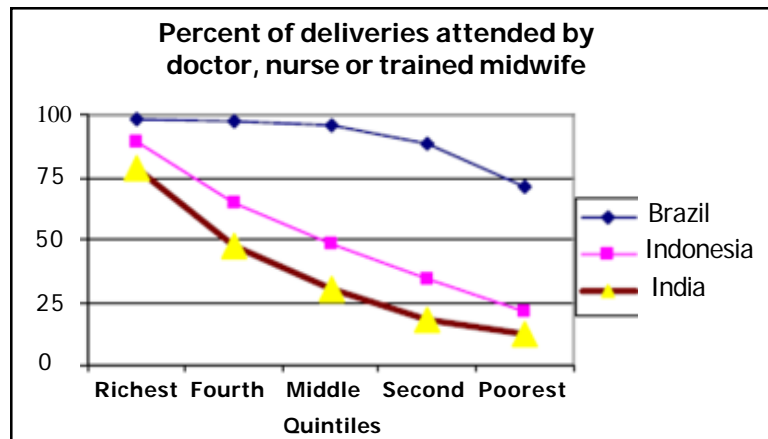
Women's Health: The Invisible Half of India's Population

Women are truly invisible to the public health system in the country. NFHS – 3 data shows that **just 17.3% of women have come in any contact with a health worker**. Just 17.9% of the Primary Health Centres (PHCs) in the country have the services of a lady doctor⁴ who can attend to women patients meaningfully. This neglect is reflected in the health status of women:

- ❖ The percentage of ever married women aged 15-49 years who are anemic increased to 56.2 % in 2005-06 from 51.8 % in 1998-99.
- ❖ The percentage of pregnant women aged 15-49 years who are anemic increased to 57.9 % in 2005-06 from 49.7 % in 1998-99.
- ❖ In 2005-06, 51.7 % deliveries were not conducted safely.⁵

Women's health, in many situations, is inextricably linked to violence that they face as a routine part of their lives. Among women age 15-49, 34

percent have ever experienced physical violence, and 9 percent have ever experienced sexual violence. In all, 35 percent of women in India have experienced physical or sexual violence, including 40 percent of ever-married women.



As a consequence of poor public facilities and low health status, in excess of 120,000 mothers die due to child birth related cases every year. The maternal mortality rate (no. of women dying of child birth related cases out of 100,000 deliveries) is still over 300, an unacceptably high figure. It is higher than the target of an MMR of less than 200 by the year 2000, set in the National Health Policy of 1983.

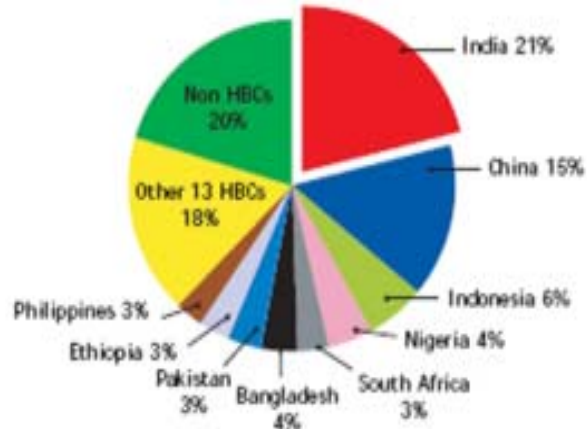
Unrelenting Burden of Communicable Diseases

India is experiencing a **resurgence of various communicable diseases** including Tuberculosis, Malaria, Chikungunya, Dengue, Encephalitis, Kala azar, Dengue and Leptospirosis. India still records the **highest number of deaths in the world every year from T.B. – about 3.7 lakh**, and 418 persons per 100,000 are estimated to be suffering from tuberculosis infection that needs medical treatment. 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. Environmental and social dislocations combined with weakening public health systems have contributed to this resurgence. Concurrently, the earlier system of surveillance has fallen into disarray, thereby compounding the problem.

HIV/AIDS has emerged as a major challenge to the health care system in the country. Recent estimates put the number of HIV positive cases in the country at 31 lakhs – the second highest in the world. In the last few years the rollout of treatment facilities for HIV/AIDS patients has led to some improvement in access to care. However a lot more needs to

**India is the highest TB burden country
accounting for one-fifth of the global incidence**

**Global Annual Incidence: 8.8 million
India Annual Incidence: 1.9 million**



Source: WHO 2007, Global Tuberculosis Control: Surveillance, Planning and Financing

be done and treatment access is still poor in many areas. A programme addressing the needs of orphans and vulnerable children affected by HIV/AIDS needs to be developed, given recent studies pointing to the spread of the epidemic among children. There is the emerging threat of resistance developing to first line drugs, thus needing the introduction of second line drugs that are -10 times more expensive. The issue is further compounded by the fact that many of the latter are being protected by patents, thus preventing the entry of cheaper generic versions. The AIDS Control programme is not integrated with the overall public health system. Unless such integration is done, the public health system will find it difficult to address the growing challenge of HIV/AIDS.

Diarrhea, dysentery, and acute respiratory infections 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.** It could be largely prevented by universal provision of safe drinking water and sanitary conditions, and most of these deaths can be prevented by timely administration of oral rehydration solution (ORS). However ORS is presently administered in only 33% of cases in urban areas and 24% in rural areas — a situation that has actually worsened in the last five years⁶. It may be mentioned here that only **28% of households in India have access to improved sanitation and about 200 million people still have no access to safe drinking water sources.**

Poor Infrastructure, Outreach and Coverage by Public Health System

India has **one of the most privatized health systems in the world**. For most households, the **private medical sector is the main source of health care** (70% of urban households and 63% of rural households). Only 5 percent of households report that they have any kind of insurance that covers at least one member of the household.

Source of Health Care ⁹								
Source	Residence		Wealth Index					
	Urban	Rural	Lowest	Second	Middle	4th	Highest	Total
Public	29.6	36.8	39.4	37.1	39.0	33.9	22.6	34.4
NGO/trust	0.5	0.3	0.3	0.3	0.3	0.5	0.5	0.4
Private	69.5	62.5	59.9	62.2	60.4	65.3	76.4	64.8
Other	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2

Source: NFHS-3

The state of the public health system forces people to access the unregulated private sector. As a consequence in excess of 80% of medical care costs are borne by people through “out of pocket” expenses. A recent survey showed that, in the case of ailments considered serious by respondents, **40 percent cited financial reasons for not taking recourse to treatment** ⁸.

As can be seen from the accompanying tables, the growth of infrastructure in the public health sector in rural areas has lagged behind demand. Between 2002 and 2007, there has been an increase of under 6% in the number of sub-centres, less than the increase in population in

Number of Sub-centres, PHCs & CHCs Functioning (at the end of VIIth, IXth and Xth Plan Periods)						
Year	Sub Centres	Change Over Previous Plan	PHCs	Change Over Previous Plan	CHCs	Change Over Previous Plan
2007	145272	5.79%	22370	(-) 2.20%	4045	32.45%
2002	137311	0.77%	22875	3.28%	3054	16.37%
1997	136258		22149		2633	

Source: Rural health Statistics of India, MOHFW, 2007

New Rural Health Infrastructure Creation Tenth Plan Targets and Achievements ¹⁰			
Type of Facility	Target	Achievement (March 2007)	Percent Achieved
Sub-Centre	8669	6630	76.48%
PHC	1714	224	13.07%
CHC	2565	938	36.57%
Source: Rural health Statistics of India, MOHFW, 2007			

this period. The number of Primary Health centres have actually gone down in this period by over 2%. While there has been a significant increase in the number of Community Health

centres, they are plagued by the problem of poor staffing and resources. Moreover, the **creation of new infrastructure has lagged well behind the targets set in the Tenth Plan period. Achievement of targets is 76% in the case of sub-centres but just 13% and 37% in the case of PHCs and CHCs.**

Even where sub-centres, PHCs and CHCs exist, their conditions are often abysmally poor. **50% of sub-centres, 24% of PHCs and 16% of CHCs function in rented or temporary premises.**¹¹ Following is an indication of gaps that exist in terms of infrastructure and personnel in the rural health system:

- ❖ Shortfall of ANMs and Male Health Workers in sub-centres is 12.6% and 53.4% respectively.
- ❖ 4711 Sub-Centres are listed as “functioning” without the services of both ANM and Health Worker Male
- ❖ 68.6% of PHCs are functioning with one or no doctor
- ❖ 807 PHCs have no doctor
- ❖ Shortfall of Lab Technicians and Pharmacists in PHCs is 41.1% and 17.1% respectively.
- ❖ Shortfall of Specialists in CHCs is 64.9%
- ❖ 1188 PHCs and 1647 PCS respectively are functioning without electric supply or without regular water supply

Knowledge and skills relating to standard public health and medicine of front line health personnel at CHCs, PHCs, Sub centres and villages is weak and their attitude towards service seekers is generally harsh. Much of this is a consequence of the manner in which the health system is administratively, financially and technically governed – extremely top down and hierarchical. While NRHM has brought in some reform, it is too little and requires massive restructuring.

Private Health Care and Essential Medicines are Increasingly Unaffordable

The private sector does not provide an escape route for the problems facing public health systems in poor countries. Evidence available shows that making public health services work is the only proven route to achieving universal and equitable health care. **Public provision of health care is not doomed to fail as some suggest, but making it work requires determined political leadership, adequate investment, evidence-based policies and popular support.** Existing private providers must be integrated into public health systems where possible and in some contexts that role could be partly extended. However to look at the private sector for the substantial expansion needed to achieve universal access would be to ignore the significant and proven risks of this approach and the evidence of what has worked in successful developing countries¹².

The Private Sector has grown by leaps and bounds, as a result of the inability of the public system to provide care. 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.** The recent trend towards promotion of Medical Tourism is creating a situation of internal brain drain where the best facilities and the best trained personnel in the country are moving to institutions that primarily provide care to foreign patients. As a consequence the **Indian tax-payer is subsidising the medical treatment of foreign medical tourists.**

- ❖ 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.
- ❖ Forty percent of hospitalised people are forced to borrow money or sell assets to cover expenses¹³.
- ❖ 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 care¹⁴!
- ❖ Irrational medical procedures are on the rise. According to just one study in a community in Chennai, 45% of all deliveries were performed by Caesarean operations, whereas the WHO has recommended that not more than 10-15% of deliveries would require Caesarean operations¹⁵.
- ❖ Due to irrational prescribing, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs.

- ❖ The pharmaceutical industry is rapidly growing, yet only 20-40% of the population can access all essential drugs that they require. There is a proliferation of brand names with over 80,000 brands marketed in India. 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. Yet there is reluctance to impose price controls on essential drugs, and at present the price control regime is almost entirely ineffective as most essential medicines are outside price control.
- ❖ The Amendment to the Indian Patent Act of in 2005 has created a new situation where new drugs are being patented by MNCs, and many new life saving drugs, including vital drugs needed for treatment of HIV/AIDS and cancers are being priced out of the reach of almost all Indians.

Health Financing: Inadequate and sub-critical

The recent remarkable growth of the private health sector in India has come at a time when public spending on health care at 0.9% of gross domestic product (GDP)¹⁶ is among the lowest in the world and ahead of only five countries—Burundi, Myanmar, Pakistan, Sudan, and Cambodia. This proportion has fallen from an already low 1.3% of GDP in 1991 when the economic reforms began. Yet India ranks among the top 20 of the world's countries in its private spending, at 4.2% of GDP. Employers pay for 9% of spending on private care, health insurance 5-10%, and 82% is from personal funds. As a result, more than 40% of all patients admitted to hospital have to borrow money or sell assets, including inherited property and farmland, to cover expenses, and 25% of farmers are driven below the poverty line by the costs of their medical care.¹⁷

Clearly, there is a need for a qualitative rise in public health expenditure. In recent years while there has been some increase in Central Allocation for Health, there has been a decline in the allocation by States. The latter is also a result of the squeeze on the finances of States due to financial reforms. As a consequence, the overall public expenditure on health has stagnated.

Broader Determinants of Health

Access to health care is only one of several determinants that impact on the health of individuals and communities. Education, gender, employment (or the lack of it), poverty, nutrition, etc. are all powerful determinants of health. In preparing a road map for a healthy India it is necessary to address these determinants and to develop an inter-sectoral approach towards policies that are designed to improve the health of the people. In addition, we detail below some important and determinants that are seldom addressed in the context of policies related to health.

Environmental and Occupational Health

The place we live in, the place we work in and the place we spend our leisure are crucial determinants of overall health. Poor regulatory norms regarding industrial hazards is resulting in India becoming a chosen destination for hazardous industries that are being relocated from developed countries. India has had the misfortune to be host to the worst industrial genocide in history – the Bhopal gas disaster. However, even today, regulation continues to be lax and hazardous wastes are known to contaminate the immediate environments of human habitation. In such situation the people most affected are the poor, both as workers in such industries and as people who are most exposed to the hazardous wastes. There is a need for regulatory policies to protect people from industrial hazards and to protect workers from occupation related health problems.

Displacement and Conflicts

Displacement affects a huge section of the Indian population today. The causes range from natural disasters like floods, drought, earthquake, tsunami, to political and ethnic conflicts in different parts of the country. The agrarian crisis has also become a major reason for migration of the rural poor. Most large developmental projects do not factor in the human cost of displacement, and those displaced are often required to live in sub-human conditions. Those most affected are the rural poor, dalits and adivasis, the latter constituting a bulk of those displaced.

The process of displacement alienates and dispossesses people from their cultural, social, political, economic and environmental resources and support systems. It intensifies poverty, and leads to social disorganisation and political unrest. The greatest burden of such displacement falls on populations that already feel the brunt of non-inclusive developmental programmes. These are communities which already have inordinately high mortality rates and suffer from communicable diseases such as malaria, TB and HIV/AIDS. These 'medical refugees' are off the map of either public health facilities or any national health programme.

Caste Based Discrimination

There is strong evidence regarding the adverse impact of caste discrimination on the health of dalits. The Infant Mortality Rate, Under 5 mortality Rate as well as the percent of malnourished is much higher among dalit communities. Factors determining the poor health status of dalits include: lack of access to resources and entitlements (especially natural resources like land); discrimination; social exclusion; lack of access to education and health care; and atrocities and violence.

In the above background, the Jan Swasthya Abhiyan proposes the following Peoples Health Manifesto. We appeal to all political parties to consider adopting it in their respective manifestos for the upcoming Lok Sabha Elections in the country in 2009.

Peoples Health Manifesto - 2009

Take effective measures to achieve the right to health, which includes the right not only to timely / appropriate quality health care but also to the underlying socio economic and environmental determinants of health.

- ❖ Food insecurity and malnutrition are particularly critical factors currently determining ill health. Serious attention needs to be paid to the current agricultural crisis. Public Distribution System (PDS) and all other schemes related to food security should be universalised with urgency.
- ❖ Ensure 100% availability of safe water without discrimination, in each village and habitation and 100% access to safe hygienic toilets in homes, institutions and public places (markets, streets, bus-stands, railway stations), along with adequate water supply and proper waste disposal system for sanitary waste.
- ❖ Ensure adequate and safe housing with legal entitlements; assure equal inheritance and ownership of land and property for women.
- ❖ There should be a moratorium on GM cropping and import of GM foods till health concerns are satisfied and the regulatory frameworks are in place.

Enactment of a National Health Act

Enact the National Health Act to guarantee the right to comprehensive, quality health care at public expense in relevant health institutions to all, where every one is entitled to the full range of guaranteed, free health services.

- ❖ The Act must ensure that all persons approaching all clinical establishments **including private establishments** would enjoy legally enshrined rights including the rights to information and records, display of rates as relevant, informed consent, confidentiality, non-discrimination, rational care according to minimum standards and management guidelines, and emergency medical care. It must restrict unethical and unlawful practices such as "cross practice", i.e. practice of one system of medicine by those trained in a different system.
- ❖ The Act must ensure the entitlements of the people to key health determinants including nutrition, clean drinking water and healthy environmental conditions.
- ❖ The Act must ensure systems and processes for community based monitoring and mechanisms for redressal at various levels towards the fulfillment of rights in both public and private settings.

To operationalise the right to comprehensive, quality health care for all as envisaged in the Act, the following policy measures will also have to be implemented:

- ❖ Substantial strengthening and expansion of primary as well as secondary, tertiary, rural and urban health facilities in public sector as models whose standards should be followed by the private sector.
- ❖ Regulation and standardization of structures and processes in the entire private medical sector. A progressively expanding proportion of private facilities providing standardised, rational care could be reimbursed through public funds at defined rates, within the framework of a Universal Healthcare Coverage Scheme.
- ❖ Universal Healthcare Coverage Scheme to include all sections of the people given the fact that any scheme targeted to the poor is implemented poorly. State's share of contribution should be 100% for resource-poor families. Rest of the population would contribute to begin with; this contribution will be progressively more as we go up the socio-economic ladder. But within 10 years, all Health Care expenses for all people to be financed by the State.
- ❖ As a key first step towards this Universal coverage, implement a Universal Social Health Insurance scheme as part of Social security for all unorganized and organised sector workers, which is mandatory and offers comprehensive health care coverage, covering all members, their families with a schedule covering all health conditions.
- ❖ Increase health care budget from current 1% of GDP to 3% within 5 years and to 5% in 10 years. This would increase the share of public funds in health-care expenditure from the current 20% to 60% in 5 years and to 100% in 10 years. Ensure increase at both the Center and State levels.

Rural Health Infrastructure and the National Rural Health Mission (NRHM)

- ❖ Ensure increased allocation and effective expenditure of funds for the NRHM. The NRHM had envisaged expenditure of Rupees 55000 crores per year by 2012 but for past 2-3 years it has stagnated at about Rupees 10000- 12000 crores per year.
- ❖ The NRHM needs to be true to its mandate of strengthening the public health system through improving infrastructure at all levels, ensuring adequate staffing, better supply systems and flexible financing.
- ❖ Take strict action to eradicate corruption in the entire public health system. Close systemic gaps that allow corruption to proliferate.

- ❖ Expansion of facilities must go hand in hand with substantial improvement in quality of care. This is particularly relevant to Janani Suraksha Yojana (JSY), in which context increased demand generated for institutional delivery has not resulted in commensurate increase in quality of services. In fact in a large number of instances there may be a deterioration as compared to home deliveries.
- ❖ Formulate a road map for the creation of 2.5 service providers per 1000 population as per the recommendation of the WHO by ensuring sufficiency of training institutions as well as increased sanctions of facilities and posts.
- ❖ The shortage of trained health personnel needs to be addressed by augmenting the capacity in the public sector to train all levels of health personnel – from health workers to doctors. At the same time, taking note of the effect on deterioration in ethics and standards of medical practice, all private medical colleges charging fees in excess of Government colleges should be closed down and the students should be absorbed in augmented capacities in the public sector.
- ❖ All health personnel including doctors, ANMs and health workers need to be provided promotional avenues, adequate remuneration and secure employment terms that are not based on short term contracts.
- ❖ Initiate massive transformation in the governance of health systems by introducing much greater decentralization of administrative, financial and technical decision making powers, and establishment of resource institutions at district and sub district levels for continuing knowledge and skills upgradation.
- ❖ Increase allocation for drugs per capita to least Rs. 50. Presently it is as low as Rs. 2 in some states. Set up systems and ensure their effective functioning for transparent procurement of drugs, equipment, etc.
- ❖ Declare national ban on any kind of private practice by all full time medical care providers in public health system whether employed by state or central government.
- ❖ All public – private partnerships (PPP) must be governed by a regulatory policy framework that protects in particular principles of equity.
- ❖ Abolish user fees with immediate effect.
- ❖ Ensure services for persons with special health needs - persons with disabilities, and those requiring mental health care within the NRHM.
- ❖ Ensure a strong political commitment to the process of Community monitoring and planning under the NRHM, envisaged as a revitalization of the Panchayati Raj system and increasing democracy in the health care system as well as the social determinants of health.

- ❖ Expedite setting up and implementation of the National Urban Health Mission (NUHM) with civil society consultation and participation.

Drugs / Medicines and Patents

- ❖ All States must immediately declare an essential drugs and consumables list and enforce the use of WHO prescribed list of medicines in generic forms.
- ❖ Withdraw all irrational and harmful medicines ensuring that medical care providers adhere to standard treatment procedures and do not prescribe unreasonable drugs, surgical and diagnostic procedures. Develop and implement an Ethical Code of marketing of medicines.
- ❖ All state governments must adopt procurement and distribution policies similar to what has been done by the Tamilnadu State Medical Services Corporation.
- ❖ Reduce prices of all essential medicines and keep them under strict price control. Withdraw excise duty from all essential medicines.
- ❖ Revive all public sector medicine and vaccine producing companies with no transfer of vaccine production to the private sector.
- ❖ Strict enforcement of Drugs & Cosmetics Act and withdraw amendment of Drugs and Cosmetics Act, 1940.
- ❖ Set up of an inter-ministerial mechanism with representation also from the Ministry of Health that examines all health related patent applications before they are granted, with a view to weighing the public health implications of a patent grant.
- ❖ Promote liberal use of the public health safeguards in the Indian Patent Act to promote access to medicines, including through issuance of compulsory licences
- ❖ Discontinue attempts to undermine public health safeguards in the patent act by linking the patent status of a medicine with the mechanism for issuing marketing approval by drug control authorities.

Gender and Health

- ❖ Abolish all coercive laws, policies and practices that violate the reproductive and democratic rights of women, including the two-child norm.
- ❖ Stop coercion in the use of contraception. Make user-controlled contraceptives available.
- ❖ Guarantee comprehensive, quality health services (preventive, promotive and curative) for women, that are accessible, accountable, irrespective of capacity to pay. Special provisions – resources and implementation- to be made to address health is-

sues specific to women. For example, access to safe abortion services

- ❖ Assure women of gender-specific health entitlements (maternity leave, abortion leave, sterilization leave, creches, toilets) in public and private employment. A national scheme for maternity entitlements in the informal sector, on the lines of the “Dr. Muthulakshmi Reddy Maternity Benefit Scheme” in Tamil Nadu (including cash support of Rs 1,000 per month for six months for care during pregnancy and after delivery), should be introduced.
- ❖ Register all deaths and initiate audits of all maternal deaths.
- ❖ Ensure safety, transparency and accountability in all clinical trials, and guarantee that the post-trial benefits of research are made available to women even from marginalized groups. Ensure disclosure of funding and of potential conflict-of-interest in all clinical trials, medical research and publications.
- ❖ Make mandatory the inclusion of women’s organizations and women’s health advocates on ethics committees, from national to local and institutional level.
- ❖ Regulate use of invasive reproductive technologies in the private sector, that covers surrogacy, genetic engineering, cloning and intensive ARTs.
- ❖ Recognise violence against women as a public health issue and ensure provision of necessary services. Ensure prosecution and conviction of violators of the Prevention of Domestic Violence against Women and Girls Act as also the PCPNDT Act.
- ❖ Include the topics of ‘Violence against women’ and ‘sexuality and gender’ as part medical and paramedical curricula to equip medical professionals deal in a sensitive manner with survivors of violence, including domestic violence. Train forensic experts on the social aspects of sexual assault and rape, collection and retention of proof in cases of individual or mass sexual violence.
- ❖ Repeal Section 377 of the Indian Penal Code, and other laws, policies and practices that discriminate on the basis of sexuality.

Child Health and Nutrition

- ❖ National policy on Child health and nutrition should be formulated with urgency. This must ensure policies and technical interventions follow the overall approach of decentralization, self-reliance and promotion of food security and local economies. A clear ‘no conflict of interest’ needs to be demonstrated by any agency that is allowed to work on child health and nutrition issues.
- ❖ A high-level overseeing mechanism (e.g. empowered steering committee along the lines of the NRHM) should be created to ensure convergence and accountability in the entire range of interventions concerned with child nutrition.

- ❖ Universalization with quality" should be the overarching goal for ICDS in the 11th Plan with adoption the two worker model.
- ❖ 10% of all Anganwadis be converted to Anganwadi-cum-crèches.
- ❖ Centre to retain full financial responsibility for the ICDS with no increase in the fiscal burden to the states.
- ❖ Infant and young child feeding counseling and support should be recognized as one of the core "services" both in ICDS and NRHM, with a clear budget head. Special sub-scheme to give appropriate supplementary nutrition to children in the age group 6 months to 3 years.
- ❖ A phased withdrawal and closure of the pulse polio programme and the reintegration of polio immunization into the Universal Immunization Programme.

References:

- ¹ National Family Health Survey-3
- ² National Family Health Survey-3
- ³ www.npsindia.org
- ⁴ Rural health Statistics of India, MOHFW, 2007
- ⁵ <http://wcd.nic.in/stat.pdf> (Ministry of Women and Child Development, 2007)
- ⁶ National Family Health Survey-3
- ⁷ National Family Health Survey-3
- ⁸ NSSO, Report No. 507: Morbidity, Health Care and the Condition of the Aged: Jan -June, 2004
- ⁹ Rural Health Statistics of India, MOHFW, 2007
- ¹⁰ *Ibid*
- ¹¹ *Ibid*
- ¹² Blind optimism, Oxfam briefing paper 125. Oxfam International 2009
- ¹³ National Sample Survey Organization. Department of Statistics.GOI.42nd and 52nd Round
- ¹⁴ Mahal A. www.worldbank.org
- ¹⁵ Pai M et al. A high rate of Cesarean sections in affluent section of Chennai, is it a cause for concern? *Nat Med J India, 1999, 12:156-158.*
- ¹⁶ WHO / NFHS 3 / National Health Profile 2007
- ¹⁷ The private health sector in India, Amit Sengupta and Samiran Nundy, *BMJ* 2005;331;1157-1158