THE ROLE OF CIVIL SOCIETY IN PROMOTING THE RIGHT TO HEALTH CARE IN INDIA: AN EXPLORATORY STUDY

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the Degree of

Master of Philosophy

Abnave Dipak Bajarang

Centre of Social Medicine and Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi – 110067
India

2011

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
New Delhi – 110067

Date: 25.07.2011

CERTIFICATE

This dissertation entitled, **"The Role of Civil Society in Promoting the Right to Health Care in India: An Exploratory Study"** is submitted in partial fulfillment of the requirements for the award of the degree of Master of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work

Abnave Dipak Bajarang

We recommended that this dissertation be placed before the examiners for evaluation

Prof. Rama Baru
(Chairperson)

Chairperson
Centre of Social Medicine & Community Health, SSS
Jawaharlal Nehru University
New Delhi-110067

Prof. Ritu Priya
(Supervisor)

Prof. RITU PRIYA MEHROTRA
Centre of Social Medicine
& Community Health, SSS
Jawaharlal Nehru University
New Delhi-110 67

Tel : (011) 26704420, 26717676, 26717557 Gram: JAYENU Fax: 91 (011) 26717586, 26704420

Contents

Annexure

Acknowledgement

My Mother had always wished a dream of "good education" for us. To fulfill this dream of giving us good education she had struggled a lot. My being student of JNU, was a great joy and matter of pride for her. 'Thanks' is not enough a word to express my gratitude to her. I would like to dedicate this dissertation to my mother for all the troubles that she took for my education.

In the middle of my struggle for getting higher education Archu has always been with me and lightened my burden with her love and affection. I would like to thank her for being with me those hardest moments of life and sharing my dream of "good education".

I would like to take this opportunity to acknowledge all those who have contributed in any way, shaped or form the completion of this dissertation. My dissertation would not have been possible without the guidance and the help of many individuals who were involved, in the preparation and completion of my M. Phil course.

When I got admission for M. Phil in JNU, I was worried about my language skill in English. But this centre of social medicine and community Health gave respect and space to express my thoughts and ideas about public health irrespective of language. First, I would like to be thankful of this centre.

The first and foremost, I offer my sincerest gratitude and heartfelt thanks to my supervisor Prof. Ritu Priya for her continuous guidance and support while writing my M. Phil dissertation with her patience, sincerity, encouragement, motivation, enthusiasm, and immense knowledge. Every feedback on chapter, write-up she gave from the bottom of her heart. That gave me encouragement to work. She knows my limitations but her cheerfulness nature constructs my hidden potential & gave confidence to work. I owe my supervisor everything, especially the painstaking evaluation of every sentence, critical and constructive comments and concrete suggestions.

I would like to convey my appreciation to all the faculty members and staff of Centre of Social Medicine and Community Health (CSMCH) for their being supportive and encouraging me during my entire M. Phil course. I would like to acknowledge and extend my heartfelt gratitude to Prof. Rama Baru for access of room no- 206 and computer lab

for late night study. I owe sincere thankfulness to JNU library, Academic staff college library and Documentation unit of CSMCH for the materials and the staff for support which made this dissertation possible. I also would like to express my gratefulness to University Grants Commission for granting me a financial assistance through Rajiv Gandhi National Fellowship.

Writing dissertation with group is a wonderful experience. This M. Phil dissertation writing moments gave acquaintanceships with new friends. I am grateful to Arathi, Shreejit for their valuable affectionate support in the hour of need and whose sincerity and help I will never forget. I would like to show my gratitude to my colleagues Daksha, Pravin, Panchi, Iqbal, Smitha, Kawshik, Shwetha, swapnali, who inspired and helped me a lot. I feel affectionate for friendliness of Aparana Arathi, Endranil being part of our group of "dissertation writers" also thanks for sharing fun, thoughts, food and memories while writing dissertation. The special thanks to Sudha and Urmi for warm and loving company during writing dissertation.

My heartiest thanks to Lakshumi for helped to write JNU entrance Exam and throughout two years encouragement and support in JNU.

I would extend my sincere gratitude to staff of SATHI- CEHAT Pune. I would also like to thank to convener and Moderator Jan Swasthya Abhiyan and Medico Friends Circle.

.... Dipak

Abbreviations

AGCA	:	Advisory Group on Community Action
ASHA	:	Accredited Social Health Activists
CBM	:	Community Based Monitoring
CEDAW	:	The Convention on Elimination of all the Forms of Discrimination Against Women
CEHAT	:	Centre for Enquiry into Health and Allied Themes
CHW	:	Community Health Worker
CPHC	:	Comprehensive Primary Health Care
CRC	:	The Convention on Rights of Child
CSDH	:	Commission on Social Determinants of Health
CSO	:	Civil Society Organisation
DANIDA	:	Danish International Development Agency
FMRAI	:	Federation of Medical Representatives Association of India
GATS	:	General Agreement on Trade in Services
GATT	:	General Agreement on Tariffs and Trade
GAVI	:	Global Alliance for Vaccines and Immunization
GOI	:	Government of India
HIS	:	Health Information Systems
ICCPR	:	The International Covenant on Civil and Political Rights
ICESR	:	The International Covenant of Economic, Social, and cultural Rights
IMF	:	International Monetary Fund
IPHS	:	Indian Public Health Standards
JSA	:	Jan Swasthya Abhiyan
MFC	:	Medico Friends Circle

MISA	:	Maintenance of Internal Security Act
MOHFW	:	Ministry of Health and Family Welfare
NAM	:	Non Aligned Movement
NDA	:	National Democratic Alliances
NGO	:	Non-Governmental Organisation
NHRC	:	National Human Right Commission
NHSRC	:	National Health Systems Resource Centre
NRHM	:	National Rural Health Mission
NWG	:	National working Group
OPEC	:	Organization of Petroleum Exporting Countries
PHA	:	People's Health Assembly
PHM	:	People Health Movement
PIL	:	Public Interest Litigation
PPP	:	Public-Private Partnership
PRHW	:	Peoples Rural Health Watch
RCH	:	Reproductive and Child Health Programme
		Rights
RKS	:	Rogi Kalyan Samitis
RTH	:	Right to Health
RTHC	:	Right to Health Care
RTI	:	Right to Information
SAP	:	Structural Adjustment Policies/ Programme
SIDA	:	Swedish International Development Cooperation Agency
SPHC	:	Selective Primary Health Care
TRIPS	:	Trade-Related Aspects of Intellectual Property Rights
UDHR	:	Universal Declaration of Human Rights
UN	:	United Nation
UPA	:	United Progressive Alliance
USA	:	United States of America
USAID	:	United States Agency for International Development
USSR	:	Union of Soviet Socialist Republics

WB	:	World Bank
WHO	:	World Health Organization
WTO	:	World Trade Organization

Chapter I

Introduction and Research Methodology

Chapter: I

Introduction and Research Methodology

Civil society and the Right to health discourse are both important phenomena in efforts to improve health conditions and access to health care. Their role has increased especially since the 1980s when the neo-liberal economic development policies started becoming effective. Civil society is currently being invoked as the prime mover of development in favour of the marginalised with highlighting of the limitations of the state in bringing about social change and transformation.

Under a welfare state, the fulfilment of social security includes ensured provision of conditions for improvement of health, including health care. The continuing gross disparities in health status and access to health care are violations of the rights of the deprived sections of society due to deep structural injustice within and beyond the health sector. In India, there has been a mixed development of health services just as of our economic system, with both a public and a private sector. However there have been tremendous changes in nature and the role of state and market after 1990, when neo-liberal policies were officially adopted in India. While on one hand there was the policy framework to cut back on the role of the state in provisioning of services and subsidies, on the other came a focus on the right to health care. The renewed focus of the right to development also resulted in human rights activism for health, advocated by WHO through various treaties, declarations, and covenants. Rights-based approaches highlighted the need to address policy and law beyond the health sector. These approaches were validated by WHO, which also engaged with developing a human rights tool. International treaty obligations increased the pressure on governments to provide adequate health services, and take other actions that improve public health. At about the same time the "rights based approach" was adopted by civil society organizations, NGOs and movement groups to claim the right to health for citizens from the state. Through this a new regime of civil society emerged in health which is advocating the UN framework right based advocacy approach. This was in the context of negative impacts of the structural adjustment policies on health and equity in access to health care.

Broad changes in the concept and nature of state and civil society can be seen from the policy and plan documents. For example the Seventh Five-Year plans 1985 to 1990, Ninth Plan 1997 to 2002 and the Tenth Plan 2002 to 2007 that emphasised on increasing the participation of Civil Society Organizations in planning and development. The government has stressed the need for the partnership with NGOs in crucial areas such as medical care and education.

The term civil society was originally coined to describe popular movements in Latin America that sought to counterbalance the power of oppressive governments on the one hand and exploitative international financial interests on the other. But it has expanded to include a variety of non-state actors, including formal organizations, informal networks and social movements. Since the end of the cold war particularly, non-governmental organizations (NGOs) have flourished and are increasingly recognized as critical actors in any democracy.[1]

Civil society has been looked at from divergent view points and perspectives but for the purpose of this research civil society refers to the arena of uncoerced collective action around shared interests, purposes and values in the context of the right to health. Civil society is a complex structure consisting of rights based individual and associational life, where the construction of a critical rational discourse based on the modes of social and political organization happens. Civil society has emerged as an important sphere in upholding democracy by virtue of its ability to interrogate the state, but the sphere itself is not devoid of the larger power structures which are concentrated in society. The sphere has to continuously reinvent itself so that it can negotiate with the state and the various hegemonising tendencies within its own sphere (Emirbayer & Sheller 1999).

Development characterizes the larger project of emancipation of the human civilization. It appears as an idea where the notion of 'good life' does matter and it addresses the wellbeing of populations. It can be seen as a process which expands the real freedoms which the people enjoy, but at the same time a historical analysis of the discourse comes up with diverse trajectories of growth and progress in the name of development

[1]International Alert women waging Peace (2004) Inclusive Security, Sustainable Peace: A Toolkit For Advocacy And Action, chapter on "Justice, Governance And Civil Society" pg – 48

(Burkett2003). The notion of development emerged during colonial times with manipulated categories whereby the colonised/newly independent, currently underdeveloped nations adopt the path of socio-economic and political change that requires following the routes which have been undertaken by the developed countries. With this, the underdeveloped nations are presented as entities 'out there' waiting for external assistance.

The development discourse historically has flourished in the domain of civil society and sometimes through the civil society itself. It has moved on from the intervention of the state and the market in this sphere to the sphere itself taking up the developmental role. Civil society necessarily does not have to be all the time against the state but remaining within the framework it can contribute to the process of development (Howell, 2006).

Civil society has been looked at from divergent view points and perspectives but for the purpose of this research civil society refers to the arena of uncoerced collective action around shared interests, purposes and values in context of right to health. The civil society exists as a mediating space between family and the state. It is a complex structure consisting of rights based individual, associational life, where the construction of a critical rational discourse based on the modes of social and political organization happens. Civil society has emerged as an important sphere in upholding democracy by virtue of its ability to interrogate the state, but the sphere itself is not devoid of the larger power structures which are concentrated in the society. The sphere has to continuously reinvent itself so that it can negotiate with the state and the various hegemonising tendencies within its own sphere (Emirbayer & Sheller 1999).

Development characterizes the larger project of emancipation of the human civilization. It appears as an idea where the notion of 'good life' does matter and it addresses the wellbeing of populations. It can be seen as a process which expands the real freedoms which the people enjoy, but at the same time a historical analysis of the discourse comes up with diverse trajectories of growth and progress in the name of development (Burkett 2003). The notion of development emerged during colonial times with manipulated categories whereby the colonised/newly independant, currently underdeveloped nations adopt the path of socio-economic and political change that requires following the routes

which have been undertaken by the developed countries. With this, the underdeveloped nations are presented as entities 'out there' waiting for external assistance.

The development discourse historically has flourished in the domain of civil society, and sometimes through the civil society itself. It has moved on from the intervention of the state and the market to the sphere itself taking up this role. Civil society necessarily does not have to be all the time against the state but remaining within the framework it can contribute to the process of development (Howell, 2006).

The discourses of civil society in India emerge with the conceptualization of modern society, and the present new manifestation of civil society came forth after fall of socialist countries (Chatterjee, 1997). It has taken over as the new propagator of development discourse. This has emerged out of a profound notion of dissatisfaction with the state in carrying out its developmentalist functions. The process of economic development has left behind many people and increased inequalities in the system. Even after fifty years of a democratic welfare system, inequalities still persist in India (Dreze, 2002). The inefficiency and unresponsiveness of the state vis-à-vis the citizens has generated a crisis of legitimacy for the state institution. Excessive bureaucratization and dominance of institutions of local governance by the rural elite resulted in exclusion of the common people from decision making. The entrenched socio-economic inequalities and divisiveness, so very characteristic of India, have on the one hand obstructed the realization of democratic aspirations of equality and equal opportunity to the unprivileged and on the other have resulted in a situation where the benefits of development have been appropriated by the dominant sections (ibid 2002).

In such a situation, where the citizens lack the resources and voice to raise their concerns, civil society initiatives claim to play a crucial role in bringing them into the public sphere so that their voice can be heard. Civil society is thus projected as replacing the state in its operations, but this notion is based on a limited understanding of the sphere itself. Since the boundaries for the functioning of civil society is provided by the state itself. So an understanding which looks at civil society independently from the state and market is flawed since classically too civil society has been looked along with the two spheres.

Civil society has been conceptualised as a space between state, market and people for claiming the rights of the people (Spurk, 2001).

India had a matured civil society during the British colonial period. This civil society fought for mainly two causes, one was political freedom and the other social change (Nilsen, 2007). In the Post independence period, in the early 1970s, the Nehruvian model of planned development resulted in widespread discontent among large sections of the population. To counter these growing discontents after the 1970s, a large number of Civil Society Organizations emerged as part of New Social Movements. Various networks emerged during this process. In the 1970-80s, the concept of civil society in India came into greater prominence in academic discourse. It has been seen as challenging the state and market authoritarianism, emerging as strong political opposition to governments. Shift occurred in the late 1980s in Indian political scenario. The reason for that can be seen as a lack of accountability and failure of the state agencies to follow the rules and orders in providing welfare to its citizens. The realization politics of welfare services gave rise to civil society organizations against the Indian welfare state. The reason of failure of welfare state in democratic India, ie the dominant social hieratical power structure, shifted into Indian political society and redistribution of wealth and power did not translate into hands of marginalized classes through the welfare mechanism (Aspalter 2003).

The larger socio-economic disparity also translated into health inequalities. To analyze causes of health inequalities and work towards substantive changes in the health system of India, the Medico Friend Circle (MFC) was formed in 1974 (Priya, 1986). This was a nation-wide group of socially conscious individuals interested in the health problems of people of India. This group has believed "that the existing system of health care is not geared towards the needs of the majority of the people: the poor. It requires fundamental changes. This would occur as a part of the total social transformation in the country, since the medical system is only a part of the total system". Review of literature shows that

MFC is one of the first civil society groups in India to give an alternative perspective (Ibid, 1986)[2].

Later, in the year 2000, the discontent due to failure of the goal of Alma Ata declaration gave emergence to the people's health movement. *Jan Swasthya Abhiyan* (JSA) emerged as the India chapter of the global Peoples Health Movement (PHM). JSA is a network of Civil Society organisations and social movements in the field of public health. JSA has been at the forefront in demanding Right to Health in India and putting forward Health as a basic fundamental human right. JSA had built various campaigns to fulfil this dream of equitable health care. From 2000, the earnest and conscientious campaign succeeded to the extent that the central government undertook the task of drafting a National Health Bill as did the Assam and Gujarat state governments. In contemporary times the right to health and health care discourse has been largely focused on universal access to health services and on the social determinants of health.

Underlying Justification for Right to Health:

Health is a state subject the constitutional and legal justification according to the directive principles of the Indian constitution. In the Indian constitution, Right to health is included in the right to life. Provision of health care has been given as a directive principle, and its various dimensions are placed under the State, central and concurrent lists. Ensuring provision of health care to the citizens, especially in life threatening emergency situations, has been established as a state responsibility by Supreme Court judgments. Therefore, there is an existing legal basis for insisting on the right to health and health care as an avenue for improving the conditions of life and wellbeing of the vast majority in India.

This study attempts to explore the role of the state and civil society in creating the right to health discourse since the end-1990s and its culmination in the right to health legislation. In this context, the present study would try to understand the changes in the nature and role of the civil society, and its relationship with the state in formulation of the right to health bill. It also makes an attempt to understand the debates and issues related to the

[2] Medico Friend Circle. Retrieved July 12, 2011, from http://www.mfcindia.org/

right to health campaigns, the nature of interventions and strategies and the content given to the right to health. In order to understand the role of civil society, the largest network that has been working in the country for the right to health, the People's Health Movement-India (*Jan Swasthya Abhiyan*) has been chosen as the case study.

Rationale of the Study

There is plenty of literature on both civil society and the right to health but it is found to be extremely limited when it comes to issues surrounding the inter-relation of the two, and the major segment of what exists comes from the Latin American context. Each one is a much used concept on its own, but connections underlying both have not been adequately researched and documented, especially for the Indian context. An interrogation of the claims of civil society as advocate for development in favour of the deprived has to be made to reach a critical understanding. It is in this context that the interconnections between the two concepts need to be analyzed and understood in relation to their historical trajectory and its impact on the public health discourse in India. This study assumes importance since there has been an active civil society on these issues in India and internationally in the past decade, and it is being increasingly involved in official policy and law making.

Objective of the Study

The main objective of this study is to explore the role of civil society in promoting the notion of right to health in India since the end-1990s. The general contention is that we can identify trends in the growth and approaches of civil society in the Indian context, by examining the various modes of social movements, non-party political formations and processes, grassroots movements, mass based organizations and social-action groups. Since these are a vast array, we will explore the role and debates of one civil society network that has been among the most active in promoting the right to health. The right to health care outcome will be examined through the legislation drafted at the national level and in two of the States after the network's advocacy campaign. Thereby, what it focuses on is the role of the network in advocating for and drafting of the health bills.

Specific Objectives of the Study

- To study the role of Civil Society in generation of the discourse on right to health in India through a case study of the right to health campaign of the Jan Swasthya Abhiyan (JSA)
- To explore the outcome of the Right to Health discourse in India in relation the form of the drafts of the National Health Bill 2009 (Draft), The Gujarat Public Health Act, 2008 (Draft) and The Assam Public Health Act, 2010.

Conceptualization

In this study the researcher is dealing with the two concepts, one is civil society and the second is rights. Definitions of both concepts remain ambiguous, complex and contested. Civil society has become an important actor and resource to health systems and people's health because of its ability to influence processes of radical social transformation, health systems design and public policy-making and in demanding from government compliance with human rights, accountability and responsiveness. There are different meanings and interpretations and, over time, different schools of thought have influenced theoretical debates and empirical research. These two conceptions are widely used in development paradigm according to the contexts. The nature of civil society and meaning of rights has diverse characterization with their pros and cons. In some context both concept has been used by dominant authoritarian regimes for disaffirmation. State and market control several civil society organizations through financial support. Some civil society groups are working in favour of government programmes and some dissent against approaches of the state. As against civil society, 'political society' is a term used for.

Rights are social claims which help individuals attain their best selves and help them; rights are claims against injustice and a demand for justice (Moser et al. 2001). Rights are guarantors of welfare gains, every winning of 'rights' likewise strengthens them (Patnaik 2010). Bosanquet defines "A right is a claim recognized by society and enforced by state". A right is an entitlement or justified claim to a certain kind of positive and negative treatment from others (Garrett, 2004). "Rights dominate modern understandings

of what actions are permissible and which institutions are just. Rights structure the form of governments, the content of laws, and the shape of morality as it is currently perceived. To accept a set of rights is to approve a distribution of freedom and authority and so to endorse a certain view of what may, must, and must not be done".[3] A right is based on principles of social justice. Rights and laws are uniquely intertwined both conceptually and politically. Social movements use the language of rights and all legal discourses are animated by weighing and competing rights (Menon, 2004). Various scholars have attempted to conceptualize the term civil society. Generally, Civil society is considered as a space between state and the market and is contributing in different ways in demanding rights of the people and civil society is an alliance or confederation of democracy (Khilnani 2002). This research applied the various elements in concept of civil society as the arena of collective action around shared interests, purposes and values engagement of different actors. It is distinct from the state, the family and the market. Civil society provides space for diverse interests to interact, where people come together to debate, discuss, associate, and seek to influence society. Civil society cannot be analyzed in isolation from the state they are interdependent. Although independence from the state is a defining feature, civil society interacts closely with the state and is shaped by the enabling environment defined by the state. Civil society in turn acts as a link between the state and citizens, promoting perspectives, accountability, voice and channeling of information to people. (Abiew and Keating 2004)

The term engagement of civil society refers to the participation of Jan Swasthya Abhiyan (JSA) representatives conducted through direct and indirect interactions with government, political society, community and external agencies to influence decision making or pursue common goals in context of right to health and health care campaign. In this regard the study has analyzed Jan Swasthya Abhiyan's engagement with the National Human Rights Commission (NHRC), programmatic engagement in National Rural Health Mission (NRHM), advocacy with political parties and engagement with the

[3] Rights, (Stanford Encyclopedia of Philosophy), access on 23 September, 2011, from http://plato.stanford.edu/entries/rights/.

international Commission on Social Determinants of Health (CSDH) process of preparing a civil society report.

The entire outcome of engagements has produced the National Health Bill 2009 (Draft), The Gujarat Public Health Act, 2008 (Draft) and The Assam Public Health Act, 2010. This study has documented the engagement process and outcome in the form of the right to health acts, as well as the debate related to both.

Research Methodology

This is an exploratory research study making use of qualitative research techniques. To contextualize this study, researcher will understand the global health movement initiatives in right to health and their relationship with Jan Swasthya Abhiyan (JSA) and it's Right to Health Care campaign. Main data source for the study has been documents of the JSA and the drafts of the three bills. Reports, minutes of the meetings, conference documents, studies etc. along with E-Mails of Jan Swasthya Abhiyan E-group from 2000 to 2010 has been used as data.

The data materials have been analysed by using the descriptive qualitative content analysis method. Content analysis is a social sciences research method.[4] It is a systematic research method for analyzing textual information in a standardized way that allows evaluators to make inferences about that information (Crowley and Delfico 1996). Numerous health researchers have been applying qualitative content analysis methods to analyze text data. This method concentrates on the characteristics of language as communication with attention to the content or contextual meaning of the text (Hsieh, 2005). This study's main propose of this method apply for text analysis aims at analyzing communication as realized by textual data. Data classify the key ideas in a written communication, such as a report, article. It is also known as a content analysis method use for analysing reports documents and article. Content analysis allows the researcher to test theoretical issues to enhance understanding of the data. Through content analysis, it is possible to distil words into fewer content-related categories. It is assumed that when

[4] Prasad, B. D. "Content Analysis, A method of Social Science Research". From Lal Das, D.K and Bhaskaran, V (eds.). (2008) Research methods for Social Work, New Delhi: Rawat, pp.173-193

classified into the same categories, words, phrases and the like share the same meaning (Elo and Kyngas 2008).

Advantages of Content Analysis: content analysis can not only help summarize the formal content of written material, it can also describe the attitudes or perceptions of the author of that material. The Researcher can extract relevant information more consistently than if they were reading the same documents only casually. Content analysis may be the sole method employed in a study, or when the findings from content analysis are not the main evidence in an evaluation, they can still be used to help corroborate other findings. (ibid 2008)

Application of Content Analysis in Health Research:

Use of Content analysis in various health researches in different context: It was first used as a method for analysing hymns, newspaper and magazine in nursing it is mostly used in psychiatry and public health studies (Elo and Kyngas 2008). Presently various studies have applying this method for diverse context such as, research on health inequalities in Latin America descriptive content analysis health research (Almeida-Filho et.al 2003). Chew and Eysenbach have used content analysis in 2009 content analysis of Tweets of Twitter during the 2009 H1N1 outbreak Pandemics (Chew and Eysenbach 2010). In 1993 'The Doctor Caregiver Relationship Managing the Care of Family Members with Alzheimer's Disease', this study of Morgan and Zhao to analyses data used content analysis method. Nichols & Chase used Content Analysis for Health Research Reported by the Daily Newspapers of Trinidad and Tobago (Nichols & Chase 2005) Graneheim and Lundman have Used Qualitative content analysis in nursing research (Graneheim and Lundman 2004). Other public health research studies have shown application of content analysis methods. Such as (Banna et al 2009), (Hoffman et al. 2011). These studies in have shown the validation and successful application of content analysis method in public health research.

Content analysis and Frame work of Analysis

Broad Frame work of Analysis developed and used to do content analysis of the Jan Swasthya Abhiyan documents and email discussions and the draft of National Health

Bill, Gujarat and Assam state public health bills in India. The content analysis of data has divided into two major sections.

One section of the analysis is focused on the civil society *(Jan Swasthya Abhiyan)* engagement with state. The major glance of analysis has what are content and methods used by civil society for right to health. The four kinds of engagement were analyses by use content analysis under Right to health and Health care debate.

1. Engagement with National Human Rights Commission
2. Engagement with political parties
3. Programmatic engagement with the National Rural Health Mission
4. International engagement in WHO's Commission on Social Determinants of Health

The second section of analysis has mainly centered to the draft of the National Health Bill, Gujarat and Assam state public health bills. The content analysis of the bills includes the framework of right to health, the implementation mechanism, redressal mechanisms. This is supplemented by the critiques and JSA debate on the Bills.

The writing of content analysis incorporates larger context of theme issues, the perspective and issues involved in that debate, content of debate, process, and strategy to dealing with issues as well as the resolution of the debates.

Ethical Considerations

1. The JSA secretariat was informed of the objectives of the study and consent sought for using the emails of the e-group. Other than that, all documents in the public domain were used for documenting the campaign and its processes.
2. The email correspondence was used to reconstruct the debate and issues of concern to members without revealing their identity.
3. Since much more triangulation and cross-checking is required for a firm analysis and conclusions, this has been limited to an exploratory study and only very broad and tentative conclusions have been reached.

Limitations of the Study

The conception of the right to health has been introduced in several spheres in India, HIV and AIDS being a prime example. This study deals only with the health bills and not with all the other dimensions where it is applicable.

There are several other civil society networks and organizations working in several different ways towards the same goal of right to health. Here, only one network has been selected, even though it is one of the most prominent ones in the past decade.

Also, many layers of the issues that have been explored in this study still require deeper investigation.

The constraints of time, and the researcher being in his phase of preliminary exploration of the subject, did not allow for more dimensions or forms of civil society to be included. What this study has shown, is therefore, that there is the need for a much larger and deeper study on the subject so as to reach a richer understanding of a phenomenon that is clearly influencing public health in the country.

Chapter Plan

This study is being presented in five chapters. This first chapter introduces the framework of the research, its rationale, and the larger questions which the research proposes to answer. It also lays down the method which the research has followed.

The second chapter is based on a literature review on civil society and right to health concepts used in research. It mainly deals with a general concept that marks divisions and co-ordinations in a conceptual scheme, such as origin of concept and definition, and issues involved in it. Different approaches in understanding both concepts.

The third chapter captures issues of civil society campaigns in health through a case study of Jan Swasthya Abhiyan's Right to Health Care campaign and its engagement with various actors in health system. It is contextualised with a section on the emergence of People's Health Movement in India for basic health rights. The fourth chapter deals with a critical review of The National Health Bill 2009 (Draft), The Gujarat Public Health Act,

2008 (Draft) and The Assam Public Health Bill, 2010. It has focused on the framework of right to health and implementation and monitoring issues in implementation of the legal right to health and health care.

The fifth chapter has incorporated a summary of the arguments, discussions and conclusions reached through this exploratory study.

Chapter - II

Theoretical Perspectives on Civil Society and Health

Chapter: II

Theoretical Perspectives on Civil Society and Health

Definition of Civil Society

There have been many different ways of defining what actually constitutes civil society and the state. This dissertation can only briefly highlight some of the key arguments developed behind conceptualization of civil society.

The term civil society owes its origins to the word 'civics', which derives from the Latin word 'civis' meaning citizen. Historical evidence shows that as a term civil society has a rich and long history of political philosophy. As a result, there is no consensus and universally accepted definition about civil society or organizations formed to represent civil society. The purpose of civil society activities is to achieve 'public good' through collective or individual action. Civil society also can be defined as "the domain of social organization within which voluntary associative relations are dominant" [5] Civil society as a space which is independent of the state and the market, has been an important agent though which people can express their voices, defend their rights and can resist the tyranny of governments (Al-Amin 2008).

Jayaram has described "Civil society as a mediating space between state and individual". This intermediate space between the state and individual can be constituted by formal and informal organizations or networks. "Civil society is usually defined as a space that allows people to make certain claims to rights that are not particular to any of the groups and communities; the very act of making these claims keeps the state from becoming authoritarian. Characteristic element of civil society is 'non state, non market actor' (Rajagopalan 2009) although Prof. T. K. Oommen pointed that an important dimension of civil society can be anti-state or pro-state (Oommen 2009). Common elements in the civil society discourse are a critique of state domination of public life, a preference for reform over revolution, and a strategy for political change based upon negotiations (Bratton 1994). Civil society is seen as a "*watchdog*" of democracy" (Das 2009).

[5] Warren, 1999: 14 in MD. AL-AMIN (2008)

The modern societies stand on four interdependent pillars: state, market, civil society and people. The state includes parliamentary institutions, courts, government bureaucracies and defence forces. The market refers to the arena of production, exchange and consumption of goods and services. Civil society consists of voluntary associations and a wide variety of non-government organizations and all the four are interconnected and civil society is a space between the state and market. Civil society organizations stand for social justice, freedom, equality, participatory planning, community decision-making, and realization of fundamental rights given by constitution (Oommen 2009). According to Beteille, civil society can be understood only in the context of the threefold relationship between (i) state, (ii) citizenship, and (iii) mediating institutions only in modern constitutional states (Beteille 1999). Civil society organizations can lobby for and mobilize people to demand the realization of fundamental rights from the government. But, ultimately, the realization of these rights depends largely on structures of governance (Chandhoke 2009). According to Giddens, civil society is the realm of activity which lies between the state and the market, including the family, schools, community associations and non-economic institutions (Giddens 2006). It represents a sphere outside state control and which gives maximum scope for individual freedom and self determination (Joseph 2002).

Carolyn M. Elliott notes that civil society "has assumed mythic proportions as a tool of the social imagination, an ideological construct for a good society" (Jayram 2005). Legal recognition and protection of the natural rights of individuals transforms a political society into a civil society" (Beteille 1999).

The most applied definition in social science academia is the London School of Economics, Centre for Civil Society's working definition, according to them.

> *"Civil society refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality,*

autonomy and power. Civil societies are often populated by organizations such as registered charities, development non-governmental organizations, community groups, women's organizations, faith-based organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups" [6]

According to Alain Touraine, "civil society is the locus of the "light side" of collective action- of social movements. Indeed, they rise and fall together: both require a certain authority from the state to exist; both can be crushed by a totalitarian state. Yet social movements do not target the state - they involve confrontations between social, civil adversaries within and over the structures of civil society. Civil society then is seen in action terms as the domain of struggles, public spaces, and political processes" (Touraine 1981). In support of this line of argument, J. L. Cohen has also argued that " *the actions of these kinds of movement mainly,* struggles in the name of authority, plurality, and difference, without, however, renouncing the formal egalitarian principles of modern civil society or the universalistic principles of the formally democratic state. *Specifically they are intended to attain* more democracy on local or functional levels, new democratic forms of representation, or direct participation, and are seen as dependent upon existing central institutions (parliaments, legality) for conflict mediation and for the representation of the unorganized." (Cohen 1985)

Jan Aart Scholte's definition of civil society builds on the concept presented above. It identifies civil society as non-official, non-governmental, and not the market. Activities are considered to be part of civil society when they involve a deliberate attempt from outside the state and the market; in some other organized fashion to shape politics, norms and deeper social structures. NGOs are one part of civil society; they are characterized by their non-profit status and, in some cases, a value-based orientation or a cadre of volunteers carrying out the organizations' mandates (Alqadhafi 2007).

The debate around concept of civil society is a three-way understanding, as one associational life, second as good society, and as public sphere and following theoretical

[6] "What is civil society?" Centre for Civil Society, Philippine Normal University. 2004-03-01. Retrieved 2006-10-30.

proposal on this concept, civil society is three things simultaneously: collective action through the associational fabric; creative action in providing proposals and consensus that take us away from formal contemporary politics; and thirdly, the promotion of values-based actions that can act as alternatives to the individualism and extreme consumerism in our current societies. In democracy, these aspects need a context of debate and communication situated in the public sphere, which is an important part of what civil society is. It is in this sense, a concept of civil society that can allow us to continue promoting alternatives for social change that lead not only to more democratic and participative societies. (Banon 2006) Civil society is the domain of social organization within which voluntary associative relations are dominant.

Theoretical Concepts and Civil Society

The theoretical and conceptual character of civil society has been contested by intellectuals and philosophers. The term has found prominence through the project of modernity which has sought to delineate the boundaries separating the society and the state. It emerged at a particular historical moment when theorists felt that, the society had increasingly become capable of organizing itself without the specific direction of state power; it also emerged to limit the state power in certain cases. (Taylor, 1989)

Civil society has undergone transitions across different periods in history of societies. It has shown a shift from the traditional to modern in contemporary times. The understanding can also be located tracing it back to the Greek civilization, to the conception of the individual as *zoon politikon* or essentially a political entity where individuals realized their true selves by taking part directly in the affairs of the state, thus emphasizing no difference between the 'social' and the 'political'. This formulation seems to be contested in the work of Charles Taylor for it appears in the Greek *Polis*. (Taylor, 1989)

Till the onset of 18th century the concept was used being of equal extent with political society used as *societas civilis* by Cicero and *koinonia politik* of Aristotle. The evolution of civil society says Krishna Kumar

> *"..... classically expressed in the Athenian polis or the Roman republic, a social order of citizenship, one where men (rarely women) regulate their relation-ships and settle their disputes according to a system of laws; where' civility' reigns, and citizens take an active part in public life."* (Kumar 1993:376)

In this conception of civil society, one sees the notion of the sphere as a regulator of extra-societal influences but these can be considered as the sphere where ideas of enlightenment were born. The idea itself took an epistemic shift after this to find its roots in the work of the social contract theorists wherein the notion of society and that of the state acquire prominence in moving away from the control of the church. Civil society to these theorists was a notion used interchangeably with political society. (ibid 1993)

The project of civil society thus has to fight against both internal domination within the sphere and external domination of the state and the market. So conflict and not consensus becomes the guiding principle for civil society. As per the moral and ideal norms for civil society, it stands for justice (Flybjerg, 1998: 229). But civil society rather than becoming a site for contestations in the western discourse itself becomes mediated by the state structure acquired legitimacy. It presents itself as a sphere that presents as an ideal for the generation of the 'ethical good life' for societies. The notion of civil society was supposed to exist only in the western sphere. The power of civil society provided the basis for the larger civilizing mission of the west. It tried to invoke structures based on the notions of scientific rationality and enlightenment. (Taylor, 1989)

The concept of civil society was first introduced in the modern times by John Locke. He viewed civil society as a community, which is non-political, formed by the people as part of their social life, in order to protect the individual's rights and property from state's arbitrary interventions (Chandhoke 1995). Locke imagined the civil society against that of the state of nature but for him the individual in the state of nature was not violent. His conception of civil society was pre-political not pre-social, but in the absence of any regulatory authority. The civil society thus set up by contract ensured freedom, security of life of person and that of property. So in the Lockean spirit while the society was natural but for it to be civil it had to be mediated. In this notion we see embedded the

values of individualism. Individual emerges as a bearer of rights who requires a sovereign to protect the same but at the same time they have the right to overthrow the same political structure i.e. the sovereign which binds them. It establishes society to what Charles Taylor calls 'extra-political reality' where

> *"the people have an identity, they have purposes, even (one might say) a will, outside of any political structure. In the name of this identity, following this will, they have the right to make and unmake these structures"* (Taylor, 1989: 56).

This concept was further developed by Charles Montesquieu, (1689-1755) who distinguished between political society and civil society, as part of elaborating his model of separation of powers. According to his concept, political society regulates the relationship between citizens and government and civil society regulates the relationship between citizens. During the elaboration of his concept, rather than presenting the contrast between political society and civil society, he was focusing more on a balance between the central authority and societal networks. In his view, the central authority (monarchy) must be controlled by the rule of law and can be determined by the countervailing power of independent organisations that operate inside and outside the political structure (Merkel and Lauth 1998:5).

The Hegelian Conception of Civil Society

The Hegelian conception of civil society arises out of his basic understanding of rights, morality and rationality, the three triads of any system which are manifested in various ways through the family, civil society and the state. Civil society thus becomes the ethical historical reality. In philosophizing, Hegel moves on from the abstract to the most concrete ending up with a picture of the state. As Mahajan puts it thoroughly:

> *"Acknowledging the primacy of the subjective particular, Hegel maintains that the universal (embodied in law) must emerge from self-will. Indeed for Hegel the universal law represents 'reflective' or 'self-conscious' will"* (Mahajan, 1999: 171).

Hegel describes that; individual freedom can only be reached through a collective freedom for all who are a part of the sphere. Civil society is the sphere where the "subjective and the objective coexist in harmony" (ibid 1999), through a mutual recognition of rights of every individual. Individuals recognize their individuality only by being part of the civil society through the process of production and exchange. The person, by being part of this sphere, realizes that one can really lead to the satisfaction of one's needs by being part of the collaborative process, through the ever widening system of division of labour and exchange. The individuals' wants are refined and cultivated in this society, and he learns to produce, within his specialty, not just for himself but for the world market (Stillman, 1980: 633). There seems to be a movement of man from being individualistic as in the classical framework to one where the conception moves to the construction of a community as an ethical entity or as Stillman puts it:

> *"Through participation in civil society, then, the individual is acculturated and cultivates himself to the intellectual, universal, and objective"* (Stillman, 1980: 633).

The civil society is a domain where the particularities of one individual meets that of the other and so it should be mediated by certain morality of the larger good that is universality, otherwise it will destroy the ethical life and thus would lead to the destruction of the civil society itself. So the civil society is thus an important moment in the transition from the family as the mode of social organization to the state as the supreme and the final form of such organization. Civil society, though a transcendental stage, cannot be left on its own but has to be consciously guided and organized. (ibid)

Control in the civil society is brought about by the division of the society into classes. An individual through an occupation and birth is a member of a class and it is the membership of a class that makes the individual conscious of common interest. These are the means of reconciliation of the universal and particular. These classes supervise the exercise of local power at the local level simultaneously working as a representational device of the political structures. Social classes, estates and corporations provide socialization convincing the individual that his salvation lies in associating with others. Through the articulation of laws, the knowledge of legal rights and other abstract rights is

sought to be brought to the society which has to be protected from getting appropriated by particularistic identities through the judiciary system and the court of law (ibid). The apparent contradiction in the Hegelian thought appears to take real form as analysed by Neera Chandhoke:

> *"If civil society is a sphere of conflict between individuals and the historic mission of the state is to overcome the conflict then the non-participation of the working class in civil and political society makes the realization of ethical life in state impossible"* (Chandhoke, 1995:132)

Hegel brought modern liberal understanding of civil society. He viewed civil society as a form of market society which in turn opposes the institutions of modern nation state. He analysed the particular point of emergence of civil society as a part of the capitalistic system. According to him, civil society is a separate realm and its ultimate aim is the satisfaction of individual interests and private property and hence anti-state. He is of the opinion that being capitalistic in nature, civil society itself will be a site of inequalities which will ultimately lead to conflicts and contradictions within the system. As he considers nation state as the most ethical form regarding the society, the nation state has a vital role to play regarding the maintenance of moral order in society: the constant surveillance of civil societies. So, he viewed the modern nation state as completely responsible for invigilating and correcting the positions of civil society.

The Marxists Framework and Civil Society

The Marxists framework explained civil society through the approaches of classical political economy. Through this theoretical framework he analyzed the shifting trajectories of capitalism. The society evolves through the development of forces of production and with it emerge new social and production relations. Civil society appears at a particular historical juncture with the development of capitalism. The classical political economists replaced the belief that society was held together by the state with the idea of society as a self-regulating entity. Civil society was thus seen as an outcome of historical formation and evolution. Civil society thus becomes a realm of suppression, oppression and alienation. Basing itself on the ideas of class, civil society marginalizes

those very workers who made this society possible in the very first place. Civil society does not follow substantive notions of freedom for the excluded, marginalized and oppressed and it emerges as the sphere where '*the powerlessness of the individual in production relations is rendered unintelligible by the empty political rhetoric of equality and freedom*' (Chandhoke, 1995)

Tensions in this sphere are not resolved by the intervention of the state since the foundations of the state, which is part of the superstructure, lies in the base which is economic spaces found in the civil society. Political society and the state then are the representatives of the interests of the bourgeoisie. In Marx's words

> "*the unsocial nature of civil life, of private property, trade, industry and the mutual plundering of different civil groups....this debasement, this slavery of civil society is the natural foundation on which the modern state rests*"(Femia, 2001:136). [7]

While agreeing on the capitalistic nature of civil society, Karl Marx considered civil society as the base where productive forces and social relations are taking place. According to him, both state and civil society represents the interests of the bourgeoisie. Thus Marx contested the positive role of state put forth by Hegel. He took the position that both civil society and state are part of the bourgeoisie and should be thrown out. He categorized society into two parts, the bourgeoisie (property owning) and proletariat (working class). The emancipation of social and economic exploitation by the bourgeois society, can be resolved through continued class struggle in the sphere of civil society. The supporting argument of Neera Chandhoke supports this argument, that though civil society represents the domain of the bourgeoisie, but by virtue of the socialization that it provides to the working class, it can equally be the site where the unprivileged classes can fight for social and economic emancipation. Having belied its promises of self-determination, self-realization and freedom, civility within the sphere is then restored through revolutionary transformation (Chandhoke, 1995).

[7] Marx in Femia, J(2001), pp. 136.

Gramsci and Civil Society

Gramsci's notion of civil society, though an abstraction out of Marxist thought, takes it to a different level altogether. It is based through the understanding of hegemony whereby the political and civil societies are not different entities but part of the same state apparatus.

In the Gramscian analysis, civil society appears to be the sphere whereby the psyche is being oriented and consent being manufactured through different cultural, educational and other institutions like the media. The production of consent is done through the process of hegemonisation of the whole sphere and this is done through the use of symbols and mythologies, institutions and practices. Hegemony provides moral and intellectual leadership to plural and dispersed practices in the civil society. Hegemony appears as the organizational principle which both organizes and provides unity. It provides the moral and intellectual leadership of the intellectual class and forges the consent for their domination. Hegemony is not a onetime process but a process through which the state re-enacts and modifies its project of domination by constantly referring to the events in the civil society (Jayaram, 2005).

Civil society being a space where the policies of the state find acceptance but it equally can be a sphere where the state policies and the consent that it manufactures can be questioned.

> *"....are like the trench systems of modern warfare. In war it would sometimes happen that a fierce artillery attack seemed to have destroyed the enemy's entire defensive system, whereas in fact it had only destroyed the outer perimeter, and at the moment of their advance and attack the assailants would find themselves confronted by a line of defence which was still effective. The same thing happens in politics."* (Femia, 2001:140)[8]

The overthrow of the bourgeois power has then to be undertaken at different levels since the last trenches of the capitalist order have to be overthrown to establish the hegemony of the working class. The concept of hegemony for the working class is of an educative

[8] Gramsci cited in Femia,J(2001), pp. 140.

nature where it teaches them to work and cooperate together for the larger interests of all. The state rather than withering away will be a sphere where the political and the civil society will merge rather than remaining as separate autonomous entity.

Even though Gramsci also considered civil society as part of the capitalistic system, which contributes to the cultural and ideological capital required for the survival of the hegemony of capitalism, he never viewed it as a problem in itself. Rather he considered it as space for problem solving, a public room which has a potentially oppositional role. As civil society is constituted of a wide range of organisations and ideologies that both challenge and uphold the existing order, it is a space where social consensus is formed. Gramsci was focusing more on using this as a space to influence the formation of social consensus. (ibid)

Alexander Tocqueville contested Hegel and defined the role of both political societies and civil societies. In the course of the development of the concept of civil society, Tocqueville emphasized the role of independent associations as civil society. According to his concept, these are the schools which are actually creating and expanding the democratic space in the society. Democratic thinking, democratic attitudes and democratic behaviour are inculcated in the individuals as a result of their functioning and that can lead to the protection of individual rights from the intervention of authoritarian regimes and tyrannical majorities in society. He was viewing these independent associations as capable of promoting civil virtues like tolerance, acceptance, honesty and trust in civic individuals. (Putnam 2000:19-26).

The term civic individuals further elaborated by Putnam in context of social capital—social networks, a rich associational life and the norms of reciprocity and trustworthiness associated with social capital as the core element of civil society, affirming that the characteristics of civil society and civic life affect the health of democracy and the performance of social institutions (Putnam 1993; Putnam 2002).

The limitations of Civil Society have been described by Neera Chandhoke as; the existence of civil society is essential but not sufficient precondition for the existence of democracy. The presence of civil society is a crucial but not adequate precondition for

ensuring state accountability. Inactive civil society leads to unresponsive state. If state is self-conscious then there is no need for civil society. The question she asks -Is civil society representative of all sections in a hierarchical society like India (chandhoke 1995)?

Civil Society in Indian Context

The following sections will explore the various socio-economic factors which were the main contributing factors for the civil societal intervention in the mid 1970s in India. This is a modest attempt to critically appraise the role of civil society in contemporary debate in India.

Nation Building Phase and Civil society

There were no major stirrings in the civil society space for almost a decade and a half after independence due to what is elusively called the phase of 'nation-building'. To understand the current Indian discourse on civil society, it is imperative to first understand the Indian experience with democracy. Indian democracy was influenced by British ruler during the colonial period, "Democracy is not defined by a separation of powers, but by the nature of the links between civil society, political society, and the state." [9] As Chandoke pointed out the conscientious of state is depending upon matured civil society. (ibid 1995)

The hopes that arose among the people of India during the colonial struggle were really high and people were looking forward to the actualization of their dream of an "independent India" So, in the first decades of post- independent India, we can rarely identify any civil society movements even though there was a matured form of civil society which led the struggle for nation liberation. Character of civil society leadership in India, it was mostly pointed out, was the western educated, upper caste, upper-class freedom fighters, who later became the engineers of the nation building process and

[9] Ivan Marquez (2001), " What is Democracy? by Alain Tourine Westview Press, Boulder,1997, Book review of Published in *International Journal of Critical and Democratic Theory*, Volume 7, Issue 3, page 443-452

failed to identify the dreams of the common people who were actively participating in the freedom struggle [10].

India adopted capitalistic and socialistic mixed development model approach for development planning. These two models have their special characteristics which influenced the strategy and position of state and civil society. Capitalist democracies model had evolved gradually on the principle of separation between state, market, and civil society. In contrast, socialist states model functioned on the institutional principle of fusion of the state, market and civil society. India as a welfare state has prime responsibility to provide basic amenities for its citizen. Role of the civil society in the welfare state is to make the state accountable towards people and mobilize people to get basic rights (Oommen 2009).

The project of nation building envisioned under the leadership of Mr. Jawaharlal Nehru was to build a modern and prosperous nation under the principles of secularism, democratic socialism and central planning. The objective of this process was to build up for political stability and self reliant economic power. The Nehruvian vision of development model was largely in favour of capitalistic development and it sidelined other concerns regarding social inequality. This model was not even satisfying the middles class Indians. The discontent among the people was getting more visible through the strengthening of regional identity formation. The 1950's witnessed the formation of linguistic states due to the pressure from the local capitalists who were not benefitting from the new government. Even though India was supposed be an agricultural nation, the governments sidelining of the agricultural field in favour of industrial development created discontent among the agricultural community (especially rural people) and the Green Revolution was the result of their protests. The Green Revolution was in favour of the people regarding subsidies and price guarantees while the slow growth rate still remained as a problem.

[10] Hemanta Kumar Adlakha, "Issues and Themes in the Civil Society Discourse," in *Fifty Years of India and China Crossing a Bridge of Dreams*, ed. G. P. Deshpande and Alka Acharya (New Delhi: Tulika, 2001): 177.

The economic model provided by the Nehru was highly in favour of a particular class and the hopes of the poor about the independence began to deteriorate. It gave way to the flaring up of nationwide protests among the people and the State also began to acquire monopolistic nature while suppressing these protests. In the 1970s a large number of protest movements and civil society organizations started interrogating the development goals as they diluted, if not abandoned, the thrust of distributive justice. Some of them criticized the state-initiated 'destructive development' leading to a ravaging of the ecology and argued for sustainable development. Prominent among civil society actors were women, students, *dalits*, *adivasis*, religious minorities, rural poor, urban slum-dwellers, and ecologists. They heralded a new beginning and manifested a new stirring in the emerging civil society. However, only a few were explicitly anti-state; quite a number only wanted the state to adhere to the constitutional vision.

1970s: A Period of Discontent and Rise of Civil Society

The discontent against the state among the various states of dispossessed society gained momentum which led to the urgency of action. The J.P. Movement which emerged during this period and called for a total revolution was a result of the feeling of such an urgency of action. This movement was a new dynamics in the history of post independent India as it challenged the democratic state for not being accountable to its citizen.

The up-surging discontent and protests from the people made the government of the time afraid of its aftermaths and it took a drastic turn. Declaration of the National Emergency was its result. That was a move which was completely against the democratic spirit and the amendments in the Maintenance of Internal Security Act [MISA] revealed the authoritarian nature of the state. The rights of the people were indiscriminately violated through the use of preventive detention etc, and both the common people and the middle class citizens realized that the state is not granting the constitutional rights and the judiciary is not providing any protection of their rights. All these factors contributed to the upcoming of Janata Party into the power in 1977. Thus the emergency and the restoration of democracy redefined and extended the scope of civil society.

If we look at the evolution of civil society in India, emergency and the related repercussions mark a major milestone. Until then, the civil rights movements were confined to issues like suppression of Naxals. The socio-political conditions related to Emergency invigorated the civil rights movements, and brought issues like democracy, citizenship and constitutional protection of fundamental rights into public debate. Various civil rights organizations for democratic rights were formed during this post emergency phase.

The response of state about this discontent was incorporation of civil society in development programmes, clearly seen in to seventh five years plan. These strategies make diversion of civil society's voice into one of co-option by the state (Oommen 2009). There are a growing number of groups that have begun to focus on 'watching' government, analyzing its performance, and advocating for social justice measures and to ensure people's participation in implementing its policies and programmes.

1980s: The Era of New Social Movements

The new social movements are "the main route to shifting political action in civil society from the current condition of mainly isolated, local initiatives, easily ignored by the power structure and vulnerable to manipulation and co-option. The ultimate objective of these many diverse movements must be embedding civil society in governance systems worldwide."[11]

The emergence of grassroots politics was a significant aspect regarding the JP movement and it paved the way for various social movements. Movements ranging from civil liberties, idea of ecology, rights of women, and Dalit identity were emerging during the 1980's. They were actually developing a space to negotiate with the government for their various demands. These movements were looking at the issues like poverty and oppression from a new perspective which was missing from the earlier class based movements. It was actually questioning the developmental paradigm and democratic

[11] Michael Carley and Harry Smith, "Civil Society and New Social Movements," in *Urban Development and Civil Society: The role of Communities in Sustainable Cities,* ed. Michael Carley and others, (London: Earthscan Publications Limited, 2001), 194.

culture of India. Thus, women's rights, ecological degradation etc. became the new concerns of the movements. In the field of health, several new community health initiatives emerged. These, together with a large number of medicos and non-medicos formed the network Medico Friends Circle (MFC). It was a group of medical professionals and social activists who were concerned about making structural changes in the Indian health system. This was probably the first civil society network in health in India. The perspective of MFC had pro-public health principles[12].

Analysis of this era by Rajani Kothari reveals to make point of failure of welfare measures and inequitable development resulted to formation of anti-state through various groups. She called as the role of *defunctive governmental apparatus with the grassroots initiatives and non-political formations*. What she saw as a real alternative strategy was a coalition of the political and non-political formations. At the same time, he informs us that "this process will lead to the direct involvement of people in both non-party and the party political spaces, and an organic conception of an autonomous grassroots politics will take place instead of a derivative of elite politics." [13]

After 1990s: Mode of Transaction in Civil Society

The 1990s saw a significant rise in the location of international Civil Society Organisations in India. International Civil Society Organisations and networks have placed global issues on the international agenda, successfully launched international campaigns and partnered in key international conferences and consultative processes International Civil Society Organisations have also made efforts to network with domestic organizations, to advocate for development issues and present alternatives to official government positions. Their involvement in the UN system has been institutionalized and continues to expand and evolve. The nature and impact of this civil society however, is debated. Some see it as a reflection of globalization processes and likely to improve global governance by promoting debate and bridging societal divides. While critics question their legitimacy and claims that such organizations are

[12] Medico Friend Circle. Retrieved September 17, 2011, from http://www.mfcindia.org

[13] Rajni Kothari, *Rethinking Democracy* (New Delhi: Orient Longman Private Limited, 2005), 51-52.

representative of international civil society (Anderson and Rieff 2004). In the global context, NGOs are a subset of civil society and represent a growing sector. Between 1990 and 1999, the number of international NGOs rose from 6,000 to 29,000. They have become increasingly significant actors in international development. NGOs engage in a wide array of activities, including undertaking research, implementing projects, advocating and raising public and political awareness about numerous issues. Many NGOs perform all of these activities, using research to develop programs and support advocacy. [14]

Role of Civil Society in Health

Civil Society has always been a prominent actor in shaping health policies, health outcomes and actions around health. This has been happening in a number of ways through articulation of needs and demands. Demands take an organised form of action through articulation of alternatives and building of models by civil society. The engagements by Civil Society's actions are linked to the existing economic and political realities. Thus, the actions of civil society organizations and movements are also informed by different historical circumstances. Such actions may vary, depending not only on circumstances but also on the nature of the Civil Society organisation involvement. However, there are in particular period's tendencies of Civil Society action and reaction towards the prevailing dominant paradigm. For example if we take the dominant paradigm in the current global context as the ideology of neoliberalism, then we also see that much of Civil Society action is located in this paradigm, whether supportive or antagonistic to it. Analysis of this context has centred on the role of the state in the creation and maintenance of civil society. A libertarian position sees the development of civil society as a means of "rolling back the state." The state is seen to interfere in the development of civil society by restricting the freedom of individuals. By contrast Román and Tovar see a central role of the state as advancing the development of civil society through the provision of state-funded structures to support and nurture it. Related issue is the question whether economic developments promote healthy civil

[14] International Alert women waging Peace (2004) Inclusive Security, Sustainable Peace: A Toolkit For Advocacy And Action, chapter on "Justice, Governance And Civil Society" pg – 48

society or does civil society promote a healthy economy (Román and Tovar 2007). With the rise of neo-liberal health sector reforms, both government and civil society activities have been grounded in market relationships. Civil society organizations have been used as instruments of economic adjustment programs, privatization of health services, and as promoters of market values and consumerist behaviours (Ford et.al 2004).

The role of civil society in health sector is seen as service delivery actors. Recently The World Health Organisation has taking involvement and promotion of civil society organisation through Civil Society Initiative programme. This is a strategic alliance between the state and civil society to improve health. These trends motivated many CSOs to new actions including health service delivery and renewed advocacy for basic health rights and access to health resources (WHO 2001). Secondly the role of civil society in addressing the social determinants of health and its contribution to equitable health policies and health care systems has been described by analyzing evidence in the way CSOs, communities and social movements have dealt with particular issues at different levels and under different circumstances (CSDH, 2007).

Chapter - III

People's Health Movement and the Right to Health Campaign

Chapter: III

People's Health Movement and the Right to Health Campaign

Introduction

The contemporary public health developments are rooted in past interventions. Health for All is an unexercised dream; the reasons are located in the approaches taken by Government of India to health service planning, the right to use of basic primary health care was difficult for rural masses, people from geographically remote area, and urban slum dwellers. The basic infrastructure of health services, rural and urban, were deteriorating in quality due to low budget allocations. Major challenges in government health services were lack of appropriate human resources, insufficient supply of medicines, poor availabilities of essential facilities for safe deliveries or abortions in Government hospitals. Issue of social exclusion and discrimination based on gender, age, caste, class and geographical identity was the major barrier while assessing health services, which has not been taken into account or realized by government. The government health services are not serving the need of the masses, and on the other side, private sector services are not affordable and accessible to common people.

Above issues gave rise to the motivation to civil society organizations to form a People's Health Movement. The present chapter attempts to document the context of people's health movement, national and global, and the components of the campaign for right to health. The chapter finds admirable strategic engagement of the people's health movement with the Indian state and political society as well as at international levels, through their right to health and health care campaign.

Health Services Development: Contextualising the People's Health Movement

1950s: Development of Health Services Mechanisms

This was the period where many new countries were getting independence and a new world political system was evolving. The focus of that time was rapid economic growth and industrialization as perceived by Nehruvian economics. This was the period when India decided to have the planned approach for development. The manifestations of this

policy were clearly reflected in the functioning of health services of India. There were a few major milestones in this period which shaped Indian public health system.

The evolution of public health in India in post independence period can be divided in three major eras' as per the political changes in the country and worldwide. These changes shaped the way public health and health services were transformed and shifted its focus and thereby having tremendous impact on the life of the common citizens. After gaining independence within three board phases whole public health care service was emerged. First is the Nation building period, second is The Period of Change in developmental interventions and third is the Period of Liberalization 1990 – till date.

The Nation Building Period was most important phase in Indian history. The country became independent. The new government had enormous task of building the nation from where the British had left and to ensure holistic development of all population and also geographic regions. The government had another major task of setting up systems for all important services like education, health, administration etc. Some initiatives were started at the end of the British Raj but had significant importance in the new India, such as the Health Survey and Development Committee (Bhore Committee) 1946. This committee was regarded as the base of India's health service delivery system. The then British government constituted the committee to study the existing health condition and the health organization in India and to make necessary recommendations. The committee studied the reasons for poor health conditions, the high maternal mortality, poor-nutrition, the existing general curative and preventive medical care facilities, availability of medical professional, training of medical professional and medical education, sanitation and public hygiene etc. This committee had made recommendation which is now the blueprint of the public health system.

The major recommendations made by this committee were, integration of preventive and curative health services in at all levels. Formation of a health service delivery system based on systematic tiers at different levels, formation of primary health centre and referral linkages with secondary and provincial health system, medical education for availability of necessary health professional and stressed to create socially committed physicians, formation of central ministries and provincial ministries to handle health

issues, specific recommendation for specific diseases. This committee also emphasized on investment on production of drugs for self reliance. It ensured community participation on curative and preventive health and provision, for social insurance for healthcare based on socio-economic condition so that no individual should fail to secure adequate medical care, curative and preventive because of inability to pay for it. Bhore committee also suggested strategies for controlling major diseases, the major disease control strategies and budget allocation for health. This committee laid the road for the country to adopt a health policy that integrated the principles of universality and equity.

Post Independence Health Service Development Shift

This pre independence assessment of Bhore committee was not translated into a social development paradigm. Main contributing factor was, after the collapse of colonial rule the nation building phase foster worldwide. One of the major challenges in confronting the independent nations was to establish better development models to provide high-standard healthcare, education, employment and other services for the people. In order to ensure this vertical programme, strategies and approaches were adopted by many countries to deliver these basic services to masses. India adopted the mixed economic approach[15] of development which was tilted towards a liberal development model.

In case of health service, vertical health programmes were imposed on the developing countries by the donor agencies and this dependency on external funds had played a major role in shaping the development of health services in the newly independent countries. In health sector, to develop health services vertical programme based model designed by developing nations. . But financial dependency of these developing countries on donor nation had major role in shaping and deciding in the development of health service systems in these newly independent nations. In the Indian context, adoption of the internationally driven programmes created dependency for modern science and technology in every day health care.

[15] A mixed economy' is an economy that includes a variety of private and public enterprise, reflecting characteristics of both capitalism and socialism.

increased within nations as well as between them as the trickle down model of development failed to distribute the benefits of growth to all section of the society (Hall 2003).

During the same time, in the early 1970s international economic crisis developed, which led down to global recession. There was hike in oil prices whose impact was felt most by developing countries. These countries became poorer due to their oil import and they got trapped in a debt crisis (Sabestian, 1994). Oil was determining factor of consumer markets, this crisis led to soaring inflation and price instability. It's not only impacted the economic sector but its effects also perpetuated into social life. The end of 1973 is known as global economic recession phase, due the oil crisis throughout the world. Conflict of interest between Organization of Petroleum Exporting Countries [OPEC] and importing nation's mainly the United State, British, and Dutch nationals was the main leading factor in this crisis, to make a decision on control of oil price (Okuonzi 2004). This translated into sudden inflation and economic recession in the industrialized countries. The developed and developing countries had negative effects because of this crisis as it led to freezing of industrial frozen by the crisis (factories cut production and laid off workers), it gave birth to unemployment; creation of marginalized social groups, certain categories of aging working and large proportion of young population were without work (Onesimus 2008). All these upheavals impacted upon health status of populations through its various determinants of health.

Which is an important period of Indian development history, the concept of revolution for rapid growth in each sector was the main focus. During previous decades India had war with Pakistan and China which changed many things for ever. The budget allocation for defence started getting priority while other sectors were neglected. The international economic crisis and oil recession was also evident in Indian economy. The Indian politics had seen some major event in this period. From unstable government to national emergency declared by Indira Gandhi. The 'production revolutions' initiated from 1960s onwards included Green Revolution (agriculture), Yellow Revolution (oilseed: 1986-1990), Operation Flood (dairy: 1970-1996), Blue Revolution (fishing: 1973-2002). Mega Mineral and capital goods factories were set up to meet national demand and also to

> *"The various medical knowledge systems and a choice of private and public sector providers within 'modern medicine....'. The public sector doctors were considered most knowledgeable modern medicine'... changing ecological conditions and non-sustainability of techno-centric disease control programme implementation, along with large-scale movement of people due to the skewed nature of economic development"* (Priya 2005: 54)

Vertical programme approach of development in health sector goes wrong by many circumstances, as it focused more on tertiary hospital and also developed hospital centric health infrastructure. Major reason for this health care programmes more focused on tertiary hospital based care. Access to basic health care was not the primary focus in health service development. This increases vast disparities in health status between rural and urban populations. The top-down approach was adopted to deliver health care but this approach was not come up to scratch. Financial dependency after political independence on developed countries (earlier colonizer countries) builds new form of colonization through economic policy, knowledge and technology. This led to a challenge all over the world to develop health service delivery systems (Desai, 1983).

Achieving high economic growth was synonymous to development and thus under this model economic indicators were given priority over the social indicators. The economic growth oriented pattern of development that assumed that the benefits of increased growth will trickle down generated disillusionment as the growth was benefiting only a small section of the society at the cost of the majority. The rich became richer and poor became poorer, thereby widening the social and economic inequalities, increasing poverty and unemployment. There was great social agitation, not only in developed countries, but also in developing countries. The agitation started in the mid- 1960s and continued during the 1970s (Navarro, 2008).

Global Factors Shaping the Health System

World-over the decade of the late 1960s and early 1970s was a period of social upheaval and unrest. The 'trickle-down' and growth oriented model of development and the gains made by them in the past two decades were questioned the world over. Inequality

contribute to the national growth. The involvement of private sector was something interesting in this period. Slowly Indian corporate started taking part in activities till then fully controlled by government. The international Aid, multilateral, bilateral and institutional donors came in to picture in a massive way. Many international foundation and organization shaped various vertical programs as per theirs design and the failure of such programme were also became visible started showing in this period only.

The failure of Nehruvian economics and economics of growth theory (Trickle down approach) led to mass movements for the rights on social issues, economic development and participation in the development in the late70s. The regional separation movement and struggle for land, equitable justice movement also marked this period. Another important feature of the period was division of countries led by the USSR and the USA on ideological ground. The war between the capitalism and the socialism made the world very volatile as cold war was in its peak in this period. India gradually emerges as a potential leader from Non-Align camp. The health programme during that time also reflected the consequence of these global phenomenons. The formation of the Non Aligned Movement (NAM) and the failure of the vertical programmes were the main factors for the initiation of Alma Ata Declaration (Banerji, 2008).

The 1970s was also a period of economic recession which further accentuated the problem of worsening social conditions for millions of poor in the third world. A number of protest movements – students, feminist, and peasant and anti-Vietnam war – characterized the period. These led development planners to come up with a Basic Needs Strategy for future developmental progress. This change impacted health planning, the WHO responded to it with the Basic Health Services strategy.

On the other hand in the field of public health revolutionary step was taken by China, Sudan, Venezuela and Tanzania to deliver primary care health service to rural masses. These countries developed comprehensive health programmes which recognized biomedical as well social determinants of health. Adaptation and replication of this model was undertaken worldwide, many countries made changes in health care delivery services based on this approaches (Hall 2003). Aimed at ensuring "Peoples Health in People's Hand" to some extent, nationwide setting up of network of primary health centres etc.

which contributed to the development of the concept of Primary Health Care (Banerji, 2008). Several developments in health took place in some countries like in China, where the new innovative concept of Barefoot Doctors was introduced. Barefoot doctor model grasp popularity worldwide, because this model based on demystification of medical knowledge and challenged monopoly of professional doctors in health care delivery. Health has been conceptualised in terms of community participation and community based health programmes. In 1973, China entered into the WHO which was major shift. All these developments culminated in the concept of 'Health for All' through the Comprehensive Primary Health Care strategy adopted at the Alma Ata Conference in 1978. It addressed the need for a fundamental change in the delivery of healthcare services in developing countries, with an emphasis on equity and access at affordable cost, and an emphasis on prevention with a combination of provision for appropriate curative services. This took place in an era where the pre-eminent role of government in the provision of health, education and welfare services was taken for granted in most developed countries. (Hall 2003, Qadeer 2010)

Alma Ata Declaration: the Primary Health Care Approach

On 12th of September, 1978, 134 member countries of WHO and 67 NGOs came together for the International Conference on Primary Health Care organized by Health Assembly of the World Health Organizations and Executive Board of the United Nations Children's Fund in Alma Ata, in the capital of the Kazakh Soviet Socialist Republic of USSR. This was a historical the document-Alma Ata Declaration-Health for All by 2000 which came out from the common consensus. According to Halfdan Mahler, WHO's Director at the time, Alma-Ata was "one of the rare occasions where a sublime consensus between the haves and the have-nots in local and global health emerged" (Lawn et.al, 2008). This conference put forward that there was a need to go beyond the bio medical techno centric approach and to become more context specific and to ensuring people's involvement in the planning, implementation, monitoring and evaluation. It also put forward the revolutionary principles of equitable distribution, universal health care, inter-sectoral collaboration, community participation, appropriate technology, social justice and 'Health for All' as a means of development and progress (WHO, 1978).

The basic principle of Primary Health Care was that every country should decide their own pathways by considering their own social, economic and political context. The declaration confesses that health is closely related to the social and economic development through which the living conditions and quality of life of the people improves. It emphasized that 'Health is one of the basic requirements for socially and economically productive life' (Makela and Hellberg, 1994). Health has been seen as right of the people and every individual has a right to participate in the health care activity. It is the State's responsibility to provide adequate health care services and social measures to the people. Comprehensive Primary health care approach in public health based on following principles, Equitable Distribution of Primary Health Care, Community Participation toward achievement of Primary Health Care, Use of Appropriate Technology, Multi-sectoral Approach (WHO 1978).

Selective Primary Health Care:

The goal of the Alma Ata declaration was soon collapsed by the changes in the power structure in the world and the vested interest of the international agencies particularly The United Nations Children's Fund (UNICEF) and later by the WHO and World Bank. It was forced to question and criticized the concept of Primary Health Care and argued that 'handling complex systems would be impractical and too costly as compared to specific medical technological interventions' (Kenneth, 1998 quoted in Qadeer, 2001). The Comprehensive Primary Health Care (CPHC) strategy of Alma Ata was soon replaced by the Selective Primary Health Care (SPHC) strategy, endorsed by the WHO and the World Bank, which from the 1980s onwards can be seen gaining an increasingly dominant role in the health sector. Though the SPHC praised the CPHC strategy as noble, yet it was criticized for being unrealistic and not achievable in the near future. The alternative to Comprehensive Primary Health Care that was proposed was Selective Primary Health Care as suggested by Walsh and Warren in 1979, by intervening in specific disease through specific interventions (Walsh and Warren, 1979). The expert driven Selective Primary Health Care strategy soon evolved without any scientific evidence (Banerji, 2008) with the strong back up of certain interest groups. It has been argued that most of countries are too poor to carry out the principles of Comprehensive Primary Health Care

(Banerji, 2005). Under this ground four interventions were best known as GOBI, which stood for Growth Monitoring, Oral Rehydration Techniques, Breast Feeding and Immunization and in the later years few agencies were added Food Supplementation, Female Literacy and Family Planning. It appeared that these interventions are best because they are easy to monitor and evaluate under the given clear targets (Cueto, 2004). This changes in the strategy was adopted the top down, techno centric, market driven approach into the public health (Banerji, 2005). There was a dominance of international agencies and they were in power all over the world by providing loans and grants to the developing countries such as in India. World Bank increasingly began to shape agenda for health world over, thus the role and importance of WHO in determining the health policies declined tremendously. Poverty, deprivation, malnutrition, lack of education, the status of women, environmental hazards, and gross misdistribution of resources were are among the primary cause of ill health which were totally neglected under the influence of Selective Primary Health care (Newell, 1988). Thus the 1980s saw the entire transformation of health planning, which reflected in India as implementing vertical programmes and to a narrowing down concern only for family planning, Child Survival and Safe motherhood programmes, universal immunization programme etc. (Priya, 2005, Duggal, 2005). This all reflects a step back and deviation from the principle of universal health care, community participation etc. which was aimed in Alma Ata Declaration.

Structural Adjustment Policies (SAP) and Public Health

The decade of 1980s was marked by recessionary trends at international level, due to the high oil prices in late 1970s. This led to banks recalling loans from third world nations which had been generously provided huge loans in the previous decade and also tightened credit in the international market. Third world nations had used a part of these loans for debt-financing and without further credit available to them; they began to default on these loans and their foreign debts witnessed a tremendous rise. This decade also witnessed the collapse of the Soviet Union (1989), which gave a huge lift for capitalism. In 1991, India's foreign exchange reserves plummeted and took loans from the International Monetary Fund (IMF) and in return accepted the Structural Adjustment Policies (SAPs), which suggested curbing of state expenditures on social sectors

including health and allowing the operation of market principles here as well. This further witnessed a decline in health expenditure. A policy of SPHC and a selected target population were adopted with greater intensity after the publication of the World Development Report: Investing in Health in 1993. Another important development in this field in the past two decades has been the role of international NGOs like Global Alliance for Vaccines and Immunization (GAVI) and bilateral agencies like United States Agency for International Development (USAID), Swedish International Development Cooperation Agency (SIDA) and Danish International Development Agency (DANIDA) who have begun to play an increasing role in financing health programmes and influencing health policies (Qadeer 2000). The 1990s saw further declines in expenditure on the health sector and weakening of public health systems and increasing role played by the private sector in providing curative services and shift from the concept of Health for All to Health for the Underprivileged. The public sector supported the role of the private sector by providing them with various incentives including land at reduced rates. NGOs too began to assume an increasingly important role in provision of health services at this time, which is also manifested with reduced decline and also stagnation in mortality rates (Scott 2007).

Emergence of the Global People's Health Movement

Two decades ago, civil society organizations were involved in the demand for equitable health care through the Declaration of Alma Ata. More than it was adopted at the International Conference at Alma-Ata on Primary Health Care its promised "Health for All by 2000". Primary Health Care approach was accepted by member countries to provide health care as frame work. But as the year 2000 approached it was clear that this promise had been, largely, forgotten by governments and international institutions around the world. The discontent rose all over world by civil society group for forgotten commitment by governments. Raised of new social movement gave shape to discontent and create platform for civil society groups in anti globalization campaign. The health civil society organizations, groups, networks, and non-government organizations part of these global and national agitations. In this context the major apprehension of civil society groups working in the area of health is how to protect the basic health rights of

people. These primary concerns were lead towards formation of People Health Movement.

At the World Health Assembly 1985 of World Health Organization, health decision-makers represented from all over the world, a meeting took place between Non Government Organization representatives who recognized the need to involve poor people in making decisions affecting their health and their lives. These leaders also recognized the need to create a forum and process that would make it possible for poor people to become involved in this way. This need of an international forum lead to the idea of a People's Health Assembly (PHA). The conceptualization of people health movement was discussed for more than a decade. In 1998 a number of organizations launched the PHA process and started to plan a large International Assembly meeting, organized in Bangladesh at the end of 2000.[16] This first People's Health Assembly was organized in Savar, Bangladesh in December 2000 by people's movements and other non-government civil society organizations from all over the world. All people health movements were demanded to make governments accountable and to take the promise of "Health for All" seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organizations working to advance the people's health in the context of policies of globalization. Structural Adjustment Policies were undermining the vision of Alma Ata. A mass movement opposing this and renewing the Health for All pledge was essential. This is the understanding with which the People's Health Assembly Campaign has been jointly initiated by thousands of organizations (JSA 2007, PHM 2000).

People Health Assembly Bangladesh an opportunity for people involved in health, development, human rights, agriculture, trade and economics, the environment and many other fields to converge, to share ideas and begin the process of building a coalition to drive change. In PHA process series of international, regional and national materials were produced (JSA 2007).

---

16 PHA 2000 General Report - People's Health Assembly - December 2000

Earlier in time to the People Health Assembly civil society groups have undertaken countrywide mobilization all around the world. Central concern was expressed in people health assembly, confirming that the right to health is one of the basic human rights to which they are entitled (Devraj 2005). Health as fundamental right campaign and future work of People's Health Movement to formulate during the PHA process as a result of People's Health Charters. This document has been vision of action of People health movement and right to health campaign.

Vision of Right to Health through People's Health Charters and Declarations

People's Charter for Health (Bangladesh, 2000)

A number of range pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a People's Charter for Health. The Charter was developed over about 18 months and involved a first consultation to identify the key guiding principles, concerns and possible areas for action. This led to an outline draft that was circulated to a wide range of organizations around the world for suggestions and inputs. The present People's Charter for Health builds upon the views of citizens and people's organizations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000. The aim of the People's Charter for Health is to present a set of concerns and vision for the future that can be used as a rallying point in the struggle for better health, social justice and equity (JSA 2007).

The basic principles were:

- Health is a fundamental and basic human right and, therefore, so is universal access to health care
- Respect for human, cultural and environmental diversity
- Respect for the right of indigenous people to their traditional ways of life in the context of public health

- Support for initiatives that empower people to fight for their own health rights
- Opposition to conscious and unconscious violence
- Opposition to inequalities in wealth distribution and health
- Support for participatory democracy

Mumbai Declaration 2004

A global conference of the PHM was held in Mumbai in January 2004. The Mumbai Declaration was a consensus outcome of the complex response to contemporary key challenges that the people of the world face today in achieving health. The declaration highlights six key challenges--End Corporate-led Globalization, End war and occupation, Implement Comprehensive and sustainable Primary Health Care, Confront the HIV/AIDS epidemic with Primary Health Care and Health Systems approach, Reverse Environmental damage caused by unsustainable development strategies[17]

The People's Charter on HIV and AIDS

The People's Charter on HIV and AIDS was officially released by the People's Health Movement during the International AIDS conference at Bangkok in July 2004. The People's Charter on HIV and AIDS is a consensus document that amplifies the voices of the people affected, infected, living with and suffering from HIV/AIDS. It aims at providing a people's perspective on HIV/ AIDS and related issues like access, rights and trade issues.

The Cuenca Declaration 2005

The Second People's Health Assembly in Cuenca, Ecuador in July 2005, analyzed global health problems and developed strategies to promote Health for all. The Cuenca Declaration builds on the People's Charter for Health (2000) and saw it as a rallying

[17] Mumbai Declaration Document 2004

document for the ongoing struggles of the People's Health Movement globally and within countries.

Other important charters of the PHM were also written, such as the Indian People's Health Charter and the Women's health Charter. All these charters and declarations have set out the framework and vision of the People's health movement to demand the right to health and health care. These declarations set vision to lead the campaigns of people's health movement. [18]

People's Health Movement in India

National Health Assembly (NHA-I) In Calcutta in 2000

At the PHA in 2000, the largest mobilization was represented by India. Several organizations participated in this extensive mobilization in about 300 districts in 20 states. The campaign was jointly led by National Networks. This was the first time the country witnessed the coming together of so many diverse organizations and movements. Based on village and Primary Health Center level enquiries, many districts drew up local health priorities which were fed into district and state conventions (JSA 2007). The civil society groups in health, national networks and organizations that had come together to organize the National Health Assembly decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (JSA). A National Health Assembly at Kolkata preceded this global event in 2000, massive mobilization across 19 states more than 2300 delegates from all parts of the country travelled to Kolkata for the National Health Assembly in five People's Health Trains. This National Health Assembly demarcated the specific issues on which the people's health movement in India would concentrate. It adopted a 20 – point charter known as the Indian People's Health Charter, outlining a critical analysis of the Indian health scenario in the context of globalization. This charter provides a statement of the shared understanding and goal that united all the organizations working as part of the network (Srinivasan 2001, JSA 2007).

[18] The Cuenca Declaration 2000 Document

A post-PHA national working group meeting was held in India on 13 and 14 January 2001. The national working group meeting decided that 7 April 2001 will be observed nationally as the Health Rights Day, having the district headquarters as the centre's of activity. At this meeting, the Jan Swasthya Abhiyan (JSA) was launched formally and the Indian People's Charter for Health was finalized, right to health campaign was adopted as the central action, with the slogan 'Health Care as a Fundamental Right'.

Perspective of Jan Swasthya Abhiyan

The Jan Swasthya Abhiyan believes that despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under constant threat. The JSA is of the opinion that these trends are to a large extent the result of the inequitable structure of the world economy, unfair world trade arrangements and uncontrolled financial speculation – all part of the rapid movement towards inequitable globalization. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis.[19]

Objectives that the JSA coalition set for itself were detailed in the people's Health Charter. JSA aimed to draw public attention to the adverse impact of the policies of iniquitous globalization on the health of Indian people, especially on the health of the poor and to focus public attention on the passing of the year 2000 without the fulfilment of the 'Health for All by 2000 A.D.' pledge. It believed that this historic commitment needed to be renewed and taken forward. It viewed the rights approach as suited to perceiving this objective in the prevailing context. Therefore its foremost goal became the campaign to establish the Right to Health Care as basic human rights. Health and equitable development needed to be re-established as priorities in local, national,

[19] Peoples Health Movement People Health Charters

international policymaking, with Primary Health Care as a major strategy for achieving these priorities. In India, policies for wider privatization of health care along with retreat of the state with poor regulatory mechanism had exacerbated the trends of commercialization of medical care. Irrational, unethical and exploitative medical practices were flourishing and increased commercialization, while establishing minimum standards and rational treatment guidelines for health care. In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care had created considerable wastage of scare resources and had failed to deliver significant health improvements. JSA sought to emphasize the urgent need to promote decentralization of health care and build up integrated, comprehensive and participatory approaches to health care that place "People's Health in People's Hands". JSA sought to develop networks with all those interested in promoting people's health. It sought to unleash a wide variety of people's initiatives that would help the poor and the marginalized to organize and access better health care, while contributing to building long-term and sustainable solutions to health problems. [20]

JSA aims to not only achieve a broad based involvement of voluntary organizations and people's movements, but also to sharing of ideas, technical, financial and human resources. The goal is to form a critical mass, needed to influence health policy in favour of the poor and organize those most affected by the trends of current policies. The major concern of JSA is to secure an adequate quality of health and health care for every person in India with a particular focus on the excluded.

Various campaign strategies interventions, these include

- Public information and education on health issues largely through publications, meetings and other events, press conferences and media information.
- Social mobilization and protest actions by means of public hearings on denial of health care, health dialogues, seminars and cultural events.
- Representation to decision makers on policy concerns, grievances and gaps in health services, while seeking increased representation for communities in local health related decision making.

20 Indian People's Health Charter

- Health surveys and studies to understand and highlight health issues concerning the people.
- Organization of people through community health programs, to help the poor cope with the burden of disease, gain better access to public health services and monitor health services.

JSA seeks to promote public health action through its constituents not only at national and state levels but also at district and local levels.

Conceptualization and Operationalisation of the JSA's Right to Health Campaign

A Seminar was organized on "Right to Health Care: Moving From Idea to Reality", on the occasion of the Asian Social Forum in Hyderabad on the 3rd and 4th January 2003, by CEHAT as one of the organizations participating in the Asian Social Forum as a constituent of the Jan Swasthya Abhiyan. The seminar created the opportunity to conceptualize a right to health campaign in India.

This seminar not only brought together activists of the JSA and other civil society groups but also a wide range of persons from academia, the legal and medical profession, and government agencies. The seminar was organized under the broader theme of 'Social Infrastructure, Planning and Cooperation'. The major focus was on 'Constitutional and Legal Framework to attain Right to Health Care and Relevant International Experience' and 'Operational and Financial Mechanisms and Campaign' Strategy to attain 'Right to Health care'[21]

In order that the dream of 'Health for All' conceived a quarter of a century ago in Alma Ata become a reality, JSA emphasized that access to quality health care is not only an essential human need, a right of citizenship and a public good, but it is also a pre-requisite to good health which is essential to achieve and enjoy fruits of

21Mail No- 850, Date: Thu Dec 26, 2002 11:20 am, Subject: Invitation from CEHAT for seminar on Right to Health Care at the Asian Social Forum

equitable development. [22] The Asian Social Forum was a good opportunity to take this first step in developing a campaign and strategy for right to healthcare in India. Main component of seminar was sharing of international experiences of four countries, Costa Rica, Canada, South Africa, and Bangladesh and discuss how to apply these diverse experiences in Indian context. The content of right to health care was to include the right to basic health care, regular supply of rational and essential drugs according to the WHO list to all public health care units, emergency health care, enforcing minimal physical and clinical standards in public and private hospitals, enforcing standards in staffing pattern in public and private hospitals, and the state responsibility that doctors serve in rural areas (CEHAT 2003).

The campaign strategies to achieve healthcare for all were also outlined. To change the landscape of health for all through solving the problem of socio-economic inequity in the society this perspective was adopted to build campaign. Poverty is the main determinate of right to health, reduction and eliminates poverty among under-privileged masses and spread awareness, organize them to fight for basic rights, and develop the alternative pathway to challenge principle of market based health care. All of this would be contextualized in a people's movement. Strengthening and reorienting the public health system, along with policy makers should be aware about ground reality and deficiency in delivering health services. There was need to build up political commitment within political society and right to health would be a political society commitment through the election manifestos of parties. *"The lack of adequate financial allocation, political will, awareness of this right among people and political mobilization has hampered the realization of this right."* To map the situation of Right to Health Care, JSA conducted a study to assess the availability and utilization of basic health services at the grass roots level. Putting forth viable operational and financial mechanisms to make the right functional and filing public interest litigation in order to bring such a right into reality, systematic efforts would have to be made to include the issue in the election manifestos

22 Seminar Report of "Right To Health Care Moving From Idea To Reality" Proceedings Of The Two Day Seminar Organized By 'Jan Swasthya Abhiyan' at the Asian Social Forum, Hyderabad On 3rd and 4th January 2003.

and to generate a political movement for the cause of health and healthcare. (CEHAT 2003)

Strategies and Action for Right to Health Care

JSA attempted to take its issues to engage with the human rights agencies, the government system, and the political parties and to the mass media. But the process of engagement was a simultaneous process by various activities.

Engagement with State through National Human Rights Commission (NHRC)

The legitimate rationale of JSA engagement with NHRC was the negligence of government towards health care it convert into denial of base right to life. Legal framework under the Indian Constitution has granted the 'Right to Life' as a basic human right to every citizen of India under article 21. Right to health has been considered as a quintessential element of Right to Life enshrined under Article 21 of the Indian constitution. In article 47 of the Directive Principles of the Indian Constitution indicates the Government's responsibility concerning public health has also been laid down. Yet the Government is backtracking from fulfilling this responsibility. This was considered obvious from the fact that the Government's proportion of expenditure on public health services has been declining in successive years.[23]

The South East Asia Regional Consultation on Public Health and Human Rights, 2001 was organized by theNHRC, the Ministry of Health and Family Welfare (MoHFW) and the World Health Organization (WHO) in Delhi Within this consultation, the NHRC stressed the need for the optimum utilization of available human power and resources to ensure that the people attain the right to health. JSA members were participants in the consultation, and had brought following issues that helped JSA to articulate the human right based framework to develop a right to health campaign.

Approach of NHRC towards health was

23 Note on "Right to Health activities by Jan Swasthya Abhiyan" (PHM-In Published on People's Health Movement, for more details (http://www.phmovement.org)

"Health should be promoted as a multi-sector area partnership among academic/ research institutions, institutions of law, public health and social sciences as well as voluntary health organizations (Non Government Organizations) and Government agencies, in order to serve national health needs". (CEHAT, 2003)

This conceptualization of NHRC about health was used by JSA to engage with NHRC for campaign of right to health. The National Working Group (NWG) of JSA developed strategic planning on right to health care and engagement with NHRC. They organized a National Workshop on 5th September 2003 in Mumbai, just before the Public consultation - to help develop their collective understanding, and to work out a more detailed, shared strategy for JSA.[24] Along with this strategy planning of state and grassroots level formulated by JSA group. In 2003,

The documentation of cases of Denial of Health Care was launched nationally. JSA collected testimonies of denial of basic health care as a human rights violation. This was undertaken all over India, public hearings were held and reports presented to the National Human Rights Commission. This was central strategy of the campaign in the years 2002 to 2005.

These cases were meant not only for the National Public Hearing, but should be fully used at the state level. A concern was expressed by JSA members that focusing on the weaknesses of the Public Health System alone might indirectly benefit the private medical sector. To the contrary it was argued that the framework and demands that were raised as part of the Right to Health Care campaign are for strengthening the Public Health System, under people's monitoring. It is only from the Public Health System that we can demand a set of comprehensive health services, since it runs on taxpayer's money and is accountable to all citizens. As we establish the legal and social right to certain basic health services, the Government would be pressurized to strengthen and reorient the public health system, in order to deliver these services

24 Mail No-1080, Date: Mon Aug 11, 2003 6:35 am, Subject: Suggestions about Right to Health Care campaign.

Jan Swasthya Abhiyan used this platform for health advocacy. The role of NHRC was identified as the bridge between people and the executive government institutions. The approach of JSA towards National Human Right Commission was more positive towards people than towards the executive.

> *"The larger health movement should not just criticize the NHRC, but rather energize it, remind it of its promises, and keep watch on what is done to implement its ideas... These recommendations obviously cannot be our main source of change. But it could be an advocacy instrument, which should be used much more effectively." (CEHAT 2003, p-12)*

The National Public Hearing held in New Delhi in December 2004 was two-day long programme, where Jan Swasthya Abhiyan and civil society representatives presented key cases of denial and structural deficiencies were noted in the various regional hearings, followed by delineation of state-wise systemic and policy issues related to denial of health care. This was followed by a joint presentation by NHRC and Jan Swasthya Abhiyan on the spectrum of health care rights, which need to be protected, fulfilled and promoted. This included the special health rights of vulnerable social groups such as women, children, persons affected by HIV/AIDS, persons with mental health problems, migrant and unorganized workers, the urban poor and persons affected by conflict or displacement.

JSA has been working consistently and systematically on specific areas within the broad framework of 'Right to Health' – such as Women's health rights, Children's health rights, Mental health rights, Urban health rights, Health rights in the context of HIV/AIDS, Health rights in the context of occupational and environmental health, and other such rights. It was important that the efforts to work in such areas of specific health rights are continued after the national hearing, with active involvement from JSA. These rights were taken account of while formulating an overall approach to operationalise the Right to Health care.

JSA Recommended to NHRC and the Government of India

- Decentralization and strengthening of the health system through involvement of Panchayati Raj institutions.
- To establish a national public health advisory body at the Centre and State public health regulatory authority in each State, to regulate public health practices and monitor the implementation of a public health program.
- Increased the strength of Public Health Human resources through training according to the need.
- Development of Emergency care through expert group, and incorporate recommendation suggest by expert group.
- Development of ethical guidelines to control irrational and unethical medical practices. This would help in regulation of the private sector.
- To put in place an updated National Drug Policy to ensure an adequate and reliable supply of cost effective drugs of acceptable quality to all citizens of India.
- Developed a strategic plan to deal with TRIPS recommendation to ensure provision of essential drugs.

State Level Public Hearings

The national public hearing in New Delhi was preceded by regional public hearings on Health and Human Rights in five regions of the country, also organized by The NHRC in partnership with the Jan Swasthya Abhiyan. During the day-long public hearings, selected cases or instances wherein individuals or groups who had suffered denial of right to health care, and had not received mandated health care from a public health facility, were presented before a panel consisting of the NHRC and the state level public health officials. Similarly, violation of health rights due to the structural deficiencies in any other health facility was also presented. The first Regional Public Hearing on the Right to

Health Care was held in Bhopal on 2004 at Regional Science Centre. That was inaugurated by Dr. Justice A.S. Anand, Chairperson of NHRC. The cases from Rajasthan, Gujarat, Maharashtra, Madhya Pradesh, and Goa were presented in this Public hearing. The overall framework for a Right to Health Care Campaign had been developed by the NWG. JSA units in each state also developed appropriate ways of developing campaign activities in their own state.

The state level strategies were focused on the dialogue and public hearing events with the health System. Depending on the specific situation in each state – including existence of certain schemes (e.g. the Health Guarantee Scheme in MP) or circumstances (e.g. the Task Force in Karnataka), which allowed the state unit to strongly demand improved public health services in the primary health care framework. Similarly, there were specific health problems (e.g. Malaria), concerns (e.g. women's access to health care) or health system issues (e.g. drug supply) that certain states decided to focus on.

The hearing for the Southern Region covering Karnataka, Andhra Pradesh, Tamil Nadu, Kerala was held on August 2004 while the Northern Region hearing for the States of Jammu and Kashmir, Punjab, Haryana, Himachal Pradesh, Delhi, Uttar Pradesh, Uttranchal was held on Lucknow in September 2004. In October 2004, the Eastern Region hearing for the States of Bihar, Jharkhand, West Bengal, Sikkim, Orissa, Chattisgarh was held at Kolkata and the regional hearing for the North Eastern Region will be held at Guwahati on 28 November 2004. Each public hearing would be preceded by a public notice by NHRC in leading newspapers of the region, regarding the date and venue of the hearings to enable wider participation.

Outcome of the Engagement with NHRC [25]

This statement was made by Justice Anand, Chairperson NHRC, during the valedictory session of the National Public Hearing on Right to Health Care co-organized by NHRC and Jan Swasthya Abhiyan in December 2004.

25 Press Release - 7 April 2005 , Implement NHRC Action Plan on Right to Health Care

"The series of regional public hearings organized by the Commission have in fact shown that the citizen's right to health care is being violated on a significant scale... Legislation such as a National Health Act needs to be drafted and enacted, which would recognize and delineate the Health rights of citizens ... this National Act could be accompanied by State Public Health Services Acts or Rules for operationalising health rights in each state of India"

This has been followed by the issuing of a finalized National Action Plan on Right to Health Care by NHRC, sent to the Central and all State Governments for action. Noting widespread and serious denial of health care and violation of health rights during various public hearings, this action plan has asked State governments to undertake a series of actions to ensure quality health services for all. On the occasion of World Health Day, JSA demanded the immediate implementation of the NHRC action plan to prevent ongoing serious health rights violations and to guarantee quality health services for all citizens, relating to care from both public and private health sectors.

A set of recommendations was issued by the NHRC to deal with the health rights violations emerging from these hearings and towards strengthening health rights, the key recommendations made to State governments are summarized below:

- Each state should enact State Public Health Services Acts/Rules. This would include delineation of lists of essential health services at all levels: village / community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a legal right to all citizens.
- These rules should also include special sections to recognize and protect the health rights of various sections of the population, which have special health needs such as women, children, persons affected by HIV-AIDS, persons with mental health problems, persons in conflict situations, persons facing displacement, and workers in various hazardous occupations.
- Each state should enact State Clinical Establishments Rules regarding health rights concerning the Private medical sector, detailing the provisions made in the National Act. These rules should ensure right to emergency services, adherence to

Standard treatment protocols and minimum standards, and ceilings on prices of essential health services in private hospitals and nursing homes.

- Each state government should ensure substantial increase in State budgetary provisions for Public health to parallel the budgetary increase at Central level, this would entail at least doubling of state health budgets in real terms by 2009 (this would require increase of the state health budget by at least 20% every year till 2009).
- Forming monitoring and consultative Committees with civil society involvement with at least half of the members of these Committees being drawn from the voluntary sector. These committees should be formed at the State level, and in all districts, and in all Class A and Class B cities. These committees would monitor health services and would periodically review the actual implementation of health rights and availability of services. This should be accompanied by instituting a Health Rights Redressal Mechanism at State and District levels to take up all complaints regarding denial of health care.
- The adoption of a State essential drug policy that ensures full and free availability of essential drugs in the public health system. The adoption of an integrated community health worker programme with adequate provisioning and support, so as to ensure a health worker in every village and urban habitation, providing basic primary care and strengthening access to health services for the most deprived sections.

The NHRC had also declared that it would periodically review the implementation of this Action Plan. In the context of the renewed national focus on Public health, JSA demands that in the interest of people's health, these extremely relevant and timely recommendations be implemented without delay. On behalf of citizens, JSA offered to collect information on the implementation of this plan and to assist NHRC in reviewing the situation of health rights. Any hindrance in implementing these long overdue measures to improve the health system would lead to continued denial of quality health care. JSA was assumed government will take up implementation of the recently issued

National Action Plan on Right to Health Care at the earliest, thus taking an important step towards fulfilling their pledge of Health for All!

Debate on Engaging with NHRC

One senior public health academician argued, there was a need to work out a framework for all the one billion people, particularly the unserved and the underserved, who account for 80 per cent of the population. Secondly, we have to consider the entire system of the health services-- medical care, preventive, promotive and rehabilitative aspects, manpower development, organizational structure, social science dimensions, research, and so on-- even if we adopt a narrow view of 'health'. There are institutions which are specifically mandated to deal with all the complex considerations for the entire population. However, this does not rule out limited, micro-level studies (e.g. for Recording denial cases) with the full realization of its limited relevance. In this light, he questioned the value of relying on the NHRC for the campaign for right to health.

> *"How capable is the NHRC, with its fancy for the 'birds of passage' to protect the health rights of the unserved? For instance, how far can they raise the issues mentioned in the extensive list of the problems of the deprived children of India prepared by your group...? It appears to me that the poor will have to fight their own fight to get their constitutional right to health".* [26]

Thus, while it was a major achievement for civil society that its demand for right to health care was being endorsed and actively pursued by the highest institution charged with human rights protection in the country, there was also scepticism about how far this could actually translate into meaningful action without concretely strengthening the managerial and technical support structures for public health.

Engagement with Political Parties

It is generally considered that civil society promotes democracy and its resistances against the state help in making political society accountable to citizens and societies.

26 Mail no- 1618 Date: Tue Dec 7, 2004 11:36 pm, Subject: Re: programme for NPH nhpp@...

Some civil society groups have been engaging with the 'political society', some working with state and most of the civil society groups who are not working with the state are not anti-state but are working with communities for action outside the state apparatus and programmes. These groups question the accountability and responsiveness of state towards society and made more influence power of the individual and local community. The unresponsiveness of India's political parties and government has encouraged the Indian public to mobilize through nongovernmental organizations and social movements.[27]

Civil society organizations in India have had a relatively weak record of organized engagement with the political society members, with very few organizations in the country that have a good conception of the nature of engagement that is required with the political classes to bring about desired change. Even when civil society groups have been successful at getting certain policies changed, in the overwhelming majority of cases the engagement and 'advocacy' has been with the government and not with the political society members. There are a growing number of civil society groups that have begun to focus on 'watching' government, analyzing its performance, and advocating for social justice measures. But these efforts need sustained work with political parties across the country (Basu 2009).

In the run up to the general election were held in India in four phases between April 20 and May 10, 2004, the 'Right to Health Care' campaign launched by JSA organised various programmes to persuade the political parties to include 'right to health' in their manifesto. For that a public event on 'Parties face the people' was organized on 12th of March in New Delhi. [28] JSA had planned various strategies as part of the advocacy process to influence Indian political society. The process and detail of pre election campaign was as follows.

27"The Rise of Civil Society" website: http://countrystudies.us/india/121.htm accessed on 10 March 2011

28 Mail No-1281, Date: Tue Mar 9, 2004 12:43 pm, Subject: Fw: JSA pre-election event - meeting with representatives of political parties

Background of Engaging with Political Parties

The meeting of National Working Group (NWG) JSA was held on 16th January 2003 at Mumbai, where decisions regarding the pre election campaign through the country were taken.

A JSA event was being planned in Delhi before the General elections. In that a symbolic 'March for health' in Delhi, with a theme something like 'Save Public Health – Ensure People's Right to Health Care!' was decided. This included proposals to hold a rally and press conference-dialogue with political parties in Delhi. JSA proposed to hold the rally on the 3rd of March 2003 and the meeting with representatives of political parties and members of the press on the 4th of March 2003. It was expected that there will be JSA representatives from all over the country and that people from neighbouring states will be present in full strength at the rally[29]

Representatives of various political parties were invited to the need to establish Health Rights, and to ensure a system that can provide Health care for all. JSA had created pressure to include a right to health as agenda in their manifestos, the central theme of the campaign was 'Making the Right to Health Care a Fundamental Right'. There was also be a press conference or press representatives were also invited, to ensure broad coverage to this event including the commitments made by parties. Some prominent personalities were had approached, to attend the event and give it a higher media profile. JSA published an 'Open letter to political parties' in Delhi newspapers, for raising the issue and inviting political parties to the event. [30] [31]

29 Mail No- 1228, Date: Mon Feb 2, 2004 1:49 pm Subject: jsa pre election campaign urgent

30 Mail No-1231, Date: Tue Feb 3, 2004 9:16 am, Subject: Urgent: JSA event in Delhi before elections

31 Mail no- 1241, Date: Wed Feb 11, 2004 10:04 am, Subject: Pre-election JSA events in Delhi on 10-11 March

Strategies of Pre-election Campaign

All national networks belonging to JSA are requested to circulate information about this event within their network, and appeal to their constituent organizations to send representatives to Delhi.

- All JSA units from states closer to Delhi, especially UP, Haryana, Rajasthan, Uttaranchal, Himachal Pradesh and Madhya Pradesh were are suggested to start planning to mobilize activists for rally.

- An 'Open letter to political parties on the Right to Health' was drafted and translated into the regional languages, and on behalf of JSA, send it to a large number of political representatives such as the MP of the locality, district or state leaders of all political parties. This was also circulated among a large number of civil society organizations in each state.

Involvement Reservation about BJP and Shivsena

There was debate around engagement of JSA with Bhartiya Janta Party (BJP) and Shivsena in the pre election campaign.

During the 16th January 2004 JSA-NCC meeting in Mumbai, there were difference of opinions about whether to invite BJP and Shiv Sena for this dialogue or not. While some JSA members had felt that all parties, including BJP should be invited for the dialogue, others had the opinion that we should not pursue BJP to come for the programme since it would give greater legitimacy to a communal party, about whom many of them had serious reservations. [32] However, the fact that the BJP was the major partner in the ruling coalition, National Democratic Alliance (NDA), and the Health Minister was from the BJP weighed heavily in favour of arguments to invite them for the consultation.. It was also felt that the other parties and media would then take the event more seriously. It was

32 Mail No- 1249, Date: Tue Feb 24, 2004 11:41 am, Subject: Suggestion to invite Sushma Swaraj for 12th March programme

also discussed whether the Health Minister should be invited in her official capacity or as a political leader of the BJP.[33]

Majority of JSA members see the "Virus of Communalism" as a major threat to health, and therefore did not think it appropriate to provide a platform to the party identified with it. Some members felt that not having representatives from all the parties would defeat the purpose of the dialogue. JSA should also use this opportunity to expose the BJP's projection of the "India Shining" image, with hard facts of declining statistics and health care indicators presented in front of those who claim the reverse. It would be strategically better if they are there than if they read about it. [34] But the decision in Mumbai meeting was to avoid BJP/Shivsena.

Policy Document for Dialogue with Political Parties

The policy document to be used by JSA for dialogue with political parties before the coming general elections, deliberately focused only on the health care system, and the recommendations were also focused on issues regarding the health care system that could be implemented in the near future. It was accompanied by the People's Health Charter, to outline the larger consensus vision of JSA regarding health. This document was printed and disseminated before the event[35].

Suggestions on the draft was related to issues of bureaucratization of the health services; neglect of the training of health administrators, state of the key institutions for education, training, research and evaluation of public health; the morbid cadre structure; the abject surrender to vertical programmes; rapid growth of capitation fee medical colleges.[36] There was no mention of the disproportionate focus on family welfare planning activities.

33 Mail No-1251, Date: Wed Feb 25, 2004 6:37 am, Subject: Re: Suggestion to invite Sushma Swaraj for 12th March programme

34 Mail No-1252, Date: Wed Feb 25, 2004 8:34 am, Subject: Re: Suggestion to invite Sushma Swaraj for 12th March programme

35 Mail no- 1261, Date: Tue Mar 2, 2004 12:09 pm, Subject: Policy document on Health

36 Mail No-1262, Date: Tue Mar 2, 2004 2:38 pm, Subject: Re: Policy document on Health for pre-election dialogue

This not only takes the attention away from core health issues but it also adds a huge morbidity burden on women as well.[37]

Post General Election 2004

The results of the general elections came as a welcome surprise, with people across the country rejecting communal politics, and also reminding the rulers that liberalisation policies divorced from the needs of the common people may be met with growing resistance. For JSA and the health movement in India, this situation was a unique opportunity. The government had been formed with a mandate of bringing back a 'human face' to development and giving greater attention to the social sector, which is combined with the strategic position of Left parties in supporting the government. Both Manmohan Singh and the Minister of state for Health had said that the government will work for 'Health for All'.

After the election, JSA planned the following strategies to take assurance from government which promises given in pre election event.

As a civil society group, JSA wrote a letter to the new Prime Minister (PM), Union health minister and State minister of health, congratulating them on their taking of office, and introducing JSA along with sending key documents. They took an appointment with the new Health Minister and presented him with the People's Health Charter and the Policy brief. JSA brought out before the elections, explaining the key demands. The issues highlighted during the meeting included: To ask for a review of the National Health Policy and National Pharmaceutical Policies brought out under the previous BJP government. Suggest the formation of a National Consultative Group to give civil society inputs to the government towards ensuring access to Health Care for all and to monitor progress in this direction. Quote the promises given in the Congress election manifesto about increasing public spending on health and launching a countrywide community health worker scheme. JSA further demanded for the review of controversial decisions like Universal Hepatitis B vaccination and the reversal of the reduction of essential drugs under the Drug Price Control Order (DPCO). Invite the Health minister for the National

37 Mail No 1271, Date: Thu Mar 4, 2004 6:08 am, Subject: Re: Policy document on Health

public hearing on health rights being organised in collaboration with NHRC in Delhi. In NHRC public hearings on Health Rights will also bring government under scrutiny for denying basic health rights. Involvement of the Health minister in the National hearing will facilitate some action from them. Meet the parties (CPI (M), CPI, and SP) which had supported strengthening of Public health during the 12th March JSA programme and asked them to push for inclusion of key public health issues in the Common Minimum Programme. JSA took initiatives for a Bill to make the Right to Health Care as a fundamental right. JSA made demands to the sympathetic Left MPs to raise key public health issues in Parliament.

Above two process of engagement with the NHRC and political society contributed to recognition of rural health care problems among the media and the policy makers. The effect of these engagements, the right to health becomes a political agenda by party manifestos of CPI (M), CPI, BSP and Congress. After general election 2004, UPA government made commitment to develop rural health care system through National Rural Health Mission (NRHM). The NRHM was the outcome of the efforts of civil society organisations. There are pressures from several other groups such as, s the World Bank and international agencies like Bill Gates Foundation to implement NRHM.

General Election 2009: JSA Dialogue with Political Parties [38]

The general elections were scheduled in the country in early 2009 and thus JSA initiated a policy dialogue with different political parties, as it was done prior to the 2004 general elections. The attempt was to encourage political parties to propose pro-public health policies in their election manifestos and in the 2009 election campaign.

As a preliminary step towards the manifesto, JSA prepared demands before the General Elections. Pressing issues was identified by JSA members. Primary concern in this process was, to develop precise and concrete demands stemming from these issues, which could be easily understood by the political parties. JSA brought out a fact sheet 'Policy Brief' to mobilize the process.

Thirty one point List of Issues was prepared for Election Manifesto in 2009.

38 Mail No 5306 Date: Sun Jan 4, 2009 1:23 pm, Subject: Policy Dialogue with Political Parties

1. Comprehensive Primary Health Care
2. Comprehensive programme by government with investment of 5% of our GDP.
3. Comprehensive need based human power plan for health sector.
4. Legal and social mechanism to regulate standards and norms in private medical/ health sector.
5. Rational drug policy & ensuring provision of free essential drugs.
6. Medical research based on epidemiological priorities.
7. Access to safe and affordable contraceptive measures without coercion, incentives and disincentives.
8. Support to traditional healing systems and home based healing traditions.
9. Transparency and decentralization in decision making.
10. Ecological and social measures to check resurgence of communicable diseases.
11. Facilities for early detection and treatment of non communicable diseases.
12. Women centred health initiatives, issues related to women's health.
13. Child centred health initiatives.
14. Occupational and environmental health measures.
15. Mental health community based and supported.
16. Programmes for health of people with disabilities.
17. Restriction of industries that promote addictions and unhealthy life styles.
18. Recognition of violence as a public health issue. (Domestic, Social and Communal)
19. Community Monitoring and redressal system
20. Vaccine policy, pulse polio, closure of vaccine companies
21. Nutritional crisis- Malnutrition,
22. Medical tourism,
23. Regulation of Medical Technologies
24. Clinical Trials- Ethics,
25. Regulation of private sector
26. Revoking two child norm
27. National Urban Health Mission (NUHM),
28. NRHM

29. Address the issues of privatization of government medical institutions (e.g., user fees. private practice by Govt. doctors)
30. Medical Education,
31. Patents related issues

An issue debated in relation to this was that the list of 31 issues can be a made even more exhaustive by adding more, but if the objective is to induce political parties to bring in actionable elements into their manifestos, wouldn't it be better to focus on one or two composite actions whose impact would be across the board? Given the attention deficit to the complexities of real issues amongst the rank and file political leaders, since the objective is political action, wouldn't it be better to prepare brief, crisp and politically compelling advocacy papers on such composite actions, circulate them widely, and use them for discussions with the political parties? In the discussions of course various issues could be highlighted in order to demonstrate the need for composite action. The composite issues suggested were:

- Right to Health legislation
- Regulatory mechanism for all kinds of private health service systems (could be part of the legislation)
- A basic minimum GDP for health (agree 5% is not too much to ask in terms of needs, but is it realistic, or is 3% a pragmatic demand? If the legislation is a valid demand, then this spending could be a part of the financial memorandum of the legislation, calculated in a segregated manner from the provisions of the legislation).[39]

  One of the members stated that, most political leaders will not be in a position to digest and act upon 31+ issues in a meaningful way. Several of these issues could be integrated under certain key policy measures. The idea is not to 'reinvent' the People's Health Charter or draft an all-inclusive list of issues. If the objective is to

39 Mail no-5309, Date: Wed Jan 14, 2009 7:37 am, Subject: Re: Policy Dialogue with Political Parties

get certain key, overarching health system policy measures incorporated in party manifestos, what we can do is the following:

- Like last time (2004), draft a JSA policy brief. The policy brief in2004 was titled 'Make Health care a fundamental right!' The brief would give not only the key desired policy interventions, but also some rationale and points on operationalising these. JSA should have a relatively compact sub-group which will take responsibility for drafting this. After it had been circulated to the larger JSA network and was finalized based on comments in a time bound manner, it should be printed in English, Hindi and wherever possible translated into regional languages by state JSA units.

- If this draft considered appropriate, it may start with / contain a shorter two-three page 'People's Health Manifesto' which encapsulates the key policy changes being proposed, and can be taken by political parties for incorporation into their respective manifestos. Some political leaders may focus on this even if they do not internalize the entire brief.

- This policy brief (with People's health manifesto) circulated to all political parties, and shared with Lok Sabha candidates with whom JSA units might have a dialogue. The idea is to widely disseminate certain key ideas regarding major changes required in the Health sector. This brief and people's health manifesto would of course be used during the national dialogue with political parties in Delhi, being organized by JSA.

- The policy brief and manifesto also be shared with other platforms and coalitions, which are interacting with political parties in the pre-election period with a pro-people perspective. [40] [41]

JAS decided to advocate concentrating mainly for Right to Health with reference to the draft National Health bill in the general election of 2009. The tentative 31 point lists of

40 Mail no- 5311, Date: Wed Jan 14, 2009 10:01 am, Subject: Re: Policy Dialogue with Political Parties

41 Mail no- 5311 Date: Wed Jan 14, 2009 10:01 am, Subject: Re: Policy Dialogue with Political Parties

issues were shortlisted through JSA group discussion and the second issue considered important to be taken up was Community based Monitoring under the NRHM.

Engagement with State through National Rural Health Mission

The Government of India launched the National Rural Health Mission (NRHM) in 2005 to improve the quality of life of rural people. For that government considered it necessary to do architectural correction in the basic health care delivery system. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. [42]

One of JSA activist was pointed in interview that the improvement of rural health care system has been demanded by civil society organizations for a long time. In context of NRHM civil society groups have claimed that NRHM is an outcome of civil society efforts. Several discussions and debates have taken place on the conceptualization and implementation of NRHM in India. It has also been much debated in the forum of JSA

Engagement of JSA in NRHM

During the emergence of NRHM, the main issues pertaining in JSA were being discussed on email group (e-group), JSA had analysis of the various components of the NRHM based on a study of the relevant documents and other information, and planning of the "People's Rural Health Watch", by JSA to monitor the implementation of the NRHM, at State and National levels, with a view to influence it in a pro-people direction. [43] Another agenda added by health activists were that planning for interaction with and providing resource support to NGOs/ civil society groups working in NRHM implementation at all levels with a view to influencing it in a pro people direction."[44]

---

42 Mission Document of National Rural Health Mission (2005-2012), p- 4, More details on http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf ,access on 9 January 2011

43 Mail no-1919, Subject: Re: Invitation for the JSA meeting on the NRHM, on 14th and 15th of May 2005, in Delhi, , Date: Fri Apr 29, 2005 4:14 am

44 Mail no- 1918 Subject: Re: Invitation for the JSA meeting on the NRHM, on 14th and 15th of May Date:2005, in Delhi., Thu Apr 28, 2005 8:54 am

The key decision of JSA was to prepare NRHM health Alert. This NRHM Alert was JSA document highlighting critical issues related to the mission. It clearly stated JSA positions on NRHM. It's prepared to state Jan Swasthya Abhiyan's position on the NRHM so as this document helped the JSA groups and partners to decide how they could possibly engage with Rural Health Mission. It was prepared based on the review of various health documents by a number of JSA people. Several JSA resource persons and activists were involved in the drafting of this document.

Discussion on Engagement in NRHM

A debate had taken place around the issue of role of JSA's engagement and role as a civil society organization in the national rural health mission. Jan Swasthya Abhiyan's goals included improving health care of the rural masses. Therefore, some members proposed that JSA members be involved in the implementation of the NRHM. This raised the larger crucial questions within JSA, as to what is the role of civil engagement as an Civil Society Organizations in the domain of public health and what would be JSA's stand or position or contribution in improving the health status or health care services for the large section of rural population. Implementation and monitoring were viewed as the possible roles. However, some others held the opinion that JSA should not get involved in implementation at all. One of the arguments for this was that designing of NRHM is unimaginative because it has not taken into account the epidemiological condition of India and therefore is bound to fail.

One group of public health activists even expressed certain reservations on the issue of NRHM watching; especially with government financing it out of NRHM funds. One senior academician argued that JSA was not well prepared to implement the services of NRHM. *"My concern is that an ill-prepared JSA will be co-opted by the establishment."* Action of JSA to watch NRHM is going to fail due to the outreach of NRHM and outreach of JSA is not going to mach.[45] and strength of JSA to implement NRHM or to watching implementation is limited, because NRHM is design for 18 state programmes.

45 Mail no- 2129, Subject: Re: [pha-ncc] Fw: NRHM Action Alert, Date: Thursday, September 29, 2005 1:49 PM

Work of JSA within country is in limited area. *"What is the outreach of JSA and what is the public health competence of the few who dare to do the `Action watching'?"*

In defence of this argument one of the public health activists mentioned that , First objection pointed that watching NRHM - both on grounds of competence and on grounds of outreach is a question mark.[46] Another group of activists defended that it's not only about watching, it is about the engagement of civil society groups in the government programme (NRHM).[47]

After much discussion a resolution was taken on the line of argument about co-option by government in NRHM. [48] The need to critically engage with the emerging NRHM, and to keep a regular 'Watch' on various aspects, including its policy, implementation and funding, based on suggestions and responses from various JSA activists, after analyzing the available documents and information on NRHM, that helped to firm up the JSA position on all aspects of the Mission; this also has a bearing on JSA related organizations deciding about 'watchful involvement' in certain activities related to the Mission. Additional discussion would focus on the idea of an NRHM 'Watch' (to be appropriately named based on consensus) what this would seek to do, how information would be analyzed and used, what responsibilities various organizations are willing to take regarding watching state and national level aspects of the Mission, and as relevant, how this would be financially supported. [49]

An alternative pathway was stated by a senior academician in his comment on the leadership in health ministry that should be pro-people. This accountability towards citizen was seen only when Community Health Worker (CHW) programme was initiated under Shri Raj Narain leadership. He was only one that strongly advocated CHW programme. This was one of excellent example of leader thrown up by people. But

---

46 Mail no- 2129 Subject: Re: [pha-ncc] Fw: NRHM Action Alert, Date: Thursday, September 29, 2005 7:19 PM

47Mail no- 2129 Subject: Re: [pha-ncc] Fw: NRHM Action Alert, Date: Friday, September 30, 2005 8:53 AM

48 Mail no- 2132 Subject: Re: [pha-ncc] Fw: NRHM Action Alert, Date: Fri Sep 30, 2005 1:37 pm

49 Mail No: 1808, Subject: Meeting on NRHM and discussion on 'Watch' Date: Fri Mar 11, 2005 12:26 pm

recently number of leadership was emerged in people health movement and engaged with state but that leadership had not shown positive results in health.

> *"the dispossessed have to generate much more powerful political movements to throw up much more dedicated leadership. Concern for their problems ought to haunt the leadership at the highest levels – the Prime Minister, the Cabinet and the Parliament. Unfortunately, the leadership provided by the long chain of health ministers during the past few decades have been far from reassuring. Ironically, the fact that Shri Raj Narain stands out among them for his daring to launch the Community Health Workers Scheme, shows the level of political leadership in health in independent India. Till a much more powerful leadership is thrown up by the people, one has to contend with marginal changes in the process which has led not only to the persistent fall in the (GDP) percentage of public investment"*[50].

The major task for leadership was to improve health system, this leadership include bureaucrats, administers, political leaders.

- Rejuvenation of the existing institutions for research, education and training of public health workers.
- Production of Managerial Physicians, who possess epidemiological, managerial, political and social competence to deal with public health problems.
- Removing the square pegs in round hole and inserting the round ones in their places.
- Formulation of a totally different cadre structure to attract highly competent personnel in the services.
- Promoting health systems research to formulate optimized health systems.
- Considering increase in allocations for investment in proven cost-effective programmes.

[50] Mail No: 1808, Subject: Meeting on NRHM and discussion on 'Watch' Date: Fri Mar 11, 2005 12:26 pm

In defence of above argument on engaging with state on NRHM,

> *"Let us say by experienced health administrators who are members of the people's health movement. I thought - and I repeat this -that the watch is the most non controversial way in which the members of the people's health movement could do anything without any significant danger of co-option. But if even this health watch role is denied than how do these organizations which have members working for social change at the district level respond to the negative trends. Is not passivity also co-option. And if you agree it is then what is the form activity should take. And if people who are not active health administrators should be concerned and should get involved , then what is the form that activity should take."* [51]

Involving critical masses in engagement process for purposive outcome was one of the concerns expressed by one of the health activists for better and critical implementation of NRHM watch.[52]

JSA finally came to this common position before the inauguration of NRHM. The analysis made of Mission document was "*NRHM documents – old RCH wine in new Mission bottle*?" and JSA had suggested some changes in mission documents. That was as follows:

- To put into operation of NRHM government of India established institutional arrangement, but *A 'National Health Systems Resource Centre' is envisaged (primarily for RCH-2) along with a 'Programme Management Support Centre' and a 'Health Trust of India.*
- Budgetary Component in Mission document is mismatch increase in budgetary allocation is not clearly defined and there is a need to re-examine budgetary figures. Allocated budget shows that more focus has been given to

51 Mail no- 2134, Subject: Re NRHM Action Alert: Co-option and co-option, Date: Saturday, October 01, 2005 6:54 PM

52Mail No: 1810 Subject: Meeting on NRHM and discussion on 'Watch', Date: Fri Mar 11, 2005 6:49 pm

RCH activities and programmes rather than NRHM. State-wide budget allocations for NRHM in 2005-06 had shown differences on activities.

- The lack of separate funding for NRHM in the 2005-06; the Government has not yet put its money on its words. In the given arrangement it appears primarily as a 'repackaged' version of RCH-II, which is where most of the funds are concentrated - and the likely implications of this are obvious.[53]
- Compensation for ASHA was not a clear issue in the mission document, funding source for this compensation, is it from village health fund, or any other source is not mentioned in the document. Another thing is amount of this compensation is not fix in the document.
- The educational criteria to appointment of ASHA, is much debated because the educational states of rural, tribal, Dalit women according to census of India criteria set by mission document have dichotomy. These criteria keep out low educational background women in selection of ASHA programme.
- The functioning of Rogi Kalyan Samiti(RKS) is for pro people or only for management purposes.
- A much more detailed and systematic analysis of all the documents is required, which hope various persons in the JSA network would be able to do in the coming period. However based on these recent documents, what seems to be re-emphasized is the need to 'Watch' NRHM very closely, and to consistently critique various negative trends.[54]

Public-Private Partnership under NRHM and JSA Engagement

Public-Private Partnership (PPP) has emerged as one of the important strategies for health sector reforms in India. This strategy was also taken under the NRHM by Health & Family Welfare Department. The justification and conceptualization of PPP was given

53 Mail No:1815, subject: Latest document on NRHM, Date: Tue Mar 15, 2005 6:41 am.

54 Mail No: 1861 Subject: NRHM documents – old RCH wine in new Mission bottle?, Date: Fri Apr 8, 2005 8:59 am

by government in mission document. That was, since almost 75% of health services are being currently provided by the private sector, there is a need to refine regulation of private sector. Under NRHM private sector regulation would be transparent and accountable towards people. Partnerships with the representative of private sector in district institutional mechanism were also initiated. Poor districts were to identify as areas of partnership, which are need based, thematic and geographic. Public sector was to play the lead role in defining the framework and sustaining the partnership Management plan for PPP initiatives at District/State and National level. [55]

A Task Force was set up with public health experts, institutional and NGOs representatives to suggest reform of regulatory bodies/creation where necessary and to develop guidelines for PPP in NRHM. Under the partnership the government was initiating contracting in, contracting out, out sourcing, and management of hospital facilities by leading NGOs, hiring staff, service delivery, including major health services provided by private sector.[56]

According to JSA, the major thrust of PPP under NRHM was on achieving RCH and family planning goals. In PPP models focus was more on franchising and subcontracting to private providers, social marketing, joint venture companies, partnership with corporate sector and professional associations etc. The role of NGOs is viewed primarily in a subcontracting role, not mainly for involvement in social monitoring and regulation. In fact regulation is mentioned only towards the end, and not as a framework for overall regulation of the private sector, but as financial and quality regulation of private subcontractors and franchisees. There is even mention of 'market based regulation'. Hence public regulation is not the foundation of PPPs, but appears as an appendage to the main enterprise of subcontracting. Public health obligations of private providers are not mentioned at all. [57] [58]

---

55 Mission Document of National Rural Health Mission (2005-2012)

56 Draft Report Of The Reconstituted Task Group On Public Private Partnership Under NRHM

57 Mail No: 1861, Subject: [pha-ncc] NRHM PPP concept note, Date: Thursday, October 06, 2005 6:16 PM

PPP model implementation is highly adopted from RCH II document. There is a need to rethink the assumption that in partnerships private sector is providing good services. The document has not taken into account the issue of regulating private sector. The document states that this partnership is to exchange skills and practice by both public and private. But this partnership is serving the interest of corporate in the name of partnership. The NRHM is supposed to focus on districts across the poorer states in India where the health services public, private and voluntary sectors are weak. But in reality, the poorest district of this country is where the formal private sector is virtually absent. The assumptions that underlie public-private partnership in this document are that the latter is providing good quality care and available across the country. Given the heterogeneity and lack of regulations, there is enough evidence, which shows the contrary: major variability in the quality of private services, with significant irrational practices and frequent lack of minimum standards (Baru 2005)[59]

JSA interpreted PPP under NRHM in the direction of Privatization and Semi-Privatization. The various forms of privatization-oriented measures to rejuvenate public health institutions, and partnerships with the private sector as the desirable direction for change, were strongly reflected in recent NRHM documents. JSA Health Watch claimed that RKS is new form of 'Public – Private Partnerships'. Overall the solution to bureaucratism and non-responsive services is sought in the document on RKS by making public hospitals into autonomous societies which would charge user fees, can contract out services and may share resources with the private medical sector. Such measures are considered to be the way forward for restructuring public health institutions. Similarly, a number of forms of 'PPPs' proposed in the recent document on this hardly emphasis strong public regulation of the private sector, and certain measures seem to dilute public responsibility by putting a stamp on activities being carried out by a private sector, regulated weakly if at all. Regarding the role of NGOs, this stream views NGOs primarily

58 Mail No – 2197 Date: Sat Nov 12, 2005 11:08 am, Subject: NRHM Alert -PPP draft comments vakkan 2000, on Pubic Private Partnership prepared for the JSA NRHM Alert.

59 Prof. Rama Baru analyzed the mission document of NRHM and circulated a note for the debate to formulate the position of JSA on public- private partnership. On the note and several other members were contributed to the discussion on PPPs and a final position statement was prepared.

as one more form of private implementing institution, sub-contractors which can provide services in a cheaper and more effective manner, and not as social mobilisers and agents for community accountability. (JSA 2006)

One public health activist had made suggestion on engaging with state in NRHM. He claims that, the vision of JSA is based on National and People's Health Charter and the Cuenca declaration 2000 and the member of JSA has to keep that in mind. PHA was born as a highly heterogeneous, amorphous group, loosely bound with the National and People's Health Charters and the Cuenca Declaration. Some of the diverse members of JSA group decide to involve directly into the implementation/monitoring/evaluation along with gigantic health administrative machinery of the NRHM, they are free to do so as individuals. [60]

Watching Government through People's Rural Health Watch

People's Rural Health Watch (PRHW) was an initiative to collect information on, access and analyze the activities under the NRHM, both at the state and national levels; communicate and disseminate all such documentation and information through reports and other means, and provide feedback for improvement. The idea of a People's Rural Health Watch (PRHW) was conceived of and outlined by JSA at a National Consultation in May 2005, following the implementation of the NRHM in April 2005 by the United Progressive Alliance (UPA) government. The PRHW was viewed as a way of taking forward the 'Right to Health' campaign of JSA, launched in September 2003. Given the objectives of the NRHM to improve rural health services, PRHW would be an activity to assess whether or not the healthcare infrastructure was being strengthened in a pro-people direction, and to assess whether or not people were getting health services with the introduction and implementation of NRHM. Information on implementation at the state level was to be collected through field surveys, it was also decided to study relevant policies and planning documents, and look at financial allocations and funding sources of NRHM (JSA 2007).

Main Findings of the Process of PRHW

60 Mail no - Sent: Wednesday, October 12, 2005 2:41 PM , Subject: [pha-ncc] NRHM Action Alert Draft

After the launch of the NRHM several concerns regarding the conceptualization of the role and functioning of the ASHA programme were expressed by JSA. From the findings it was observed that:

- There is need to modify the criteria for selection of the ASHAs, role and responsibility of ASHAs, payment structure.
- Second finding was regarding un-tied funds to sub-centres. problems with the distribution or utilization of untied funds main finding shown by JSA
- Fact finding exposed, that there was problem in getting money of Janani Suraksha Yojana (JSY) under NRHM.
- Regarding budgetary allocations and financing under NRHM no new (structural) measures have been introduced, which can be seen to be contributing to strengthening the health infrastructure. Budget heads have been merely shifted/re-positioned and placed under NRHM. The money under NRHM continues to be spent on: Family Welfare Programmes that includes RCH II, Routine Immunization and pulse polio immunization, National Disease Control Programmes.
- The other basic problem is lack of essential medicines at Sub Centres- Primary Health Centres- Community Health Centres is also not being addressed.
- Improvement of health infrastructure addressing shortage of infrastructure and personnel, the basic problem of lack of adequate staff still remains to be tackled adequately.
- For decentralized planning there was a need for necessary groundwork for preparation of District Action Plans.
- There are several problems regarding composition of Rogi Kalyan Samiti.
- Implementation of NRHM in Bihar pro-privatization of health services

The Operational Framework of the NRHM and the developments in the field, it is clear that the NRHM basically brings together all the elements of these reform initiatives scattered across various states/districts, and seeks to implement them

uniformly across all the districts in the country, rather than bringing in long overdue, genuine initiatives aimed at improving and providing accessible and quality health services (JSA 2007).

Community Based Monitoring and JSA

JSA had organized a nationwide Right to Health care campaign in 2003-04, enabling activists to document and publicizes cases of 'denial of health care' in a 'Right to Health' framework. In order to prevent the recurrence of denial of health-care needs of the people, and to move towards fulfilling the goal of people's right to health care, a series of recommendations were presented to the government in a public hearing in 2004. It is important to note here that need for a community based monitoring system of health services was originally articulated in this set of recommendations. Further, in the National Public hearing on 'Right to health care' organized in 2004 by JSA, a National action plan was released by the National Human Rights Commission (NHRC) in which operationalisation of mechanisms for joint monitoring at District, State and National levels involving Health departments and civil society representatives was clearly recommended (JSA 2006, Kakade 2008).

In parallel to these activities, JSA also organized a dialogue with national political parties in March 2004, thus ensuring that strengthening the public health system became a part of the political discourse in the 2004 national general elections. In response to these and other factors, the NRHM was launched in 2005 by the Union Ministry of Health and Family Welfare, under the United Progressive Alliance government (UPA). NRHM had a range of components related to strengthening of public health services in rural areas. However, two key factors facilitated the inclusion of Community based monitoring of health services (CBM) within the NRHM framework. First, the planners of NRHM felt that introducing an officially sanctioned community monitoring programme would fill a critical gap in the Mission's system for validation of information. Second, the framework of CBM was significantly shaped and promoted through sustained people-oriented advocacy by members of JSA.

In 2006, the Union Health Ministry constituted a panel of civil society experts called the Advisory Group on Community Action (AGCA) to support community based action

related to NRHM. Several of its members were members of the JSA network. The AGCA discussed the possible modalities for operationalising community based monitoring and noted that CBM requires more complex and diverse partnerships compared to other elements of NRHM. They recommended that a pilot program be implemented in selected districts in nine states of the country (Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, and Tamil Nadu). (Kakade 2008)

This activity which is built into NRHM and is supported by the public health system, involves participatory monitoring of health rights by community members and civil society organizations, including regular preparation of community 'report cards', discussing the required improvements in multi-stakeholder monitoring committees, and periodic conduction of public hearings on health rights. Although strictly speaking it is not an activity of JSA groups alone, JSA groups and individuals have played and continue to play a central role in this activity in various states.[61]

CBM is a framework and space for establishment of Health rights within the public health system. This framework is being used by JSA member organizations to ensure that people can claim their right to health care in the context of rural health services. CBM seeks to significantly change the traditional vertical power relationship between educated, articulated health care providers and less educated, less influential village community members. The CBM model that has evolved in Maharashtra is a significant step for moving towards such equalization of power. This model is towards making the health system accountable to people, and enabling people to demand their health rights. Enabling citizens to monitor and hold accountable public systems can become a vehicle for community empowerment and democratizing social systems beyond the health sector.[62]

61 Note on Right to Health activities by Jan Swasthya Abhiyan(PHM-In Published on People's Health Movement, (http://www.phmovement.org)

62 Note on Right to Health activities by Jan Swasthya Abhiyan(PHM-In Published on People's Health Movement, (http://www.phmovement.org)

International Engagement of JSA with Commission on Social Determinants of Health

The World Health Organization has constituted Commission on the Social Determinants of Health (CSDH) in 2005. This is a clear indication of recognition of need for a greater focus on upstream determinants. The Commission has marked them "causes of the causes". The main objective of Commission on Social Determinants of Health was to reinforce and unite actions and policies that promote equity and address the social determinants of health. In this regard, CSDH has identified what civil society organizations are doing and what they need in order to strengthen their work on social determinants of health (Marmot 2005, Baum 2006). Major focus areas of CSDH are compile evidence on successful interventions and formulate policies that address key social determinants, particularly in low-income countries; raise societal debate and advocate for implementation by member States, civil society, and global health actors of policies that address social determinants and define a medium and long-term action agenda for incorporating social determinants of health interventions, approaches into planning, policy, and technical work within WHO (Marmot 2005)

Rationale for Engagement with CSDH

Advocacy on social determinants of health has been the global agenda of People's Health Movement. PHM's agenda included advocacy strategies and their proactive and assertive promotion of these deeper determinants of health and health care in framework of people health Charter. The principles of the PHM charter state that "health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making. And the preamble of the charter has included "Health is a social, economic and political issue and fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalized people" (Narayan 2006)

After the First People's Health Assembly 2000 at Savar, Bangladesh, the evolving people health movement set up a small WHO advocacy circle that began to use every

opportunity to engage with WHO and encourage it to rediscover its original mandate and commitment to the social determinants of health. Over the next three years, this continuous engagement led to a series of interesting events and dialogues that began to put people pressure on WHO in different ways. These included a set of provocative in-house workshops at WHO headquarters by a PHM-linked health policy resource person in April 2001. These workshops led to the announcement of the Civil Society Initiative by the WHO Director-General and an invitation for dialogue to a group of PHM leaders at the next World Health Assembly in May 2001. The active participation in World Health Assembly 2001 helped to put the Social Determinants of Health on the global agenda through continued engagement with the WHO. PHM helped gather evidence for the WHO final report on the Social Determinants of health released in August, 2008 (Narayan 2006).

Concern areas of PHM in Commission on Social Determinants of Health

Commission on Social Determinants of Health used the primary health care approach and this was primary concern by civil society group in the engagement process. Second concern was

> *"The Commission has on addressing "inequity". Addressing mere inequality is not enough, because the extent of inequality in health cannot give us adequate information to assess health equity".* (WHO 2007:9).

Civil society groups consider that the ultimate goal of commission should focus on poor while working on health policies. Make an effort to bring about significant policies that directly address the social determinants of the inequitable distribution of resources. Civil society groups had taken opportunity to advocate for equity and for the structural changes that will do away with the social, economic and political determinants of health.

> *"Civil Society views its role not as that of an instrument of advocacy for the Commission, but as a significant partner of the CSDH that brings in fresh, people and community centred, perspectives and has the potential to shape the Commission's work in many ways. In order for Civil Society to play this*

role it is imperative that it retains the right to formulate its own independent analysis of the Commission's work". (WHO 2007:9)

Strategic Engagement of PHM

Represented in the Commissioners and Knowledge Networks

Members of PHM represented civil society and were engaged as commissioners in the various Knowledge networks of CSDH. The Commissioners comprise an independent body charged with WHO Secretariat coordinates; the various areas of work of the Commission Knowledge Networks provide the evidence base on which to identify priority actions and interventions. The Scientific Secretariat helps to coordinate the evidence base generated by the Knowledge Networks. This strategic engagement of PHM with CSDH had helped to put forward the civil society agenda at the global level.

Dominating the Civil Society Component

Civil Society had provided an important input in terms of experiences on the ground and across sectors. The major roles of civil society had been to frame critical analysis about the rapid changes happening in health and formulate public opinion on the issues of health as a basic fundamental right; to engage in dialogue with policy planners and Government functionaries for ensuring the health to all; to. Build campaigns on critical health policy issues; and to mobilize community for people monitored health systems.

Civil society organisations are seen as one of the arms of the Commission, based on a perception that they can play a balancing role in the work of the Commission and influence some of its recommendations by bringing in experiences that are people and movement centred. JSA members feel that this move is a genuine attempt to make this Commission more responsive to people's concerns.[63].

Civil society was viewed as important to provide 'the people's perspectives', and to carry on the process so that it produces something larger when the Commission's life ends in 2008. The CSDH process is a progressive move by WHO and JSA had used this

63 Mail No:-2111 Date: Thu Sep 15, 2005 6:14 am, Subject: CSDH: For Immediate Response

opportunity given to it as a Civil Society organization. If JSA do not engage, there will be others to fill the gap, which may divert the CSDH process to undesirable conclusions. However, given the background of some of the Commissioners, JSA should be vigilant at every stage of the process, even while engaging with the process.[64]

People's Health Movement India has perspectives on Social Determinants of health, articulated through the Indian People's Charter for Health 2000, Asian People's Charter on HIV/ AIDS, 2003, The Mumbai Declaration, 2004, National Right to Health Care Campaign Documents, 2004-05. They have used this perspective in order to engage with the CSDH process.

Major achievement of engagement with CSDH:

- Civil society Mobilization: Several countries based and regional consultation meetings.
- Role of PHM in Knowledge commission generation: Active participation in the Knowledge Networks' processes of evidence collection and creation.
- Three independent civil society reports submitted to the Commission on Social Determinants of Health.

Other Campaigns and Issues Related to Right to Health

The civil society organizations and networks in the JSA have their own independent activities. In addition, the JSA has coordinated national or regional campaigns/activities that involve all or a major section of its constituents. Besides the right to health care campaign, some of the major campaigns initiated and coordinated by the JSA are as follows:

Campaign against Sex Selective Abortions: In response to the Public Interest Litigation filed in Supreme Court regarding Pre Natal Diagnostic Tests and Sex Selective Abortions JSA initiated a campaign related to constitution of appropriate authorities, registration of

64 Mail No-2125, Date: Mon Sep 26, 2005 5:01 am, Subject: Report of WHO regional Consultation on CSDH

ultrasound centers, ban on advertisements, displaying posters in clinics and the issue of son preference. This campaign was taken up intensively in a number of states especially in Tamil Nadu, Haryana and Himachal Pradesh in the second half of 2001

Hunger Watch: JSA set up a 'Hunger Watch' group consisting of public health and nutrition experts to provide assistance to the Right to Food Campaign. The group has prepared a protocol to investigate cases of hunger-related or starvation deaths.

Involvement in the Right to Food Campaign: In several states, surveys have been conducted by JSA constituents on the status of mid-day meal and other schemes. In several states, a convention on 'Right to food - Right to health' has been organised. A resource material package in the form of a book "If even one person goes hungry...." was brought out by Tamil Nadu Science Forum and Bharat Gyan Vigyan Samiti (BGVS) for the Right to Food campaign and it has served to inform the public and keep the issue alive. There is a growing focus on 'Children's Right to Food' and JSA has played a key role in the development of this campaign and issue within the overall campaign for the Right to Food.

TRIPS and the Indian Patent Amendment Act: The TRIPS agreement required India to change to a Product Patent regime in the area of pharmaceuticals and food, from the earlier system provided in the *Amendment of the Indian Patents Act of 1970* which did not provide for Product Patents in these areas. Such a move has many negative implications on people's ability to access essential medicines. The JSA has been an active partner in the campaign to pressure the government to make full use of the safeguards available in the TRIPS agreement to safeguard Public Health.

Initiatives related to Drug Policy: The JSA has been active in pursuing the development of a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance. The National Policy on Pharmaceuticals was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared. JSA participated in a public campaign concerning the Pharmaceutical Policy, which was initiated by one of its constituent organisations – the Federation of Medical Representatives Association of India (FMRAI). Many states have

held discussions regarding an essential drug policy and to build public awareness on the impact of globalisation on the pharmaceutical sector

Initiatives related to Health Policy: The JSA has been involved in a number of critiques of government policies both at the state and at the national level. The JSA elaborated a detailed critique of the National Health Policy draft in 2001. The critique served to educate all the JSA member organizations on this development, and has been published in booklet form. A series of seminars and press releases explained this position to the general public

The summering the basic arguments of this chapter as JSA has promoting the improvement of health system structures of governance and processes of participation at community, local, national and global levels with global health movement. It has been emphasizing on universal health care, global solidarity for right to health, comprehensiveness of care, and equitable access to health care and other social services; promoting participative health policy formulation and implementation. JSA has alliance with global people's health movement for global health campaigns and advocacy on the right to health and other social rights, social determinants of health, improving the access to primary health care and issue of regulation of private sector. Mobilization at national levels for current macro-economic policies, social policies; improving health systems participatory structures and encouraging people's participation in policy formulation and decision-making processes.

The JSA's thrust on right to health care has brought it to engage with various initiatives by national and international public health organisations. One significant engagement that has not been discussed in this chapter is that with the legislation on Health either in the form of Bill or in the form of Act. The next chapter analyses them in detail, both as articulation of the right to health care by the governments and for JSA's role in their preparation.

Chapter - IV

Review of Right to Health in India and the Draft National and State Health Bills

Chapter: IV

Review of Right to Health in India and the Draft National and State Health Bills

Context of Right to Health Campaign

In India, right to health has been said to be claimed by three approaches. First is the right to life, second directive principles of state policy and third is based on the programmatic approach under the welfare provisions. The Constitution of India recognises the right to life and liberty of every individual. Articles 14, 15, and 21 of the Constitution, recognize the right to life as a fundamental right and place, the obligations on the Government to ensure protection and fulfilment of the right to health for all, "Right to life is an inalienable right referring to natural rights things that we can enjoy on our own, without depending on government. The only way that rights exist is through positive government action. Rights as if they are created by government, not derived from the "laws of nature". In the present context the natural rights theory is both outdated and discredited." (Feinberg, 1978).

There are numerous judgments of Supreme Court of India related to the right to life which has helped to fulfil the demand of right to health. This approach has been effective in individual cases but unsuccessful in addressing the problem of denial and violation of right to health at larger level. The biggest constraint to right to life is the meaning of 'right to life' itself as it can be interpreted differently in different contexts as seen by the various judgements given by the Supreme Court (Byrne, 2009).

Right to Health: Definition and Meaning

Sixty years ago, the Universal Declaration of Human Rights laid the foundations for the right to the highest attainable standard of health. This right is central to the creation of equitable health systems (Backman et al 2008). Human rights are based on generally accepted principles of equality and justice and protecting individuals and groups from elementary forms of injustice. Human rights belong to all and must never be regarded as a favour, gift, or privilege conferred by the state or by any organization or individual.

Another basic feature of human rights is that they regulate relationships between the state and individuals or groups. Human rights are claim rights (Asher 2004).

The distinction between Right to Health and Right to Health Care is important as it defines what is being claimed from state. "The right to health is obviously not the right to be healthy. The ideal state of a particular individual being healthy cannot be demanded from the Government any more than one can demand the 'right to be wise' or 'right to be satisfied'. However, what can be justifiably demanded are the basic conditions and services necessary for one to be healthy which is the right to health care, just as we can demand a right to education or right to food security" (Shukla 2008: 3). As put by Roger "Right to health care implies, on its face, a right to certain services; by contrast, a right to health seems to imply a right to be healthy, which is an impossible standard" (Ruger 2006: 274). However the issue of right to health care is intertwined with the issue of right to health. Though health services form only a small part of the determinants for health, yet issues like right to clean drinking water or nutrition are major determinates of health. As stated by Dr. Shukla, "there is need to think creatively, how to link the existing health initiative with such issues"[65].

> *"The right to health care has more to do with healthy pro-poor politics than law. The corollary legislation in relation to this is the right to information, the right to participation, and the right to monitor, which should all be demanded."* (CEHAT 2003)

According to the international covenants document, right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standards of health, Article 25 of the Human Right Declaration 1948 recognizes health as a right by assuring that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services,

[65] Dr. Abhay Shukla of CEHAT, for the Seminar on 'Right to Health Care' organized on 3-4 January 2003 during the Asian Social Forum at Hyderabad.

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".[66]

During conceptualisation of the Right to Health Campaign, Jan Swasthya Abhiyan refuted the feasibility of operationalising this definition and so narrowed it down to Right to Health Care. The justification was based on the ground that right to health is a difficult claim through the judicial system, while on the other hand right to health care is straightforward to claim and operationalise.

WHO Constitution defined right to health as the 'Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'[67] The 1978 declaration of Alma-Ata claim explains right to health in context of the nations as the ability to ensure availability of the essentials of primary health care.[68]

The United Nations Special Rapporteur on the right to health describes "The right to health can be understood as the right to an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system"[69]. This right includes both the right to all the underlying determinants of health besides health care such as access to safe drinking water, food security, housing, adequate sanitation, education, health-related information, and other underlying determinants of health it includes freedoms, such as the right to be free from discrimination, a healthy working and living environment. The right to health care is the

[66] The Universal Declaration of Human Rights.1948, Article 25 (1) access on Jan 29, 2011, from http://www.un.org/en/documents/udhr/index.shtml

[67] See WHO Constitution 1948

[68] 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 organized by Jan Swasthya Abhiyan, Report prepared and published by CEHAT for Jan Swasthya Abhiyan

[69] The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2006)

right to the entire spectrum of preventive, curative and rehabilitative services plus health education and promotive activities. The right to essential primary health care is sub part of right to health (ICESCR 1976).

The Supreme Court of India stated that to claim Right to health care the term 'health' implies more than mere absence of sickness. Article 21 of the Indian Constitution guarantees protection of life and personal liberty by providing that no person shall be deprived of his life or personal liberty except according to the procedure established by law. Guarantee of health of citizens is certified as a part of directive principles in the constitutional mandate. This directive principle is a guiding force to shape policy, though it does not mandate on the state to provide as fundamental right. However the Apex Court in India has recognized the right to health as a part of the fundamental right to life. This expanded meaning is completely justifiable as an individual can not enjoy life and for that matter every other fundamental right guaranteed by the constitution, in absence of good health. Healthy life is a means to enjoy all freedoms guaranteed by the constitution. Through this the Supreme Court of India has imposed obligation on the state to take care of health of its citizens. This has given prime importance to the maintenance of health as an obligation of the state and made it as a constitutional goal (Byrne, 2009).

State being guarantor of rights, government must persist in enforcing the rights of people and take every necessary action against the factors that interfere with the ability of people to enjoy their right. At the same time it is the duty of the government to see to it that, the right of the people is not violated by any other element in the society such as health care institutions or providers. The welfare state is a guarantor of the rights and its duty is to protect welfare of its citizens. [70]. Inequities in rural urban, gender, caste and class wise access to health care services in India need to be addressed for making right to health care operational (Dilip 2005).

The state discharges its duty towards its people through various institutions. To maintain health of the people state provides health care by organizing the public health system. All

[70] An important judgement (Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996), the Supreme Court of India

the institutions under the purview of public health are obligated to deliver their duty towards maintaining health of the people. The human resource engaged in the health system is bound to offer their services to preserve human life. Failure of any of such institutions to treat or to provide services to citizens of this country is violation of right to life guaranteed by article 21 of the constitution[71].

History of legal efforts in health advocacy has resulted in numerous acts, declarations, treaties, guidelines and principles that are formulated in India. Within the constitutional powers of Government of India under Item 14 in List I (Union List) in Schedule VII of the Indian Constitution, to legislate on matters that require to be legislated upon for implementing its international obligations under the international treaties and declarations that are the principal subject matter of right to health'.[72] It is constitutionally mandated on state to implement treaties and declarations, and thus international global politics influences the implementation of national laws. The Constitution of India envisages establishment of a welfare state at the federal level as well as at the State level, where the primary duty of the Government is to secure welfare of the people. Article 21 of the Constitution imposes an obligation on the State to safeguard the right to life of every person. It is the constitutional obligation of the State to provide adequate medical services to the people to preserve human life.

The Supreme Court Judgments on Right to Health[73]

Supreme Court had given judgments on rights to health under the right to life framework and assured that state has a role to protect right to health. Some of the relevant judgements are as follows: In the case of Consumer Education and Research Center v. Union of India [1995 (3) SCC 42]: The government has a positive duty to provide the basic conditions necessary to lead a life that is more than mere animal existence, including a Right to Health, Right to Clean Environment, Right to Privacy.

[71] Case of The Medical Association of India Vs VP Shantha pronounced on 13/11/1995 (AIR 1996 SC 550)

[72] The National Health Draft Bill, 2009 (Draft)

[73] Right to health. (2011). Retrieved Feb 13, 2011, from http://www.legalindia.in/right-to-health

In the case of Parmanand Katara v. Union of India [1989 (4) SCC 286], the Supreme Court said that whether the patient was innocent or a criminal, it is an obligation of those in charge of community health to preserve the life of the patient.

In the case of Paschim Banga Khet Mazdoor Samity vs. State of West Bengal, [1996 (4) SCC 37], the Supreme Court ruling, in summary, stated that there must be:

- Adequate medical facilities to give immediate primary treatment to stabilize the patient's condition.
- Upgradation of hospitals at the district level and Sub-Division level that serious cases can be treated there.
- Facilities for giving specialist treatment in the hospitals at the district level and the Sub-Division level.
- A centralized communication system so that an emergency patient can be sent immediately to the hospital where bed is available, where appropriate treatment is available.
- Proper arrangement for ambulance transport of a patient from the Primary Health Center to the district hospital or Sub-Division hospital and from the district hospital or Sub-Division hospital to the State hospital.
- Ambulances, which are adequately provided with necessary equipment and medical personnel.
- Emergency preparedness in Health Centers and hospitals for larger volumes of patients needing emergency treatment, during certain seasons, accidents, or mass casualty.

Review of Proposed National Health Bill 2009

Rights and laws are both interdependent in conceptual and political circumstance. As Social movements and civil society organisation use the tool of rights and all legal discourses are animated by weighing and competing rights (Menon 2004). Health services through legal provision is increasingly being recognized and used as a tool for improving the access to health care of populations at global, national and sub-national levels. As a means of public health improvement, public health laws focus on the

government's responsibility to create the conditions for people to live healthy lives in ways that are consistent with human rights (Magnusson 2009).

But within the academia there have been debates on whether health should be a fundamental right or not and under which circumstances it should be recognised (Sen, 2011, Mathiharan 2003). After sixty years of independence, the civil society groups in health had advocated and pressurised the government of India to draft the first National Health Bill in 2009. The findings of the public hearings across the country on the right to health care conducted by the National Human Rights Commission in collaboration with *Jan Swasthya Abhiyan* in 2004 were sent to the government recommending the enactment of a legislation to recognise and implement the right to health care of citizens. The Ministry of Health and Family Welfare (MoHFW) came out with the draft Bill which aims to provide health, health equity and justice to all citizens of the country. It seeks to legalise the right to health care of every citizen along with other issues associated with health rights like access to good treatment, emergency care, etc. with a view to "provide for protection and fulfilment of rights in relation to health and wellbeing, including those related to all the underlying determinants of health as well as healthcare; and for achieving the goal of health for all; and for matters connected therewith or incidental thereto" (Draft Bill, 2009).

The Role of Public Health Act

There is lack of basic legislation to underpin public health services in India. In 1955 and again in 1987 the central government developed drafts of a Model Public Health Act, but did not use its very considerable fiscal clout to encourage states to adopt them.[74]

A Public Health Act is used as proactive measures to prevent threats to public health before a crisis occurs. The public health acts clearly define the legal and administrative structures under which a public health system functions, assigns responsibilities and powers to different levels of government and agencies, and specifies their source of

[74] A committee was constituted by Government of India in 1978 to examine Model public Health Act prepared in 1955 and other acts and suggest revised/modified updated draft Model Public Health Act. This publication was revised with commission of several chapters from old act of 1955 and addition of few new chapters, which were relevant to the context in those times. This was compiled in January 1987. The issue is not priced.

funding for discharging these duties.[75] It sets out powers for taking action for protecting the public health, including powers of regulation and of inspection and the responsibility to use these powers to monitor any situations or activities that could potentially threaten public health, and seek to redress them if needed. Public health laws set standards of quality measures for public health care and specify the responsibility for assure and ensure that these standards are met (Gupta et.al 2010).

Presently to take action on legal public health, administrators are highly dependent on the Epidemic Act of 1897 and the Indian Penal Code of 1860. Furthermore, local body Acts such as the Municipalities Act and Panchayati Raj Act offer much less comprehensive provisions than a Public Health Act, and they (by definition) do not apply uniformly across a state. (ibid 2010)

Some efforts are now underway to strengthen public health legislation in India. The National Health Bill 2009 drafted under the National Rural Health Mission seeks to encourage states to prepare Public Health Acts. Some states, such as Gujarat and Assam are working on drafting Public Health Acts. These three Acts framework provide the fundamental legislative underpinning for public health action and service delivery. The draft the of National Health bill 2009, Gujarat Public Health Bill 2009, and Assam Public Health Act 2010 have followed the same kinds of designs to formulate Drafts. The Gujarat Public Health Bill has included one chapter on right to health in emergency situations such as a natural calamity and communal violence; two factors that had been experienced as a massive impact on the Gujarat public health system.

The Ministry of Health and Family Welfare in coordination with other departments and ministries concerned with the obligation of providing people with minimum nutritionally adequate essential food, adequate supply of safe drinking water, sanitation through appropriate and effective sewage and drainage systems and access to basic housing facilities. The Ministry of health and family welfare is to fix the responsibility and accountability of departments and agencies concerned, in case of repeated outbreaks or recurrence of communicable, viral and water-borne diseases in a particular area and

[75] Hamlin and Sheard 1998 cited in Gupta et.al 2010.

proved to have taken place because of the failure to improve sanitation and safe drinking water facilities. These draft Acts delineate health rights of citizens, duties of the public health system and specify broad legal and organisational mechanisms to operationalise these rights.

National Health Bill (Draft) 2009

The Draft National Health Bill 2009 has been considered an 'umbrella legislation' to protect the right of citizens to health and health care through stating entitlements, implementation and regulatory mechanisms. The proposed legislative framework includes one umbrella statute with consistent state Public Health Acts for governance and regulation. This proposed National health bill takes the first step in a systematic, rights-based theoretical basis for the health of the population. It defines the role and responsibilities of the national government, including setting standards and goals for the health system. It defines which level of government has responsibility for various health function areas that will need more detailed subsidiary legislation, and responsibility for performance of that function.

The needed state level subsidiary legislation has been provided for by the Gujarat Public Health Bill 2009, and Assam Public Health Act 2010. But the formulation of the Gujarat public health act preceded the drafting of the National Health Bill and is reflected in much of its structure and content. The Assam Public Health Act structure was adopted from the National Health Bill. Thus, more or less the structure of all three bills has followed the same definitional structure.

Assam Act and Gujarat draft Bills aims to regulate public and private health sectors for achieving good public health by introducing necessary monitoring mechanisms and establishing state and district level authorities. Assam has become the first state in the country to enact a legislation declaring right to health as an inclusive right of every citizen of the state. The Assam Public Health Bill, 2010, was passed without any hurdle in the Assembly April 2010, though ti was the last to be drafted.

These two Acts guarantee the people's right to health and make it obligatory on the part of the government to provide access to healthcare services to every citizen and ensure

that there shall not be any denial of healthcare directly or indirectly to anyone by any healthcare service provider, be it government or private. The bills makes it mandatory for all Government and private hospitals and nursing homes to provide free healthcare services for first 24 hours to any patient in an emergency. Patients who cannot afford treatment at private hospitals or nursing homes may be shifted to government hospitals after 24 hours. The Act makes it mandatory for all hospitals and nursing homes, government or private, to maintain appropriate protocol of treatment for first 24 hours to an emergency patient of any kind.

Another significant aspect of the Act is that it empowers the state Health Department to fix responsibility and accountability of departments and agencies concerned in case of repeated outbreak of communicable, viral and waterborne diseases. The Act guarantees people the right to appropriate medicines and right to effective measures for prevention, treatment and control of epidemic and endemic diseases.

The Role of Civil Society in Drafting Bills

The processes of Public Hearing had created demand for legislation to prevent violation of basic health rights. At same time Gujarat Jan Swasthya Abhiyan was involved in Gujarat's health policy formulation with the Gujarat state's Health and Family Welfare Department. After the realisation of need for a legal framework through the NHRC report, the Gujarat Jan Swasthya Abhiyan also engaged with the Gujarat state's Health and Family Welfare Department in drafting of the Gujarat Public Health Bill. The major involvement of Jan Swasthya Abhiyan networking organisations, individual Public health activists and health lawyers had given substantial inputs in this whole process. The draft created was a comprehensive Public Health Act, which would cover mandatory steps to move towards ensuring health and health care as a right.

Subsequently, the major work of drafting the National Health Bill 2009 was done by the National Health Systems Resource Centre (NHSRC) for the central ministry. NHSRC is a technical support institution under the National Rural Health Mission, Ministry of Health & Family Welfare Government of India. The main legal framing contribution was

provided by a human rights lawyer at NHSRC, in consultation with Jan Swasthya Abhiyan members and other health as well as legal experts and senior administrators.

The National Rural Health Mission programme has considered the eight north-eastern states as those among its category of the 'high focus states' based on the need to improve health services. Technical support has been provided to improve health systems by NHSRC to the health and family welfare departments of all the eight states including Assam. The process of engagement gave vision to formulate the Assam Public health Act 2010 with the major support of by National Health Systems Resource Centre and State Health and Family Welfare Department of Assam.

Strengthening the Right to Health bill is a critical first step towards legal recognition of the right to health and health care in India and its operationalisation, and therefore necessitates an in-depth understanding and analysis of its provisions. Various civil society groups and individual public health activists in health have expressed their views on the health bills. Civil society originations put forwards their position on the Bills through consultations and workshops. Sama[76] organized a two-day workshop on the draft National Health Bill, This workshop follows several requests those were received from various organisations and provided an opportunity to develop a comprehensive understanding of the Draft Bill based on a public health and gender analysis. Another National Consultation on the Draft National Health Bill, 2009 was organised by the Centre for Legislative Research and Advocacy (CLRA). Jan Swasthya Abhiyan's state level workshops were held in various parts in India. Major civil society opinions and debate took place on National Health bill 2009 blog of National Rural Health Mission. Based on several opinion and comments Jan Swasthya Abhiyan came out with its position paper on the draft of the National Health Bill 2009.

National and State Bill Drafts: the Relationship, Structure and Content

The national bill defines the degree to which central and local governments are responsible for implementing the human rights framework. This rights based framework is used by civil society groups in health to deal with inequalities in the current scenario.

[76] Sama is a women's group working on women and health in India

The proposed National Health Bill 2009 recognizes "health as a fundamental human right and states that every citizen has a right to the highest attainable standard of health and well-being".

Three bills related to the right to health have been drafted in the past three years and are being analysed here--the National Health Bill 2009, The Assam Public Health Act 2010 and The Gujarat Public Health Bill, 2009.

This analytical review will focus on the framework of the bills, strategies to implement right to health envisaged in them, and limitations of the three documents. However, the fundamental argument and questions for analytical review is, why state has not made health as fundamental right in the constitution of India? Why is the government using international human rights framework to claim right to health? Is it a realistic option to deal with social determinants and pursue inequalities in health? This critique also analyses the liberal concept of human rights. The primary concern of researcher is to identify the issues that will strengthen the "operationalisation of health as a fundamental right".

Optimism in National Right Health Bill

The draft of the proposed National Health Bill is unique compared to the other health legislations because it is based on the understanding that, health care and *"justified health care as a special social good."* (Ruger 2006: 275). It endorses health-care rights of every individual rather than just delivery of health-care services. It is based on the fundamental belief that individuals have an equitable right to health. Its character is as an umbrella law that works towards the aim of health for all.

This proposed legislation demarcates the rights of an individual with respect to health and health care and regulates the services presented by health institutions and health-care providers by providing adequate health-care information and systems for redressal. It gives importance to the Panchayati Raj institutions and local organisations while also addressing the needs of marginalised and vulnerable people in society. This is done through addressing the determinants of health not just health care. According to the draft health bill the effect on health will mandatorily assess every proposed law, policy,

programme, project, technology, or a potentially damaging activity, in relation to health. The bill envisions a transparent and accountable process by the government and private institution that will protect the right to affordable, inclusive, and convenient health care which will be accessible, available, and acceptable and optimum services will be in provided in a non-discriminatory way (Reddy et.al, 2011). The draft bill presents a number of optimistic promises.

The present bill has accepted the following rationale for inclusion. The transformation of social inequalities based on class, caste, gender; race and ethnicity into health inequities and discrimination are clear evidence of violations of the right to health that influence the outcome of health status of marginalized and poor section of society. The principle of non-discrimination is mentioned in the draft bill but the affirmative action to prevent discrimination while accessing health care has not been clearly defined in the proposed bill.

The present framework of National Health Bill has not clearly differentiated between individual rights and collective rights. The bill has incorporated both the above mentioned rights in one ambit group. The assurances for individual rights are indeed in the bill, but the mechanism for violation of collective right is not mentioned.

It is agreed that health rights of the people are being violated and the bill proposes to prevent this violation. Although the regulatory mechanism present in the bill is questioned by many, the private sector which is the market forces present as part public-private partnership (PPP) has been accepted in the Bill. This bill provides a major space to the private sector without questioning the issue of private regulation mechanisms but in practice the nature of market forces indicates that collective rights are no more easily asserted or protected from violation. Although it is clearly stated in the bill that

> *"Provide free and universal access to health care services and ensure that there shall not be any denial of health care directly or indirectly, to anyone, by any health care service provider, public or private, including for profit and not for profit service providers, by laying down minimum standards and appropriate regulatory mechanism; Provided that notwithstanding the above*

the Governments have an immediate duty to prioritize the most vulnerable and marginalized persons and groups,-who are unable themselves to access means for adequate and appropriate health care services, and ensuring them at least the minimum conditions of health care" (Government of India 2009: 13)

Understandings of health reflect cultural, social, and economic circumstances; it is not unique in nature and health itself is a relative concept which further creates ambiguity and imprecision. The proposed national health bill is complicated by a lack of clarity in the area of identification of violation of the right to health as well as in ensuring mechanism to monitor the observance of the law. Lack of accountability of the meditating administrative and bureaucratic institutions becomes a major obstacle in getting legal redressal if basic health care is denied. There is also a general distrust among the people towards these government institutions. Another major barrier in getting legal access is the economics involved in it. The Domestic Violence Act 2005 makes the implementation process evident, including for instance that lack of awareness about legal mechanism becomes a major problem and there is a dire need to improve legal literacy (Frattaroli 2006). At the implementation level, it is necessary to recognise the need for providing legal literacy and training of judges, judicial officers and public health advocates to work with a public health perspective. If the judiciary and the law enforcers work with a public health perspective it will help health movements to hold the government accountable to conduct their functions and make health truly a right (Magnusson 2009).

Space for Civil Society in the National Health Bill

Civil society organisations have been involved at different levels in framing the proposed bill. The state sees civil society organisations as representing the voices of the marginalised. As stated in the bill

"Ensure comprehensive involvement of civil society, especially vulnerable or marginalized individuals/groups by enabling them to effectively articulate their health needs and to participate in all health related

decision-making processes, including in setting health priorities and goals; and in devising, planning, implementing and evaluating the policies and strategies for health and well-being at every level; also integrally incorporating their roles and participation in the contents of such policies, strategies and plans; and ensuring demonstrably serious consideration to diverse expert views, in the planning of health care"(Government of India 2009: 13).

The challenge is that civil society is far from a homogeneous monolith. It embodies contradictions, different perspectives, even different ideological strands; institutionally it is made up of NGOs, trade unions, social movements, and so on. There is a vast spectrum of ideologies that are encompassed in the term civil society and this very difference becomes a barrier when it comes to implementation of the national health bill. There are certain civil society organisations that have political affiliations and organisations with communal agendas which play a vital role in the implementation of different bills and acts. The ideological construct in perspective of these organisations reflect in the framing, implementing and structuring of the bills and acts where there are no assurance that these kind of civil society organisation will work towards serving the best interest of the people. The bill does not mention the criteria for selection of civil society organisations. There is a significant space given to the private sector in the structuring of legal framework for right to health care through these bills. The justification has given that health care provider role of private sector, 80 present of health care provision is done by private sector in India. This actually "legitimises the role of the private sector in health and also under the garb of including civil society organisations the agenda of public private partnership has gained importance. Thus marginalising the role of the public sector and weakening the position of the state". (CEHAT 2003)

Implementation & Monitoring Mechanism Bill

The proposed bill includes a chapter on Implementation & Monitoring Mechanism of health as a right. This chapter states that Community Based Monitoring (CBM) would be an appropriate method to make health a right and to increase the community ownership on health care.

Community based monitoring was envisaged as a communitization process. As R.S. Pandey rightly critiques that, "communitization is a contract between the government and the community. In this contract, the community becomes the owner of the government institutions and assets and is granted powers and resources to manage the employees and maintain institutions. In other words, it is privatization of government-owned public institutions in the hands of the user community. It is 'empowerment, delegation, decentralisation and privatisation at the same time' (Yhome, 2011). The process of CBM evolved from the global health governance debate which had called for the broader involvement of civil society and the private sector in the development of policy and decision making process (Pollock et.al 2003).

A major challenge of Community Based Monitoring approach is faced in its implementation at community level. Officials and professionals who have never undertaken participatory development processes before cannot transfer the necessary skills and capacities to the facilitators and then from them to members of the community. The framework has a utopian notion in defining "community" in the entire framework. The process of CBM has the government, civil society groups and the community as the stakeholders. Although the process is said to be primarily giving power to the community but it is the weakest among the stakeholders when it comes to the negotiating. Implementing the monitoring process and sustaining the specialized functions entailed in this strategy are challenging in the community setting.

Participatory tools for monitoring and monitoring indicators have been pre- decided by policy makers and a number of indicators have been developed by civil society organisations involved in operationalising the community monitoring, which leaves very little role for the community. The present experiences have shown that central power is in the hands of the civil society and they monitor health care through the community. It is a top-down approach in monitoring framework in the name of decentralised planning and implementation. [77]

[77] Based on personal experience of organizing and conducting public hearings for Community Based Monitoring under National Rural Health Mission

Disputes Resolution and Redressal Mechanism for Health Rights

There are three mechanisms suggested in the proposed National Health Bill. Disputes resolution through public dialogue, public hearings, and grievance redressal through in-house complaints forums at the institutional level and finally cause of action for complaints related to health before designated district courts. These mechanisms have both positive aspects as well as some limitations when it comes to the implementation level. Public hearing approach is to primarily ensure that victims have access to justice by providing compensation if they suffer damages. An effective system of public hearing mechanism would create a deterrence effect and thereby help to enforce the law. In the public hearing approach the violation of right to health is solved by public or private organisations, it is the civil society originations funded by public resources that act on behalf of those whose rights have been violated. The public hearing mechanism is an important and effective legal tool but cannot be a substitute for the public sector intervention. The effectiveness of public hearing approach depends upon the mobilisation by civil society at the grassroots level but functions of these organisations are diversified, hence getting them under one umbrella is very difficult. Thus conditions cannot be generalised at the community level making it very complex if policy makers follow a top down approach. It is also not feasible that policy decisions are made based on public hearings.

Another hindrance to making public hearing an effective mechanism is the notion of 'people' in the bill. The term is used without regard to specific details or exceptions. 'People' or community are viewed as a homogeneous entity without any structural hierarchies while in reality the existing power structure plays a prominent role during the conduction of public hearings. The people who give testimonies are also part of the existing social and economic hierarchies and they face discrimination and isolation from the system. There is no proper mechanism that offers security to them after public hearings. Public hearing in CBM is dominated by civil society organisations and does give a voice to the people themselves who are supposed to be the real 'owners' of this process.

These public hearings adopt an 'anti- bureaucrats and health care providers' approach and it becomes a blame game between the civil society and the bureaucracy/ health care providers. This blame game does not provide space for combined efforts by the civil society and bureaucracy to work towards betterment of the people, neither there is a questioning of the systemic flaws that exist which violate the rights of the people. In the public hearings the bureaucrats/providers have a self defensive attitude as they are not given space to express their problems. This anti bureaucratic stand does not help to improve the public health system nor helps to provide better services to the people. The main focus of public hearings has remained demanding better medical services or highlighting the obstacles faced by people in accessing medical services. It has failed to use this method by placing demands within a holistic public health perspective. Preventive and promotive measures necessary for good public health are not demanded or lack of it is not questioned, making public hearing a very narrow approach.[78]

Although the National Human Rights Commission has given instructions that the violators of health rights should be made accountable, these cases which are presented at public hearings rarely get adequate importance or attention from the state commissions.

Discussion and Comments on Draft National Health Bill 2009

The MoHFW placed the draft National Health Bill on the ministries website in 2009 and there were comments sought from the public on this draft. They received many comments and suggestions to improve the bill from academicians, practitioners and health advocates. This section highlights and analyses the responses on draft national health bill.

In an online discussion, one public health expert and senior academician responded that, "response to the Draft Bill will be an effort to raise the voice of the voiceless and expose the series of betrayals." He argues that there is no such strong reason to advocate the National Health Bill 2009 as Indian state has always failed to be accountable towards its people and not even fulfilled the promises since independence. He says that health bill is the latest promise in the series of false promises made by the government of India and

[78] Based on the personal experience of organizing and conducting public hearings for Community Based Monitoring under National Rural Health Mission.

presents his arguments giving examples of the failed vertical health programmes like Polio eradication, AIDS programme, Revised National Tuberculosis Control Programme, the Universal Immunization Programme.

He questions the need for a draft health bill when it is enshrined in the Directive Principles of the Indian constitution for state policies that 'the state shall protect and promote health and nutrition of the people'. He comments that the Draft Bill ignores the fact that health is a state subject and most of health actions take place at the state level while the power is allocated into the hands of the centre. Which post independence played into the hands of international players allowing them to impose their will over the states in the form of `centrally sponsored' schemes. The Family Planning Programme is an outstanding example of such imposition. He has expressed his reservations against the National Rural Health Mission (NRHM) which has failed to reach the expected standards that it has set to achieve. This he says has been the case with all the health programmes in the country where both the Centre and the states have grievously suffered due to virtual decimation of the once towering key public health institutions like the All India Institute of Hygiene and Public Health, the National Institute of Health and Family Welfare, the National Institute of Communicable Diseases, the Planning Commission and ICMR. He also says that inspite of the institutional mechanisms where there has been an unbridled growth of communicable diseases like Japanese Encephalitis, Kala-Azar, Dengue Hemorrhagic Fever and Malaria. He states that although there was revised National Health Policy (NHP) 2002, which was based on review that the vertical programmes were not cost effective or sustainable and there was an increased focus on 'curative care', 'urban oriented service model' and is 'privileged class oriented', there are no particular visible changes seen in the health programmes formulated in the country after that. The recommendations of the different committees like the Sokhey Committee of 1938, Bhore Committee of 1946 and Mudaliar Committee of 1963 or the plans framed in the Five Year Plans, political manifestoes and several other solemn promises made to the people have not become a reality as envisaged. He says many problems exist with the public health system like, the bureaucracy of India not serving interests people of the country and being more aligned in favor of politicians and foreign agencies. *Specialists in public health and health administration must be "eliminated" to make way for the racketeers.*

The clinician dominated Central Health Services is also convenient to the rulers because they know so little about people's health. Many problems like losing the cadre structure of physicians and institutions for education and training for public health physicians and the support staff, problems associated with the near non-existent National Health Information and Evaluation System, vital element in health administration are also put forth by him.

The major three points that emerge from the above comments on the draft Bill are that government of India has made historically misleading promises. Welfare provisions in health has failed at a bureaucratic and institutional level to identify basic health care right of citizens or to transfer health rights at grassroots level. Main reason for this is inadequate finance provisions distorting health of the people. He questions the very need for the bill based on the above arguments

A senior advocate of the Supreme Court of India and human rights activist has highlighted some of the concerns about the National Health bill (draft) 2009. He points out that the civil society organizations have vague and ambiguous ideas regarding what is to be achieved through the National Health Bill (2009) and he also questions the very need for the bill. He points out that the bill is "essentially a very sophisticated and elaborate reversal of all that we have stood for in terms of health rights for the poor". He questions the very nature of the bill stating that the bill is not clear regarding which are the policies and practices that are sought to be reversed through it. He points out the politics behind the formulation of the bill when he states that the bill has not been formulated out of the blue but is the strategy of the UPA government, which after coming to power began formulating statutes on the Right to Food, the Right to Education and the Right to Health Care with the help of certain civil society organizations. After comparing the Right to Education Act with the National Health Bill, 2009 he brings out striking similarities between the two, like the significant role played by the private sector in both of them and the larger state funds getting allocated towards the private sector. Both the bills implicitly accept the decline of government facilities as inevitable and the clauses involved in the bill are devoid of any specific rights. He questions that should civil society accept the idea that, increased privatization is an inevitable fact and the poor will

have to turn towards the private sector like is the state of education now. The bill fails to address the fundamental issue of regulation of the private sector. He points out that accepting the bill is like agreeing with the mandates of globalization and privatization. He also discusses that if that is not the case then there is need to go beyond just a favoring of the few progressive ideas that the government has put forth in the bill and have important and serious discussions with them which is the duty of the health movement.

Major concerns expressed to improve health care are:

a) Need to define free and guaranteed health services to poor population and comprehensive health care services which would include all the medicines necessary, proper hospitalization when necessary, adequate treatment, food during the period of hospitalization.

b) Proposed Bill 2009 is incapable of being exercised unless, the state takes substantial responsibility for providing and running hospitals and other health care institutions. Thus the principal health care provider for the poor must invariably be the state.

c) State officials are hardly interested in regulating private enterprises in any real sense of the term. Any frame work which downgrades the role of the state to a regulator of private enterprises rather than the principal provider of health care services is antithetical to the Right to life.

He states that, there are just general obligations mentioned in the bill and does show any mandatory obligation to the marginalized and vulnerable sections to provide at least minimum health care facilities. Health care for all depends on the financial capacity of government while not providing any assurance of free services. In the proposed bill document the word 'free' does not appear anywhere, instead the term "affordable" amount is used which the poor are expected as per their capacity. This is completely a pro-World Bank stand who repeatedly insist that free services ought to be restricted to the vulnerable and marginalized and the rest should pay "user fees".

The definition of vulnerable and marginalized group is not clear in document "vulnerable and marginalized are well established terms in government parlance and the list is easily

available. Reference to women is not meant to cover all women but women headed households or women over 65 and destitute. It is well settled that the vulnerable and marginalized sections occupies the bottom 1/3 of the BPL list and numerically comes to about 10% of the entire population. Surely such a qualification in the draft Bill was not introduced accidentally unaware of the common meaning, both in the government as well as the voluntary sector, of the term".

He also points out that the bill does call for the strengthening of the public sector and states that all idealistic definitions are clubbed into the document. Isn't all this so cleverly crafted so as to be compatible with a privatized system with the government acting as a lapdog (sorry watchdog)? How do these sections help you advance the argument that the Bill requires the government to concentrate on reinforcing the public health care system?" The public sector and the private sector establishments are taken together throughout the Bill which is problematic and should be opposed by the civil society. A 56 page national bill nowhere mentions free services which he says are unacceptable. Free services, he claims, should include: (i) free medicines, (ii) free tests, (iii) free admissions to hospital, (iv) free bed, (v) free treatment, (vi) free food and so on. Instead of using the term 'free' the term used is 'access'. This term 'Access' is defined in section 9 (b) as under: (b) accessible to everyone, such that 'accessibility' shall mean and entail: (iii) economic access or affordability which is precisely the logic of the user fee system. Summarizing the above comments it can be said that the UPA government has failed to protect the social and economic rights of the people. It is also depoliticizing the present role of civil society organizations by applying the principle of cooption. There should be a definitional clarity about what comprises a "vulnerable and marginalized group" and term 'free' rather just using the term "access".

One member of the drafting committee and civil society representative has responded to the above comments justifying the need for the right to health bill 2009. He says that it is necessary to throw the bath water i.e. "inadequate framing of certain provisions" but keep the baby i.e. "the detailed set of provisions for health rights" stating that there is space for improvement in the Bill. He says that there is widespread and massive denial of Health rights of citizens at multiple levels, in both the public health system and the private

medical sector. The legal provisions to protect the Health rights of citizens in India are inadequate. He argues that placing the national health bill in this context it should be first recognized that the bill makes a genuine attempt to establish comprehensive health rights of people in India. He says that the act does not stand in isolation, but should be contextualized by the systemic structures actually existing on the ground. While a major advance in furthering people's health rights could be made through the medium of such an act, this must be accompanied by corresponding changes in health policy and the functioning of the health system.

The drafting of this act was seen as an opportunity to raise related issues regarding strengthening of the public health system, regulation of the private sector and an effective system for universal, free access to health care. He says that unless there is an effective and functioning health system, a perfectly worded act would fall short of fulfilling the rights defined in the act. This is the parallel challenge that civil society groups need to take up, while defining people's health rights in the act.

He responds to the major opposition that there is inadequate mention of the concepts of free and universal access to health care in the bill by pointing out to the intrinsic points in the bill in section 3 (c) and (d) which provides for free and universal access to health care services only for the vulnerable and marginalized persons today and states that the beginning part of 3 (c) starts with the provision making it the "immediate duty" to provide free and universal health care services only for the "vulnerable and marginalized people".

Explaining the positive points in the bill he says that, the chapter on obligations of the government in relation to health the role to be played by the governments are clearly stated as Government of India and the State Governments have general obligations at all times to provide optimum facilities to the people within the maximum limits of their available resources and ensure transparency, equity and proper distribution of their resources for health and health related issues and concerns. The government should undertake steps addressing bio-medical and socio-economic, cultural and environmental determinants of health and should ensure the progressive realization of health and well being of every person in the country without any discrimination. It should ascertain that

free and universal access to health care services should be provided and there should be minimum standards and appropriate regulatory mechanism laid down for the private sector. Finally the Governments have an immediate duty to prioritize the most vulnerable and marginalized persons and groups, who are unable themselves to access means for adequate and appropriate health care services, and ensuring them at least the minimum conditions of health care

He contradicts the questions raised by the critiques of the bill by stating that, there is scope for improvement but cannot be discarded completely as it places the 'vulnerable and marginalized individuals or groups' at the centre. In the bill, this group is defined as 'vulnerable and marginalized' individuals or groups i.e. individuals or groups who require special attention due to their physical conditions, or who are marginalized due to their social or economic status or conditions or due to their historical, traditional and/or current exclusion from political power and resources, including but not limited to: women, children, adolescents, older persons, persons with disabilities (mental and physical), persons with stigmatized, communicable diseases (like HIV/AIDS, leprosy), persons from Scheduled Castes (SCs), persons from Scheduled Tribes (STs), people of rural or remote areas, trafficked persons, migrant sections of population, internally displaced persons, persons in conflict situations, refugees. The bill, he says is not just for the 'BPL' sections but covers a large ambit of people who are otherwise socially excluded and that the bill presents a broad framework to strengthen the public health system which is the need of the day.

He elaborates that the meaning of the term access [79] is very wide and inclusive of not just medical services but also other components of public health making this term very

[79] The draft bill defines Right to access, use and enjoy: Every person has the right to access, use and enjoy all the facilities, goods, services, programmes and conditions necessary for ensuring the right to health, including but not limited to at least (a) Right to food; (b) Right to water; (c) Right to sanitation; (d) Right to housing; (e) Right to appropriate health care, and health care related functional equipment and other infrastructure, trained medical and professional personnel, and essential drugs. Accessible to everyone, such that 'accessibility' shall mean and entail: (i) Access without discrimination on any of the prohibited grounds; (ii) physical access; in case of persons with disabilities further ensuring adequate access to buildings, and infrastructure through reasonable accommodation measures; (iii) Economic access or affordability; and (iv) access to information and ideas concerning health issues; in case of persons with disabilities, further ensuring access to information through reasonable accommodation measures.

important part of the document. He argues that instead of just opposing the concept of user fee, the civil society needs to deliberate on formulating an effective public funding model and also a regulating mechanism for the private sector.

According to him the starting point of the bill being a Rights Based framework gives ample space and voice to ensure universal right to health services and health determinants which will emerge through a pro-people social process. Under this social process he states that Universal free access to health care with elimination of user fees would be at the centre of this agenda while completely opposing the neo-liberal agenda. This rights based framework is the 'heart' of the bill which includes wide ranging rights to health care as well as social determinants of health, which are unprecedented in any Indian official document on health till date. He has raised concerns that because of the large ambit that the bill covers, it will be opposed by the private medical lobby and resistance from short sighted public health bureaucrats who may be uncomfortable with being held legally accountable. Also at a higher level he say that the Finance ministry and Planning commission may object to the significantly higher levels of public spending required for fulfilling the obligations of the state . As a concluding remark in support of that taking advantage of the rights based approach and the entry point received by this bill the social activist must endeavor to struggle for a pro people national health bill.

Summary Analysis of Discussion

The first demand of people health movement is that the right to health should be a constitutionally guaranteed fundamental right as they are superior to standard laws. Fundamental Rights represent a very strong pillar of Indian democracy ensuring equal justice and freedom to all. In the present situation civil society organizations have been advocating right to health as fundamental human right under the international human right framework. There has been a shift from right to health as a constitutional fundamental right framework to international human rights framework. In addition the state has become signatory at the international level in guaranteeing protection for the human rights of all citizens but at the national level it fails to incorporate constitutionally provided fundamental right. Qadeer and Chakravarthi (2010) appropriately points out to the shifting nature of the demand for right to health in the bill as

> *"How the government has appropriated the idea of universal access to health services and health as a fundamental right, to suit its ideas of health as a right in terms of economic access. The Bill promotes the idea of shift in state obligations from one of providing services to ensuring economic access to affordable healthcare services"* (Qadeer 2010: 52)

The legal response of the state related issues of health and healthcare has always been fragmented, isolated and devoid of any intention to actually address the underlying determinants of health[80]. State is showing an optimistic view towards national health bill stating that it will ensure accountability from both the central and the state governments. But there is an urgent need to address healthcare in India in a way that ensures the state's obligations so that it can be held accountable for the promises made. However, since independence state has dealt with as *"health subject in atomistic way"*[81]. When observing and amalgamating the experiences of different acts in the present times like the right to education, right to food, National Rural Employment Guarantee Act, the role of government is seen to be one side as a promoter on one side and on another side is violator for not fulfilling the commitments stated. The National Health Bill seems more like a wish list and a work of passion rather than a serious piece of legislation. One Supreme Court lawyer, who has been leading the tirade against the draft Bill called for dumping the proposed law and starting the process afresh.

Commentator's remark on the proposed bill that, there is widespread confusion about the draft Bill was because it does not clearly specifying its real intent. It is silent on many issues, a securing the rights of health of the marginalised and the vulnerable and meaning of free and universal access to health care.

> *"The Indian Bill demonstrates that behind the veil of 'health as a fundamental right', medicalisation and commodification of services, reduced provisioning and transformation of public health to poor quality primary level care can be pushed, ignoring that an efficient integrated public health*

[80]India has an obligation towards health for all.(2010) assesses on July 22, 2011, from http://southasia.oneworld.net/todaysheadlines/india-has-an-obligation-towards-health-for-all

[81] Rebecca J. Hester Field Statement #2, The Body as Border

system lowers costs of health care and even reduces state deficits, as shown by the US example."(Qadeer 2010: 62)

Qadeer and Chakravarthi (2010) have analysed the conceptual framework of proposed draft of National Health Bill 2009. They point out that the present draft bill is more in favour of accessing 'affordable' health care. They draw attention on the three definitional issues in proposed National Health Bill. First, some definitions lack clarity; second, some key concepts used in the text are not defined and third, some key concepts are missing altogether, without which the Bill is incomplete. In the national health bill the definition of Right to health has not been conceptualised well, there some overlaps in 'standards' and 'life in dignity', and concept of 'access' is not clear enumerated and it has been equated with 'affordability'. As they state,

"Ensure equitable distribution of and access to essential health facilities, goods, drugs, services and conditions to all is proposed but "essential services" remains undefined". (Ibid 2010: 53)

The definitions of health care, essential health care and essential public health services and the responsibilities of public and private sectors have no clarity; also core obligations of the state are not clearly stated. There is no demarcation between the responsibilities of public and private sector providers. The role Public private partnership has been accepted with no opposition in the implementation of public health programmes.

The most gross concern remains the ignoring of the fact that the state has the major responsibility of providing Comprehensive Primary Health Care. The private sector has been allocated responsibilities but the proposed bill lacks regulatory mechanism to control this powerful sector. In name of universalisation India "moving towards universal coverage through private insurance, taxation to subsidize this coverage and some restrictions on insurance companies in one context, and the state moving away from universal provisioning at the cost of the poor towards privatization of services and by ensuring economic access through health insurance". The Indian draft Bill never clarifies the nature of insurance system that it repeatedly promotes. It retreats from universal provisioning and the target approach is back to haunt the government documents where

'vulnerable and marginalized groups' will be supported without any guarantee for universalisation of health care. The categorisation of 'life style disease' excludes vulnerable and marginalized groups, and poverty and occupation associated disease have been excluded. (ibid 2010)

This proposed draft Bill cannot be furthered unless there is a strong political and financial commitment by the state. At a very general level, it was agreed that the Right to Life and the Right to Health could not logically or morally be separated. It was recognized that the neglect of economic and social rights prevents any meaningful implementation of the Right to Health and in fact, the fulfilment of these rights depends a great deal on macroeconomic, political and structural factors, which are beyond the control of the people and their communities.

Chapter – V

Discussion and Summary

Chapter: V

Discussion and Summary

It is evident from the preceding chapters that civil society has played a major role in highlighting the issue of 'right to health' as a means of ensuring access of all sections of the Indian population, and especially the deprived and underserved, to quality health care as per need. This chapter brings together the analysis presented in previous chapters, ie. The implications of the international discourse on right to health in the present context, JSA's activities as a Civil Society Organization in India related to advocacy for the right to health care and the legislations drafted to encode the right, which can be seen as partly an outcome of these efforts. In the final analysis, we find that the civil society activities have encompassed advocacy as well participation in drafting of the bills at state and national levels. It has also attempted to work towards the same objective through participation in the national government initiatives to strengthen the health service system through the National Rural Health Mission. While some successes can be attributed to the systematic civil society campaign in terms of the official action towards which the campaign had built pressure, the debates around various components of the campaign activities and the present situation as regards the official operationalisation of this various dimensions highlight the dilemmas and potential limitations.

International Agenda: Right to Health Care

The formulation of right to health acts at national and state levels came in diverse ways. The contemporary claim for right to health has based on the human right framework. This framework adopted by *Jan Swasthya Abhiyan* for advocate the right health campaigns. The right to health framework has certain obligations on state. The 'health of the nation[82]' is government responsibility. Ensure that the responsibilities, government act at various levels to protect public health under the set of international human rights standards and guiding principles. Right to health has an instrument for implementing international guiding principles in India. The increasing dependencies on international

[82] The Lancet Health of the Nation Summit, July 1, 2010, London, UK

standards maintain that, the right to health requires concerted action for its realization at the national and the international level.

The contemporary framework for right to health is outcome of global processes. The research study has contextualized this new emerging debate on right to health as part of global governance politics. For at least the past two decades the development alternatives have been looking beyond their own country's jurisprudence to international law. The decisions based on international law documents are used (such as the various treaties and covenants) in order to frame and apply domestic law. "This wide spread practice is part of a phenomenon that Anne-Marie Slaugher calls "Judicial Globalization"[83]. .....outside the United States Judicial globalization of this sort is all but taken for granted. Leading national courts in this regard cut across all imaginable lines: India, Canada, Zimbabwe, Hong-Kong, South Korea, and Botswana all borrow form legal sources outside their borders" (Flaherty 2004). The analysis in this study shows that the process of right to health in India is certainly a process of judicial globalization. This judicial globalization in health has adopted the soft new form under the human rights framework of international laws for global governance in health. The global social and economic development actors are promoting and developing a global governance framework for regulation in a roundabout way of Judicial Globalization.

> *"These legal developments have resulted from a combination of "judicial globalization" and "globalized advocacy."....justice is increasingly exposed to foreign law through travel to international conferences. These peer-to-peer interactions, together with internationalized advocacy strategies, appear to have significantly influenced the perspective of our federal courts. Additionally, the use of comparative human rights principles in the courts is now also emerging at the state level... Human rights resolutions, several with economic and social rights as a major focus, have been passed at the state and local level"* (Albisa and Sekaran, 2006).

[83] Anne-Marie Slaughter, Judicial Globalization, 40 VA. J. INT'L. L. REV. 1103 (2000); Harold HongjuKoh, Bringing International Law Home, 35 HOUS. L. REV. 623 (1998).

The related evidence was found while reviewing the global processes of contemporary right to health. The rights based approach in health gained importance at a global level through, the international actors. The WHO, UN agencies, World Bank, and large-country aid programs that lift up the issue of regulations in public health. Thus, emerges of global health governance framework which was led to the development of the global health governance plan to fulfil the demand of health regulation. The key role in this framework was played by international multilateral, bilateral and private agencies like the WHO, UN agencies, World Bank, and Bill and Melinda Gates Foundation; Bloomberg Philanthropies; Clinton Global Initiative) and public/private partnerships (e.g. Global Alliance for Vaccines and Immunization Alliance (GAVI); Global Fund to Fight AIDS, Tuberculosis and Malaria). Alliances among these large funders, industry partners and civil society organizations created an effective partnership to develop global health governing framework. These players had a significant influence on development of global health governance mechanisms. In the global health governing framework legislative measures were seen as a major tool for combating against health inequalities and global health problem. As the largest international health organization and one of the larger specialized agencies of the United Nations, WHO was given the lion's share of the responsibility in health lawmaking at all levels. The current global political scene and neoliberal policies have influence the work of WHO and UN. The hidden agendas and vested interest of the international organisations presented in right to health by human rights documents (Magnusson 2009). As Langlois pointed that, "it is one thing for the globalised elite of state leaders to sign on to human rights norms, but it is another thing for these norms to be reflected in the multifaceted and heterogeneous worlds that exist beneath the superficial veneer of international politics, diplomacy and decision-making." (Langlois, 2003) The Right to health concept framed and advocated by the international lobby through the global governing framework is a glorification of reality by building the optimistic view through various treaties and covenants.

A number of international treaties, guidelines and covenants were prepared to develop the public health law and legal mandate or a normative framework. India was signatory to these treaties and conventions, guidelines and global standards prepared at the international level. In the present context there are two dominant sets of international law

making lobbies, one advocating for rights and the other the market lobby that promotes profit making policies. The process of globalization has increased health inequities in the developing countries and the policies perpetuating these inequities are being pushed by the market lobby. Through this 'right to health framework' there is an attempt made by this lobby to develop regulating mechanisms that will help to justify their policies and pave way for their hidden agendas to be fulfilled. On one side the rights framework was developed under the sponsorship of the UN to address world security, socio-economic issues and bring about peace. On the other hand the very same agencies are engaged in various trade- related agreements and treaties like GATT, GAT. These international actors are promoting the idea of right to health while on the other hand they are abusing this very idea through restrictive treaties regulating state. This has de-politicized the very concept of right to health (Magnusson 2009). The Major limitation of these international treaties and covenants in application for right to health, it has own ideal definition of 'Health' which is impossible to achieve and claim for right to health.

The origin of legal right to health framework was setup at global level under global health governance plan by international actors. The World Health Organization and UN were plays major role in development global governing framework for health. Global People's Health Movement has engagement with World Health Organization. The Global People's Health Movement had taken this opportunity to engage with legal Right to health process with World Health Organization. Through Global Health Movement the agenda of legal right to health has been taken up in many countries. In India Jan Swasthya Abhiyan as part of Global Health Movement the legal right to health process got strengthens with previously JSA's right to health campaigns (PHM 2006).

Jan Swasthya Abhiyan's Role in the Right to Health Discourse in India

The theoretical perspectives and contextual circumstances indicate that Jan Swasthya Abhiyan has contributed directly in joint action with the state to improve health outcomes and reduce health inequalities in different ways. JSA has been promoting the improvement of health system structures of governance and processes of participation at community, local, national and global levels with global health movement. It has been emphasizing on universal health care, global solidarity for right to health,

comprehensiveness of care, and equitable access to health care and other social services; promoting participative health policy formulation, decision-making processes and implementation. JSA works in alliance with the global people's health movement for global health campaigns and advocacy on the right to health and other social rights, social determinants of health, improving the access to primary health care and issue of regulation of the private sector in health.

The major JSA right to health care campaign can be analysed under three heads of Jan Swasthya Abhiyan's engagements:

- JSA's Engagement with the National Human Rights Commission
- JSA's Engagement with political Parties
- JSA's Engagement in Commission on Social Determinants of Health

Engagement with National Human Rights Commission:

NHRC is the official body for entertaining complaints, regarding violation of human rights by investigating state practices and providing redressal in various forms to protect human rights. This was a strategic engagement of JSA with NHRC. The right to health and health care campaign of Jan Swasthya Abhiyan was seeking responsible state action to ensure equitable health care. It has proved to be one of the effective strategies of *Jan Swasthya Abhiyan* able to hold government accountable through the NHRC. Engaging with NHRC and with political parties, *Jan Swasthya Abhiyan* pinned its hope on mobilizing people's opinion on the issue of mass denial of right to health care and generating pressure to compel the state to act in the right direction. Thus, Jan Swasthya Abhiyan has significantly invested in pressure politics on the state in their efforts to solve the basic health care problems.

'Seeking Justice' stands as the most urgent concern in Jan Swasthya Abhiyan's interventions on the issue of right to health care violations. The social programs are providing basic services to secure the right to live with dignity. In the provision of health care issue of dignity was question by JSA. Different kinds of purposeful activities were carried out by Jas Swasthya Abhiyan all over in India during engaging with NHRC. This helped mobilize opinion of people in favour of justice in denial of health care. This was

the first intervention by Jan Swasthya Abhiyan in the context of actualization of the idea of justice and retributive measures to protect citizens against the denial of health care. JSA has reach at the stage to ensure the protection of rights through NHRC, and in the area of health holding the government accountable by making the government conscious of the fact that there is massive health care denial in India.

Concerning Issues Involved With in Engagement with NHRC

- Jan Swasthya Abhiyan consider the role played by the NHRC as vitally important in obtaining interventions from the Apex Court in matters of justice which provided symbolic optimism and hope in the legal system.
- In this case of Jan Swasthya Abhiyan engagement to a limited extent with the NHRC has succeeded in sensitizing the central and state governments regarding observance of international human rights norms.
- Governments of India had ratified some international human rights instruments, but such policy is not reflected in a national health law.
- The scope of NHRC work imitated to regulating government action but it cannot investigate into any private sector or private dispute between individuals or any complaint against private doctors.
- NHRC has limited power of work since it cannot fine, imprison or in any other way punish any person against whom a complaint is made.
- Therefore it is still to prove its success in making the state effective in delivering justice in the cases of right to health violations.
- Engagement with National Human Rights Commission therefore has these inherent limitations in providing substantive justice - the future course in pursuing the goal of justice under the prevailing situation depends upon the role of civil society, state and NHRC.

Engagement with Political Parties

An important role has been play by political parties and civil society groups in a democracy. Both political parties and civil society organizations mediate between the

individual and the state, but they do so in different ways and have different functions. Civil society groups help to organize and articulate various interests in a society. In essence, civil society helps provide part of the "demand side" in politics. At the same time, political parties provide the "supply side." That is, parties help turn citizen interests and demands into policies and laws base on civil society groups lobby for change (Dippell, 2000).

Civil Society engagement with the political parties remains weak in the arena of health. There are plenty of exciting examples of Civil Society groups in health who have not been able to engage with other actors such political parties. But this was a conscious attempt by Jan Swasthya Abhiyan to engage with the political system with the objective of democratizing the health care issues. It was an attempt for expanding the space for democratic action for right to health.

Jan Swasthya Abhiyan engaged with political parties based on assumption that it will encourage citizen engagement in the political process, increase the responsiveness of political parties to citizens' health care needs and expand political participation for people dealing with right to health care issues.

JSA engagement with political parties made it possible to work on agenda setting. The major issue during 2004 general election campaign was demand for improve rural health care delivery system.

JSA has ideological closeness towards pro-left position that was reflected during approach with political parties during election campaign of 2004. Most important participation shown by Communist Party of India (Marxist) (CPM), Communist Party of India (CPI) and Samajwadi party during pre-election engagement of JSA with political parties. The Indian National Congress Party and Bahujan Samaj Party (BSP) did not participate in the pre-election engagement but they have included points of people's health manifesto in their Party manifestoes for the general election 2004 along with the left parties.

The Post general election 2004 results, left parties were alliance with congress party during formation of United Progressive Alliance (UPA Government). That helped to Jan

Swasthya Abhiyan to put on agenda of rural health care. These strategic processes were helped to engaged and strengthen civil society in National Rural Health Mission development and implementation.

During 2009 pre-election campaign major issues were Right to Health through national health bill 2009. Second most important issue was Community based Monitoring under National rural health Mission with other concerning issues of health care. The improved budget allocation on health care this was major demand continuously advocate by Jan Swasthya Abhiyan from 2004 General Election to 2009 General Election. The review of discussions of emails shows that, major strategic failure of this engagement was 'no sufficient involvement of voters of political parties". JSA gave focus to media involvement in pre-election campaign.

But fewer dialogues with political parties took place in 2009 general election as compare to dialogues in 2004. Only people's health manifesto was sent to all political parties.

Outcome of these processes was, that the first "People's Health Manifesto" was incorporated by Political parties in their "party Manifesto". But the promises of manifestos were not followed by wining party of both elections. But the process of political parties' pre-election dialogue strengthened the position of Jan Swasthya Abhiyan as an active civil society group.

Engagement in Commission on Social Determinants of Health

Global People's Health Movement (PHM) works to address the Social determinants of health, including in particular, the growing inequity within and between nations attributed by them to unfair economic structures which lock people into poverty and poor health. Global People's Health Movement helped to put the Social Determinants of Health on the global agenda through continued engagement with the World Health Organization. Members of Global Peoples Health Movement were appointed as commissioners on the WHO Commission on Social Determinants of Health. Working with other civil society organizations, Global Peoples Health Movement helped gather evidence for the WHO final report on the Social Determinants of health released in August, 2008. PHM's engagement with the Commission's work also resulted in the publication of a Civil

Society Report on Social Determinants of Health. As part of Global Peoples Health Movement, Jan Swasthya Abhiyan members were involved in processes of Civil Society Report on Social Determinants of Health. The major outcomes of these processes were representation on knowledge commission of CSDH, Mobilization on issues of social determinants of health regional consultation.

From the evidence reviewed, it is not possible to conclude that civil society and the health sector in them might make a difference and be more effective with the state in addressing inequalities and the social determinants of health. Joint actions between civil society and the state are needed. The health system transformation grounded on principles of social justice and universality seems to be required in order for this joint action to be effective in improving people's health and in building equitable health systems.

Critique of Right Based Approach for Health Care

The based approaches to right to health development in India stand on human rights framework. India being a signatory country to these various covenants, treaties and declarations is principally bound to ratify the international and regional human rights treaties and frame national laws that reflect the international obligations. There are many limitations to the human rights framework as pointed out by various human right scholars Langlois raises some basic questions about the confusions in the term human rights -- Is it legal, political, moral, metaphysical, natural, confessional, religious, contractual, institutional, cosmopolitan, communitarian or some pluralistic combination? (Langlois 2003) These confusions are reflected in the legal and political domestic and inter-national institutions that are mandated with the task of monitoring and protecting human rights, and the popular support received by these institutions. (Langlois 2003). There is always a discrepancy in the implementation of the human rights framework when placed by the western world and adapted into non western context. This is reflected in the statement by Batliwala,

> *"Human rights have been gradually developed as goal and instrument of a modern-day civilizing project in the non-Western world. The current body of human rights has not been evolved through a genuinely multicultural ground-*

> *up debate, distilling what is authentically universal from the highest values and ethical frameworks of societies around the world Western-influenced rights advocates even in India"* (Batliwala 2007:14).

Human rights philosophy has considered all human being as equal. In implementation humanity is centrally regarded, not our class status, our ethnic origin, our wealth, our relation to the law (Langlois 2003). Critics of the rights approach to health argue that the concept is too abstract and rhetorical and has achieved little (Batliwala 2007) because rights frame work aims to achieve the social determinants in health through legal rights approach. Kennedy explains that;

> *"The rights were usually defined in terms of equality, but equality in a special sense. They did not involve the demand for equality in the distribution of income or wealth between social classes, regions, or communities, but rather "equal protection" for individual members of previously subordinated social groups."* (Kennedy 2002: 198).

As stated by Batliwala "the critical role of informal mediating structures like communities and clans, and a range of customary and informal social structures played to determine the access of rights Most deprived and exploited social groups negotiate their lives, resources and rights are the determining layer through which their individual circumstances are mediated. Even the rights of citizenship are mediated by communities and identity groups of various kinds." When contextualizing the National Health Bill 2009 within the above arguments it is seen that it is ambiguous on providing universal and free healthcare while accessing of legal rights is in fact mediated by intersecting institutions like the family, clan, caste, economic status play major role. The rights based approach in programmes such as the NACP has also been analysed for its universal principles and lack of local context specificity (Priya 2005).

Approaches to Claim Right to Health in India

Government has always given priority and preference to civil and political rights because they protect 'democratic' authoritarian state interests. The social and economic rights have been neglected to a great extent although it is a provision under the welfare state of

India. Right to health falls under the domain of social and economic rights. With the state being partial to the civil and political rights, a doubt remains whether the state will give adequate importance to the right to health bill.[84]

In practice, the right to life cannot be granted without a "fundamental" right to health. There are a number of situations where states may deprive individuals of life itself and to which international human rights law does not raise an objection. The use of the death penalty is one such example. Human rights law does not prohibit the use of the death penalty as a punishment for crimes but does encourage its abolition and seek to limit its use. The use of violence in self-defence lies at the base of other justifications for the taking of human life. Killing is permitted at times of war save for the murder of civilians and prisoners of war. Human rights law thus tries to respond to the myriad of ethical dilemmas raised by the right to life by establishing a range of prohibitions and exhortations.[85]

As seen in the abortion debate "right to life" becomes rhetorical device used by pro-life advocators. Pro-life advocates argue that prenatal humans are human persons and have the same fundamental "right to life" as humans have after birth. Generally speaking, those identifying themselves as "right-to-life" believe abortion is impermissible. The term "right to choice" is also rhetorical device used in the abortion debate by abortion-rights proponents. Abortion rights advocates argue that prenatal humans are not human persons and do not have the same fundamental "right to life" as humans after birth. It is evident by the above debates; right to choice has gained priority over right to life argument[86].

Under the Directive Principle of State Policy in the Indian Constitution, Article 38 imposes a liability on the State that it will secure a social order in the promotion and

---

[84] The Indian Constitution details the rights of the citizens elaborating civil and political rights, which are guaranteed and enforced by the Supreme Court and the High Courts. Civil and Political rights included right to vote, freedom of speech, of the press, of assembly and meetings, street processions, demonstrations and the right to association. Social and economic rights include the right to work, right to rest and leisure, right to material maintenance in the event of sickness and disability, right to health protection, right to housing, right to education. (Abdulrahim 2009)

[85] Right to life, from http://www.hrea.org/index.php?doc_id=427, access on June 19, 2011

[86] Abortion - An in depth overview of the issues debated around abortion. Retrieved July 9, 2011, from http://www.quickoverview.com/issues/abortion-debate.html.

welfare of the people. Article 39(e) related with workers to protect their health. Article 41 imposes duty on State to provide public assistance basically for those who are sick and disabled. Article 42 makes provisions to protect the health of infant and mother by providing maternity benefits. Article 48A ensures that State shall endeavour to protect and impose a pollution free environment for good health. Directive principles are only guidelines to formulate social policies and the implementation of these principles depend on the political will. Thus these principles cannot guarantee health care which would help to develop adequate health programmes. Public health provisions are required to enforce Directive principles; unless there is a collaborative effort taken by different sectors in the ministry it is impossible to improve the conditions of public health. In the present context the essential collaborative effort seems impossible[87].

Post–independence directive principles have been used by the state as an instrument to provide piece meal services to the people. India being a welfare state always had vertical programmes for health, this was a strategy used to suppress the voices of the marginalized and vulnerable sections. This strategy of the 'interventionist welfare state' helped the state to function without providing for the health of large sections of the society as development strategy without a rights based approach could only yield limited results and outcomes. It is understood that for the issues to become sustainable political agendas, they must be contextualized in the 'rights' domain. Right to health and healthcare cannot be realized within the current programmatic development agenda unless there are adequate measures taken to support and fulfill what is written on paper (Duggal 2007)

The concept of the welfare state seeks a redistribution of wealth through welfare provisioning, but in reality it does not translate into practice. The main reason for the failure of welfare state was meaningfully analysed by Nirja Gopal Jayal

> *"the neo-liberal agenda in India, not least because rights have never been central to the philosophy of welfare that underpins the welfarist initiatives of the Indian state. Since welfare is not expressed in the*

[87] Right to Health. (2011) access on June,2, 2011, from http://www.legalindia.in/right-to-health

language of rights, its abandonment could arguably be a relatively simple matter, as there are neither legal/constitutional nor moral or political criteria defining the claimants of welfare rights. A right that has never been conferred is self-evidently difficult to claim or defend" (Jayal 1994: 19-20).

The reason for the failure of welfare of citizens is that government has never critically analyzed and changed the perspective of welfare. The series of failures in welfare interventions in India is an evident fact. This is the argument that provides the rationale for a rights-based approach and legislation for health care rights.

Problem with Judicial System in India and Dispute Resolution and redressal

Dispute resolution and redressal is the responsibility of the district court. In a country like India where the judiciary is bogged down by the load of pending cases[88] , it does not seem realistic that the court as mechanism will be helpful. The problems like shortage of judges, unavailability of courtrooms, and delay due to the negotiation process are common. The numbers of judges in a court are decided by dividing the average number of main cases in that institution during the last five years by the national average, or the average rate of disposal of main cases per judge per year in that high court, whichever is higher. Although the citizen of India by the Constitution is guaranteed right to speedy trial under the Article for right to life, it does not materialise into reality. The executive and the judiciary have taken many corrective measures for speedy disposal of cases. The Centre has been extending the judge strength from time to time, but not to the extent of the recommendations of the Law Commission. Also the increase in advocate fee and

[88] **Indian judiciary having high burden the case backlog : Supreme Court have** civil and criminal cases pending total 39,780, **High Courts** Total - 39 Lakh Cases Pending (7 Lakh Criminal, 32 Lakh civil). Allahbad High Court - 11 Lakh Cases pending Madras High Court - 4 Lakh Cases pending Bombay High Court - 3.6 Lakh Cases pending. **Subordinate Courts**: Total - 2.63 Crore Cases Pending, state wise data UP - 46 Lakhs Cases, Mahrashtra - 41 Lakh cases, Gujarat - 39 Lakh Cases,West Bengal - 19 Lakh Cases,Bihar - 12 Lakh Cases, Karnataka - 10 Lakh Cases, Rajsthan - 10 Lakh Cases, Orissa - 10 Lakh Cases Andhra Pradesh - 9 Lakh Cases. **Undertrails** Total is 2.5 lakh under-trails languishing in Jails .Mahrashtra 15,784 undertrails, Madhya Pradesh - 15, 777 Undertrails **Under trails in jails for more than 5 years without any judgment on their guilt or innocence.** 2069 have been in jail for more than 5 years , Bihar - 628 ,Punjab – 334,Uttar Pradesh – 212, Delhi - 344 **Judicial Strength** India has 14,576 judges as against the sanctioned strength of 17,641 including 630 High Court Judges and 31 SC judges. India accounts for 10. 5 judges for every million persons.

other costs have increased many times in the last 50 years making the judiciary accessible to the people.

Pending Cases

Courts		2008	2009	2010
Supreme Court*	Admission	26863	30834	33352
	Regular	19,024	19,329	21,512
	Total	45,887	50,163	54,864
High Courts*		3743060	3,874,090	4,060,709
Lower Courts**		25,418,165	26,409,011	27,275,953
Total (All Courts)		29,207,112	30,333,264	31,391,526

*Statistics as of March 31, 2010
**Statistics as of December 31, 2009

Vacancies in courts[89]

Courts		2008	2009	2010
Supreme Court*	Sanctioned	26	31	31
	Vacancy	1	7	2
High Courts**	Sanctioned	876	886	895
	Vacancy	284	251	267
Lower Courts*	Sanctioned	15,917	16,685	16880
	Vacancy	3,393	3,129	2,785

*Statistics as of March 31, 2010
**Statistics as of December 31, 2009

The contemporary approach to redress the problems related right to health care is through Public Interest Litigation (PIL) filed in the supreme court, this has not proved to be an effective strategy as *"Supreme Court does not normally interfere with policies or financial allocation to various sectors"* (CEHAT 2003).

In drafting public health legislation, it will help to pay careful attention to implementation mechanisms. Regulatory enforcement carries challenges in implementation need to be

[89] Extracted from "Pending Litigations – 2009-10: 3.13 crore cases, 3054 Judges required". (15Jul, 2010).. Retrieved June 22, 2011,from http://barandbench.com/brief/2/843/pending-litigations-2009-10-313-crore-cases-3054-judges-required

relooking at. Some of the key issues for effective regulatory implementation are, the slow judicial processing of cases in courts with large backlogs, setting reasonable standards, disseminating information on the regulations, minimizing the scope for discrimination and minimizing reliance on the judiciary.

The health status is in large measure determined by the degree to which rights are enjoyed. Poor health and inadequate health care are often related to human rights violations. And violation and under fulfillment of human rights are often due to poor health and lack of access to health care. Health is the sum of empowering education, adequate nutrition, safe environments, social support, and community cohesion. The language of rights makes people conscious of both their oppression and the possibility of change. It is high time for the state to make positive provisions for promoting the 'Public health' and also to ensure that, no person should be denied medical help in emergency and none should be deprived of his right to healthcare.

JSA's Programmatic Engagement with the National Rural Health Mission

Recognition of the limitations of a right to health care campaign by Jan Swasthya Abhiyan brings with it the realization that right to health cannot be possible without developing health services systems. This understanding makes the role of Jan Swasthya Abhiyan in the process of National Rural Health Mission complementary to its right to health campaign. Jan Swasthya Abhiyan used it as an opportunity to strengthen the public health system within the constraints of the prevailing conditions.

The National Rural Health Mission (NRHM) was initiated by the UPA government to improve rural health conditions in 2005, after the NHRC recommendations. There were two sets of positions within Jan Swasthya Abhiyan on engaging with National Rural Health Mission. Should Jan Swasthya Abhiyan as civil society engaged with NRHM or not? One position was involvement in NRHM to improving the programme strategies and second position was that JSA shouldn't get involved in any activities of NRHM. JSA should take a position from outside, watching programme activity and act like pressure group. The final consensus made with majority opinion was that JSA would engage in

Community Based Monitoring under NRHM, and that members could decide on their own to engage more actively with programme implementation if they so desired. The Jan Swasthya Abhiyan network organizations engaged in Community Based Monitoring under National Rural Health Mission, while some members of JSA have contributed through implementation support and technical expertise for making the most of the NRHM.

JSA's major disagreement with the National Rural Health Mission was that most of the activities of NRHM were a replica of the Reproductive Child Health programme.

Some activists of JSA believe that the National Rural Health Mission is not a solution for real crisis of public health in India. And through civil society engagement in NRHM, state will create a voice-less civil society in field of public health in India by co-opting members of JSA.

Jan Swasthya Abhiyan was involved in NRHM mainly in Community Based Monitoring, in conception and implementation of its pilot phase, mainly monitoring and assisting the process of community health planning. In the Accredited Social Health Activists (ASHA) programme trainings of ASHAs and mentoring of the programme involved several civil society members. Some members of JSA conceptualised the process of public-private partnership based on JSA perspective. Role of watching NRHM activities through People's Rural Health Watch would be an activity to assess whether or not the healthcare infrastructure was being strengthened in a pro-people direction, and to assess whether or not people were getting health services with the introduction and implementation of NRHM. Jan Swasthya Abhiyan members were also part of the Advisory Group on Community Action (AGCA) to support community based action related to NRHM.

Thus the civil society has played multiple roles in strengthening the right to health discourse in India and in strengthening of public health services. The central and state governments have taken a commendable lead in drafting legislation on the citizen's right to health and health care. However, the national bill draft has been put on the website for public opinion since 2008. No progress seems to have been made for two years now. Only one state, Assam, has passed its bill to make it an operational Act. The NRHM is

ending its stipulated term and its outcomes in terms of improving access to healthcare needs to be evaluated. Meanwhile, the Planning Commission of the government of India has also set up a High Level Expert Group (HLEG)[90] to draft a policy framework for Universal Health Coverage by 2020. The HLEG is actively engaging civil society groups including JSA in its deliberations. It remains to be seen when and in what form the right to health legislation sees the light of day. The real challenge will then be in implementing the right to health in its true spirit, overcoming the constraints of the present neo-liberal policy framework. What is evident is that civil society will have to continue its struggle for ensuring that the state seriously owns its responsibility to ensure conditions of health for its.

Also to be examined further is whether civil society is fulfilling the expectations from it as articulated earlier-- though civil society represents the domain of the bourgeoisie, but by virtue of the socialization that it provides to the working class, it can equally be the site where the unprivileged classes can fight for social and economic emancipation. Having belied its promises of self-determination, self-realization and freedom, civility within the sphere is then restored through revolutionary transformation (Chandhoke, 1995). Alternatively, is it acting as part of the capitalist system as stated by Gramsci, whereby it contributes to the cultural and ideological capital required for the survival of the hegemony of capitalism? Gramsci never viewed this as a problem in itself since he considered it as space for problem solving, which has a potentially oppositional role. Both challenging and upholding the existing order, it is a space where social consensus is formed (Jayaram, 2005). What needs to be examined is the direction in which the consensus is being steered in the name of right to health, that favouring the international corporate medical industry and professional interests, or towards the operationalisation of the right to health in terms of the ground realities of the majority of those deprived of their rights.

[90] In October 2010, the Planning Commission under the approval by the Prime Minister, appointed the High Level Expert Group (HLEG) to develop a framework for Universal Health Coverage, (UHC) to be implemented over 2010-2020 HLEG's terms of reference include investment plan for human resource requirements; physical and financial norms to ensure quality UHC; critical management reforms to improve efficiency, effectiveness and accountability; guidelines for the constructive participation of communities; policies regarding the production, import, pricing, distribution and regulation of essential medicines; role of health insurance system for UHC.

Bibliography and References

Bibliography and Reference

- Abiew, F. K., and Keating. T. (2004), "Defining a Role for Civil Society", in Keating, T. and Knight, W. A., (eds.) in *Building Sustainable Peace*, Edmonton: University of Alberta Press, pp. 93-117.
- Al-Amin, M. (2008), "In Search of Reality: Promoting Democratic Good Governance Through Civil Society", *Asian Affairs*, Vol.30, No.1, pp.5-20.
- Albisa, C., & Sekaran, S. (2006). Realizing Domestic Social Justice Through International Human Rights: Foreword. *New York University Review of Law & Social Change*, vol-*30*, pp-351–739.
- Almeida-Filho, N., Kawachi, I., Filho, A., Norberto J. and Dachs, W. (2003), "Research on Health Inequalities in Latin America and the Caribbean: Bibliometric Analysis (1971-2000) and Descriptive Content Analysis (1971-1995), *American Journal of Public Health*, Vol.93, No.12, pp.2037.
- Alqadhafi, S. A. I. (2007), "*The Role of Civil Society in The Democratisation of Global Governance Institutions*", A PhD Thesis Submitted to the Department of Philosophy of the London School of Economics.
- Asher, J. (2004), *The Right to Health Resource Manual for NGO's Commonwealth* Medical Trust, London. Pp.7.
- Aspalter, C. (2003), "The State and the Making of the Welfare System in India", *Journal of National Development,* Vol. 3, No. 1, pp.149-79.
- Backman, G., Hunt, H., Khosla, H., Strouss, C. J., Fikre, B. M., Rumble, C., Pevalin, D., Páez, D. A., Pineda, M.A., Frisancho, A., Tarco, D., Motlagh, M., Farcasanu, M. and Vladescu, C. (2008), "Health Systems And The Right To Health: An Assessment Of 194 Countries", *Lancet,* Vol.372, pp.2047 -2085.
- Banerji, D. (2005), "Politics of Rural Health in India", *Economic and Political Weekly*, Vol.40, No.30, pp.3253-58.
- Banerji, D. (2008), 'The World Health Organization's Decennial Rituals of 'Remembering' the Alma Ata Declaration', *Global Social Policy*, Vol. 8, No.2, pp.149-152.

- Banna, S., Hasan, H., and Meloche, J. (2009), "Opportunities for Interactivity in Public Health Websites: A Content Analysis Approach", Paper prepared for European and Mediterranean Conference on Information Systems, Izmir, pp-1-14.
- Banon, S. R. (2006), "Civil Society and Gender Equality: A Theoretical Approach" in *General Introduction To Civil Society,* (Ed) Professor Jude Howell, Civil Society Working Paper No-24, pp-1-31.
- Basu T. and Madhukar C V (2009), "How to Engage with the Political Class" *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010.
- Batliwala, S. (2007), "When Rights Go Wrong- Distorting the Rights Based Approach to Development", *India-Seminar*, Vol.569, pp.89-94.
- Baum F. and Harris L. (2006), "Equity and The Social Determinants of Health", *Health Promotion Journal of Australia*, Australian Health Promotion Association, pp.161-4.
- Baum, F. (1997), "Public Health and Civil Society: Understanding and Valuing the Connection", *Australian and New Zealand Journal of Public Health*, Vol.21, No.7 pp.673-675.
- Baxi U. (1989). "The Struggle for Human Rights", Rethinking Human Rights. Edited by S Kothari and H Sethi. Bombay: Tripathy.
- Baxi U. (2002), "The Future of Human Rights". *Oxford University Press.* New Delhi.
- Beteille, A (2000), "Civil Society and its Institutions" in Elliot, C. M. (ed.), *Civil society and Democracy: A Reader*, Oxford University Press, New Delhi, pp.191-210.
- Beteille, A. (1999) "Citizenship, State and Civil Society" Source: Economic and Political Weekly, Vol. 34, No. 36, Sep. 4-10, pp. 2588-2591.
- Bratton M. (1994), "Civil Society and Political Transition in Africa" Institute for Development Research (IDR)Report, Volume 11, Number 6.
- Burkett, P. (2003), "*Marx's Vision of Communism and Sustainable Human Development*", Paper prepared for Conference on Work of Karl Marx and

Challenges For The 21st Century, Institute of Philosophy, Havana, Cuba, pp.5-8.

- Byrne, I. (2009), "Enforcing the Right to Health: Innovative Lessons from Domestic Courts" *Realizing the Right to Health.* Swiss Human Rights Book Vol. 3, by Andrew Clapham /Mary Robinson pp.1-576.
- CEHAT (2003), *Right To Health Care Moving From Idea To Reality*, Seminar Report, Asian Social Forum, Hyderabad, pp.1-127.
- Centre for Civil Society, London School of Economics, "What is Civil Society," available at http://www.lse.ac.uk/collections/CCS/what_is_civil_society.htm as accessed on January 16, 2011.
- Chandhoke N. (2009), "Putting Civil Society In Its Place", *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010.
- Chandhoke, N. (1995), *State and Civil Society: Explorations in Political Theory,* New Delhi: Sage Publications
- Chatterjee, P. (1997), "Beyond the Nation? Or Within?", *Economic and Political Weekly*, Vol.32, No.1/2, pp.30–34.
- Chew, C., and Eysenbach, G. (2010), "Pandemics in the Age of Twitter: Content Analysis of Tweets During the 2009 H1n1 Outbreak, *PloS One*, Vol.5, No.11, pp.e14118.
- Cohen, J. L. (1985), "Strategy or Identity: New Theoretical Paradigms and Cotemporary Social Movements," *Social Research,* Vol.52, No.4, pp.669.
- Committee on Economic, Social and Cultural Rights (CESCR) (2000), *The Right to the Highest Attainable Standard of Health*, General Comment, Geneva, available at http:// www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En as accessed on 8th April 2010.
- Committee on Economic, Social and Cultural rights, General Comment.

- Crowley B. P. and Delfico J.F.(1996), "Content Analysis: A Methodology for Structuring and Analyzing Written Material", United State General Accounting office. Paper series 1
- Crowley B. P. and Delfico J.F.(1996), "Content Analysis: A Methodology for Structuring and Analyzing Written Material", *United State General Accounting office*. Paper series 1
- Cueto, M. (2004), 'Primary Health Care and Selective Primary Health Care', *American Journal of Public Health*, Vol. 94, pp.1864-74.
- Das S.K. (2009), "Civil society as a moral moment", *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010
- Desai, P. (1983), "Social Dynamics of Health Care", in Bose, A. and Desai, P. (ed), *Studies in Social Dynamics Of Primary Health Care,* Hindustan Publishing Corporation, New Delhi, pp.1-9.
- Devraj, A. (2005), "You Can't Blame Liberalisation For All Our Woes", *InfoChange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010.
- Dilip T. R (2005) "Extent of Inequity in Access to Health Care Services in India" *Review of Healthcare In India,* publish by Centre for Enquiry into Health and Allied Themes, section 4, pp-247-268.
- Dippell M. (2000) "The Role of Civil Society and Political Parties in a Democracy", *Presentation to Special Commission on Inter-American Summits Management*, National Democratic Institute for International Affairs, pp-1-3.
- Dreze, J. (2002), "Democratic Practice and Social Inequality in India" *Journal of Asian and African Studies*, Vol.*37 No.*2, pp.6-37.
- Ellora Puri (2004), "Civil and Political Society A Contested Relationship?", Economic and Political Weekly, August 7, PP.- 3593-3594.
- Elo, S., and Kyngäs, H. (2008), "The Qualitative Content Analysis Process, *Journal of Advanced Nursing*, Vol.62, No.1, pp.107-115.
- Emirbayer, M., and Sheller, M. (1999), "Publics In History", *Theory and Society*, Vol.28, No.1, pp.143-197.

- Feinberg, J. (1978). "Voluntary euthanasia and the inalienable right to life". *Philosophy and public affairs*, Vol-7(2), PP-93–123.
- Femia, J. (2001), "Civil Society and the Marxist Tradition", in Kaviraj, S. et.al. (eds.), *Civil Society: History and Possibilities*, Cambridge University Press, pp.131-146.
- Flaherty M. S. (2004) "Judicial Globalization in the service of self-Government *Princeton University,* Princeton Law and Public Affairs Research Paper Series, Paper 1
- Flyvjerg, B. (1998), "Habermas and Foucault: Thinkers for Civil Society?", *The British Journal of Sociology*, Vol. 49, No. 2, pp. 210-233.
- Ford, N., Wilson, D., Bunjumnong, O., and Angerer V.S. (2004), "The Role Of Civil Society In Protecting Public Health Over Commercial Interests: Lessons From Thailand", *The Lancet*, Vol.363 No.9408, pp.560-563.
- Frattaroli, S. (2006), "Understanding and Informing Policy Implementation: A Case Study of the Domestic Violence Provisions of the Maryland Gun Violence Act" *Evaluation Review*, Vol.30, No.3, pp.347-360.
- Giddens, A. (2006), *Sociology*, Fifth edition, Polity Press Cambridge.
- Government of India (2009), *Draft National Health Bill: 2009*, Ministry of Health and Family Welfare, available at www.mohfw.nic.in/nrhm/Draft_Health_Bill/General/Draft_National_Bill.pdf as accessed on 9th July 2010.
- Graneheim, U. H., and Lundman, B. (2004), "Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to Achieve Trustworthiness", *Nurse Education Today*, Vol.24, No.2, pp.105–112.
- Hall, J. and Taylor, R. (2003), "Health For All Beyond 2000: The Demise Of The Alma-Ata Declaration And Primary Health Care In Developing Countries" Medical Journal of Australia, (Global Health), Vol. 178, No.1, pp.17- 20.
- Heredia R.C. (2009), "Society and State" *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010

- Heredia, R.C. (2009), "Society and State", *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010.
- Hoffman, K. M., Poston, W. S. C., Jitnarin, N., Jahnke, S. A., Hughey, J., Lando, H. A., Williams, L. N., et al. (2011), "A Content Analysis of Tobacco Control Policy in The US Department Of Defense, *Journal of Public Health Policy*,vol- 6
- Howell, J. (2006), "The Global War on Terror, Development and Civil Society", *Journal of International Development,* Vol.18, pp.121-135
- Hsieh, H.-F. (2005), "Three Approaches to Qualitative Content Analysis", *Qualitative Health Research*, Vol.15, No. 9, pp.1277-1288.
- Jan Swasthya Abhiyan (2006), "Health System in India: Crisis & Alternatives", Published by National Coordination Committee, Jan Swasthya Abhiyan, pp.1-87.
- Jan Swasthya Abhiyan (2007), *Health Services and The National Rural Health Mission: An Interim Stock-Taking*, Report Of People's Rural Health Watch, Jan Swasthya Abhiyan pp.1-30.
- Jan Swasthya Abhiyan (2007), *Report of Second National People's Health Assembly*, Submitted to World Health Organisation, New Delhi.
- Jayal N.G (1994) "The Gentle Leviathan: Welfare and the Indian State" *Social Scientist*, Vol. 22, No. 9/12, pp. 18-26
- Jayram N. (2005) "Civil Society: An Introduction to the Discourse" in On Civil Society Issue and Perspectives, Sage Publications India Pvt Ltd New Delhi. Pg- 15.
- Jayram, N. (2005), "Civil Society: An Introduction to the Discourse" in *On Civil Society Issue and Perspectives,* Sage Publications, New Delhi, India, pp.15.
- Jayram, N. (2005), *"Themes in Indian Sociology 1- On Civil Society, issues and perspectives"*, New Delhi/thousand oaks/London: Sage, pp.15-42.
- Joseph S,(2002) "Society v/s State" *Economic and Political Weekly*, Jan-March, pg 299-304

- Kakade, D. (2008), *Report on First Phase of Community Based Monitoring of Health Services under NRHM in Maharashtra*, SATHI-CEHAT, Pune, pp.1-96.
- Kakarala S. (2010) Human Rights, Pluralism and Civil Society Reflecting on contemporary challenges in India, Pluralism Working Paper no 6 pg-1 -34
- Kennedy, D. (2002), "The Critique of Rights in Critical Legal Studies", *Left Legalism/Left Critique*, pp.178-228.
- Khilnani, S. (2002), "The Development of Civil Society", in Sudipta Kaviraj and Sunil Khilnani (eds.), *Civil Society: History and Possibilities*, Foundation Books, New Delhi pp.11-32.
- Kumar, K. (1993), "Civil Society: An Inquiry into The Usefulness Of An Historical Term", *The British Journal of Sociology*, Vol.44, No.3, pp. 375-395.
- Lawn, J., Rohde, J., Rifkin, S., Were, M., Paul, V. and Chopra, M. (2008), 'Alma-Ata 30 Years On: Revolutionary, Relevant, and Time to Revitalize' Alma-Ata: Rebirth and Revision 1, *The lancet,* Vol. 372, pp.917-27.
- Lee, K. (2000), For Debate: The Impact of Globalization on Public Health: Implications for the UK, *Journal of Public Health*, Vol.22, No.3, pp.253-262.
- Magnussen, L., Ehiri, J., and Jolly, P. (2004), "Comprehensive Versus Selective Primary Health Care: Lessons for Global Health Policy", *Health Affairs*, Vol.23 No.3, pp.167-176.
- Magnusson, R. (2009), "*Report Of The Rapporteur ,International Expert Consultation On Public Health Law*", The International Development Law Organisation (IDLO), The O'Neill Institute for National and Global Health Law, Georgetown University, The World Health Organisation (WHO), Rome, Italy, pp.1-17.
- Mahajan, G. (1999), "Civil Society and Its Avatars, What Happened to Freedom and Democracy?" *Economic and Political Weekly*, pp.1188-96.

- Makela, M. and Hellberg, H. (1994), 'Health For All-Or For Some Only?' in Lankinen, Bergstrom, Makela, Peltomaa (eds), in *Health and Disease in Developing Countries*, Macmillan Education Limited, Malaysia, pp.461- 68.
- Marmot, M. (2005), "Social Determinants of Health Inequalities", *The Lancet*, Vol.365 No. 9464, pp.1099-1104.
- Mathiharan K (2003), The fundamental right to health care, Indian Journal of Medical Ethics. Vol-11, no-4, pp-1-2
- Medico Friend Circle. Retrieved September 17, 2011, from http://www.mfcindia.org Accessed Friday, July 08, 2011 11:41:01 PM
- Menon, N. (2004), "Recovering Subversion: Feminist Politics beyond the Law" *Urbana and Chicago;* University of Illinois Press, pp.288.
- Morgan L. D. & Zhao P. Z. (1993), "The Doctor Caregiver Relationship Managing the Care of Family Members With Alzheimer's Disease" in *Qualitative Health Research*, Sage Publication, vol-3, pp-133
- Narayan, R. (2006), "The Role of the People's Health Movement in Putting the Social Determinants of Health on the Global Agenda" *Health Promotion Journal of Australia*, Vol-17, No.3, pp.186-188.
- National Health Bill (2009): *"National Health Bill, 2009 – please read, please discuss."* Access on June 24, 2010, from http://nationalhealthbill.blogspot.com/2009/08/national-health-bill-2009-please-read.html
- Navarro, V. (2008), 'Neoliberalism and Its Consequences: The World Health Situation Since Alma Ata', *Global Social Policy*, Vol. 8, No.2, pp.152-155.
- Neocleous, M. (1995) "From Civil Society to the Social" *British Journal of Sociology*, Vol 46 No 3 September, pg 395 -409
- Newell, K. (1988), 'Selective Primary Health Care: The Counter Revolution', *Social Science Medicine*, Vol. 26, No.9, pp.903-906.
- Nichols, S., and Chase, N. (2005), "A Content Analysis of Health Research Reported by the Daily Newspapers of Trinidad and Tobago", *West Indian Medical Journal*, pp.308–314.

- Nilsen, A. G. (2007), "On New Social Movements and "The Reinvention of India", *Forum for Development Studies,* Vol.34, pp.271-293.
- Okuonzi, S. (2004), "Political Economy of Health With Reference To Primary Health Care" *Health Policy and Development*, Vol. 2, No. 1.
- Onesimus, K. (2008), "The International Monetary Fund; Illegitimate Governance and Failed Policies", in Sihanya, Ben (ed) in *The Impact of IMF Policies on Education, Health and Women's Rights in Kenya*, Action Aid, Keniya, pp.24-40.
- Oommen T. K. (2009), "A fine balance", *Infochange News & Features*, November, Pg-
- Oommen, T. K. (2009), "A Fine Balance", *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010.
- Pandy, R. S. (2010), *Communitisation: The Third Way of Governance*, Published by Concept Publishing Company Pvt. Ltd, New Delhi, pp- 172
- Pendse S, Roy A.K, and Sethi H,(1982) "People's Participation: A look at Non-Party Political Formations in India". A mimeograph.
- Peoples Health Movement (2001), "People Health Assembly 2000: A Resounding Success" *News Brief-5*, Gonoshasthaya Kendra, Dhaka 1344, Bangladesh, pp.1-4
- Peoples Health Movement India. (2011). access June 24, 2010, from http://phm-india.org/
- Phadke A,Gaitonde R, Shukla A (2010), "Moving Towards Universal Access to Health Care:Gaps and Barriers in Existing Health System" Concept Note for MFC Annual Meet 2010, Medico Friend circle Bulletin 337-338
- PHM (2002), People's Charter for Health: People's Health Assembly, *Journal of Public Health Policy*, Vol.23, No.4, pp. 387-398.
- PHM (2006), "The Assessment Of The Right To Health And Health Care At The Country Level", A People's Health Movement Guide, http://www.phmovement.org/files/RTH_assmt_tool.pdf Accessed Friday, June 18, 2011 11:06:04 PM

- Pollock, R.B., Whitelaw, G. S., and Atkinson, D. K. (2003), *Linking Community Based Ecosystem Monitoring to Local Decision Making and Policy Development on Sustainability*, Report Canadian Nature Federation, pp.1-96
- Priya R (2002), "Introspecting Upon AIDS Control in India", paper presented in the workshop on 'Societal Concerns and Strategies for AIDS Control in India', 18th -20th January, a project of CSDS and CSMCH, JNU, New Delhi.
- Priya R. (1986) "Voluntary Action for an Alternative Health System". *Lokayan Bulletin* , Vol.4, No. 3-4,
- Priya R. (1995) "Community Health and NGOs: Myth and Reality". *Lokayan Bulletin,* Vol.-No. 12-3, pp-41
- Priya R. (1997) " "Health and Nutrition: People, Policies and Politics". *Lokayan Bulletin,* Vol.-No. 14-1, pp-63
- Priya, R.(2005), 'Public Health in India-A Historical Perspective', in Gangoli L, Shukla A. and Duggal R. (Ed) *Review of Healthcare in India*, CEHAT, Mumbai.
- Puri, E. (2004), "Civil and Political Society A Contested Relationship?", *Economic and Political Weekly*, Vol. 39, No.32, PP.3593-3594.
- Putnam, R D. (1993), "Making Democracy Work: Civic Traditions in Modern Italy". *Princeton*, NJ: Princeton University Press.
- Putnam, R D. (2002),"Democracies in Flux: The Evolution of Social Capital in Contemporary Society". *Oxford*, Oxford University Press.
- Qadeer, I and Chakravati E. (2010), "*New Reproductive Technologies And Health Care In Neo-Liberal India*" (Essays), Centre For Women's Development Studies, New Delhi.
- Qadeer, I. (2000), "Health Care Systems in Transition III. India, part I. The Indian Experience" *Journal of Public Health Medicine*, Vol.22, No.1, pp.25-32.
- Qadeer, I. (2001), 'Impact of Structural Adjustment Programs on Concepts in Public Health', in Qadeer, I. Sen, K. and Nayar, K. (Ed), *Public Health and*

the Poverty of Reforms: *The South Asian Predicament*, Sage Publications, New Delhi, pp.118

- Rajagopalan S (2009), "Civil society and the production of (in)security", *Infochange News & Features,* available at www.infochangeindia.org as accessed 25th October, 2010
- Reddy, S., Patel, V., Jha, P., Paul, V. K., Shiva Kumar, A. K., and Dandona, L. (2011), "Towards Achievement of Universal Health Care in India by 2020: A Call To Action", India: Towards Universal Health Coverage 7 (Series)
- Right to Health, (2011), as available on http://www.legalindia.in/right-to-health as access on 9th July, 2011.
- Román V.R. and Tovar M. T. (2007), "The Role Of Civil Society In Building An Equitable Health System", Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health, pp.1-43.
- Ruger, J. P. (2006), "Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements", *Yale Journal of Law & the Humanities,* Vol.18, pp.273- 326.
- Sabastian, K. (1994), "National Health Initiatives: In The Context of Primary Health Care and Alma Ata Declaration," Unpublished MPhil Dissertation, Jawaharlal Nehru University, New Delhi.
- Sama (2010), "Advancing Right to Health: The Indian Context" *Beyond the Circle Project*, Sama - Resource Group for Women and Health, New Delhi, pp- 1-111
- Scott, F. (2007), "Legacies of Primary Health Care in An Age of Health Sector Reform: Vietnam's Commune Clinics in Transition", *Social Science & Medicine,* Vol.64, No.8, pp.1611-23.
- Sen, B. (2011). Securing the right to health for all in India. *The Lancet*, vol-*377*(9765), pp-532-533.
- Shukla, A (2008), "The Rights Approach to Health and Health Care A Compiled Review" *Beyond the Circle*, MASUM Pune, pp.1-35.
- Solberg, K. E. (2009), "Health Issues Sidelined in India's General Election", *The Lancet*, Vol. 373, No.9674, pp.1509-1511.

- Spurk, C. (2001), "Understanding Civil Society-History, Debates, and Contemporary Approaches", *Civil Society Peace Building*, pp.1-26.
- Srinivasan, S. (2001), "Reasserting the Right to Health", *Indian Journal of Medical Ethics*, Vol.9, No.1, pp.1-2.
- Stillman, P. G. (1980), "Hegel's Civil Society: A locus of Freedom", *Polity*, Vol.12, No.4, pp.622-46.
- Taylor, A. L. (2002), "Global Governance, International Health Law and Who: Looking Towards the Future", *Bulletin of the World Health Organization,* Vol-80, pp.975-980.
- Taylor, C. (1990), "Modes of Civil Society", *Public Culture*, Vol.3, No.1, pp. 59-118.
- Thania P. and Spurk C. (2006), "Civil Society, Civic Engagement, and Peacebuilding", Conflict Prevention & Reconstruction Social Development Department, The World Bank Washington, Paper No. 36 Pp- 5
- The Committee on Economic, Social and Cultural Rights: General Comment 14 on 'The Right to the Highest Attainable Standard of Health'.
- The Right to Health, by Melik Özden, http://www.cetim.ch/en/documents/bro4-sante-A4-an.pdf Accessed Friday, July 08, 2011 11:41:01 PM
- The Universal Declaration of Human Rights (1948), as available on http://www.un. org/en/documents/udhr/index.shtml as access on 29th Jan, 2011.
- Touraine, A. (1981), "The Voice and the Eye", *Cambridge University Press, New York,* pp.115.
- Unger, J. P., and Killingsworth, J. R. (1986), "Selective Primary Health Care: a Critical Review of Methods and Results", *Social Science & Medicine (1982)*, Vol.22, No.10, pp.1001-1013.
- Vellani A (2009) "Planned obsolescence", *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010

- Vellani, A. (2009), "Planned Obsolescence", *Infochange News & Features*, available at www.infochangeindia.org as accessed 25th October, 2010.
- Warren, M. E. (1999), "*Civil Society and Good Governance*" published as part of the U.S. Civil Society Project, Directed by Virginia Hodgkin-son and Located at the Centre for the Study of Voluntary Organizations and Services, Georgetown Public Policy Institute, Georgetown University.
- WHO (1978), *The Report of the International Conference on Primary Health Care Alma-Ata*, USSR, World Health Organization, Geneva.
- WHO (2001), *"Strategic alliances The Role of Civil Society in Health"*, Civil Society Initiative, External Relations and Governing Bodies, Discussion Paper No.1, pp.1-12.
- WHO (2007), *Civil Society Report*, submitted to the Commission on Social Determinants of Health, at the meeting of the Commission held in Vancouver, pp.1-15.
- Yhome, K. (2011), "Communitisation: The Third Way of Governance", *Community Development Journal*, Vol.46, No.1, pp.147-149.

Annexure

Annexure -I

National Coordination Committee Members JSA

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- Association for India's Development (AID India)
- Bharat Gyan Vigyan Samiti (BGVS)
- Breastfeeding Promotion Network of India (BPNI)
- Catholic Health Association of India (CHAI)
- Centre for Community Health and Social Medicine , JNU
- Centre for Health Enquiry into Health and Allied Themes (CEHAT)
- Christian Medical Association of India (CMAI)
- Society for Community Health Awareness, Research and Action (SOCHARA)
- Forum for Creche and Child Care Services (FORCES)
- Federation of Medical Representative Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Voluntary Health Association of India (VHAI)

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Abhiyan campaign as participating organizations. [1]

---

[1] From- JSA (2006)"Health System in India: Crisis & Alternatives" Towards the National Health Assembly II Booklet 2

Annexure II

List of JSA Material Referred for Study

No	Name of Material
	EVENTS
1	Summary of Demands of Maharashtra State Health Assembly
2	Report Urban Health Meet 6th Nov 2007
3	Report of WHO regional consultation - 15th - 16th Sept. 2005
4	Report of Maharashtra State Health Assembly
5	Report of 2 Day Consultation on Vulnerable Groups
6	Programme Schedule of Consultation on Access to Health Care of Vulnerable Groups
7	Programme schedule - Second National Health Assembly 1
8	Programme Schedule - Second National Health Assembly *2*
9	Programme Schedule - JSA NCC meeting 18-19 Dec. 04
10	NHRC Western Hearing
11	NHRC North-Eastern Public Hearing report
12	NHRC Eastern Hearing – Report
13	NHRC Eastern Hearing – Programme
14	Mumbai Jan Sunwai Report
15	Minutes of the JSA workshop on material preparation for NHA-II Bangalore - 24 Feb, 06
16	Minutes of RHW meeting - 2nd September, 2005
17	Minutes of JSA NCC meeting -18th April 2005
18	Key decisions – JSA meeting - 14-15 May, 2005
19	Key decisions of JSA NCC meeting - Dec. 04
20	Key Decisions - NHA-II Feb. 2006
21	Invitation - 14th July 06 JSA NCC Meeting
22	Information Package and Registration Form
23	Hunger Watch programme Schedule
24	CSDH JSA Presentation
25	Concept Note on health care of Vulnerable Groups
26	CBM workshop in Urban Context - 26th Nov. 2010
27	Agenda for the Preparatory Workshop National Health Assembly II
28	Agenda for the JSA NCC meeting - 14 July,2006
	Documents
1	World Health Day 2008 HindustanTimes

2	World Health Day 2008 Express NewsLine
3	Swine Flu Patrak
4	Report of consultation on access to health care of vulnerable groups in Mumbai
5	Patients Rights Consultation July2009
6	JSA position paper on National Health Act
7	National Health Bill JSA press note
8	JSA and NCC Meeting Reports
9	Patient right constitution _July 2009
10	Report on Urban Health meet
11	Report on CBM in Urban Context
	Health policy
1	Budget 2005-06 By-Ravi Duggal
2	Health policy Brief
3	Is India Shining (Note)
4	Report National Level Dialogue with Political Parties
	Hunger Watch
1	Hunger Watch Programme details
2	Hunger Watch Report August_03
3	Hunger Watch Draft Guidelines Starvation
	NRHM
1	Financing the National Rural Health Mission-Ravi Duggal
2	The Politics of Rural Health in India- D. Banerji
	Population policy
1	CMP health and population policy initiatives population policy initiatives
2	Memorandum to Minister of Panchayati Raj - Population policy initiatives
3	Population fact sheet- Population Policy Initiatives_
	People's Rural Health Watch (PRHW)
1	Controversery over the new UNICEF executive director. Health activists set up UNICEF watch
2	JSA South Newsletter
3	PRHW final Report
4	Status Report Chhattisgarh
5	Summary final Report

6	Tsunami and Health
	Public Hearing
1	Bangalore Jan Sunwai 19Aug04 Report
2	Case analysis guidelines
3	Case Presentation Guidelines
4	Case Selection Guidelines
5	How to organise a Jan Sunwai
6	Mumbai_Jan_Sunwai_23Nov04_report
7	NHRC Delhi programme draft
8	NHRC eastern hearing programme
9	NHRC east hearing report
10	NHRC national hearing brief report
11	NHRC north east hearing report
12	NHRC September workshop report
13	NHRC south hearing programme
14	NHRC south hearing report
15	NHRC Suggested Action Plan
16	NHRC west hearing report
	Manifesto
1	JAA Manifesto in English- final
2	JAA manifesto in Marathi - final
3	JSA Peoples Health Manifesto 2009
	Right To Health Care
1	Case selection guidelines
2	CHC checklist
3	Dantewada Report Final
4	Exploring Rights Based Approach- By Shukla
5	Make Health a Fundamental Right
6	PHC Checklist
7	Policy brief
8	Rational Prescription in Children by Vandana Prasad
9	RTHC Denial Documentation Protocol
10	RTHC Denial documentation Questionnaire
11	Suggestions about Right to Health Care campaign
12	Suggestions for 3rd Patent Act Ammendment by Amit Sen Gupta
13	Gujarat JSA policy

14	Report Second National Peoples Health assembly
	ISSUE
1	Amendment to Patent Act by Amit_Sen_Gupta
2	Deconstructing the GPEI
3	Disaster Preparedness Programme for Kerala-B Ekbal
4	Ethical issues for polio programmes
5	GATS and Health Sector- B Ekbal
6	GPEI Information note for IMA
7	Health Policy brief
8	India Patents Act Amit Sen Gupta
9	Make Health a Fundamental Right
10	Memorandum on polio eradication initiative
11	Patent Bill Critique –B, Ekbal
12	Polio Eradication
13	Polio eradication experts have misled us
14	Report national level dialogue with political parties
15	Suggestions for 3rd Patent Act Ammendment-Amit Sen Gupta
16	The Challenges of Humanitarian Aid-Thomas Siebert
17	WTO Members should reject bad deal on medicines
	Booklets
1	Booklet 1- globalisation
2	Booklet 2 - Health System in India
3	Booklet 3 - Women's health
4	Booklet 4 - Child health
5	Booklet 5 - New Technologies
6	Booklet 6 - HIV AIDS Treatment Access
7	Booklet 7 - Access to Essential Medicines
8	Draft Booklet 8- Peoples Health Movement India
9	Health Care case laws
	Other Material
	News In Newspapers