"Modern human rights, precisely because they were initially developed entirely outside the health domain and seek to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary, and form of guidance for public health efforts to analyse and respond directly to the societal determinants of health than any inherited from the biomedical or public health tradition."

Jonathan Mann

This quotation of Jonathan Mann, a doctor, who led the efforts to develop the interface between health and human rights, clearly indicate that health is a decisive factor of an individual’s quality of life. It is a subjective as well as an objective evaluation of the physical, mental & social status. Since the dawn of independence, rapid strides have been made in the improvement in the quality of health care services to the people. Infact, this study reflect that the incorporation of health concerns in the ‘right’ discourse, both at international and national level, recognises that the legal system bears the liability of aiding the medical profession in advancing the ‘right to health’. The onus of governmental agencies not only confined to policy choices pertaining to environment protection, labour laws, social security provisions, education, housing etc but it also has to regulate and support medical profession and research and development (R & D) in the medical field.

In recent years, various development in the medical field has expanded the scope of the ‘right to health’ and thereby, called on

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The World Health Organisation’s (WHO) International Health Regulations which are issued time to time act not only as a guiding framework for domestic policies, but also help in strengthening the link between human rights and health. WHO continues its efforts to support improvements in health care for affected populations through the establishment of telemedicine and educational programmes and by supporting research.

The foregoing study by the researcher has revealed that how in India, the judiciary has attempted to establish the inter-relatedness between rights through the expression of the understanding of the ‘protection of life and liberty’ under Article 21 of the Constitution of India. The apex court of India through its liberal, flexible approach has tried to create harmony between fundamental rights and directive principles in several cases. This has resulted in the recognition of the ‘right to health’ as a part of Article 21 of Constitution of India. Further, the study of various legislation in relation to the ‘right to health’ suggest that despite

2. ‘Respecting’ the right to health means that the Government must refrain from taking actions that inhibit or intervene with people’s ability to enjoy their right. ‘Protecting’ the right to health suggests that the State must try to protect the people from having their rights violated by third parties, such as health care providers, pharmaceutical companies, researchers etc. ‘Fulfilling’ the right to health indicate that the Government is required to take positive action to implement this right by adopting such policies which allocate public resources to correct deficiencies in health facilities and services. Patricia C. Kuszler, ‘Global Health and Human Rights imperative’, Asian Journal of WTO and International Health Law and Policy, Vol. 2(1) March 2007 at 111-112.

3. For instance, Article 3(1) of the International Health Regulations says : “The new International Health Regulations shall be implemented with full respect for the dignity, human rights and fundamental freedom of persons”. World Health Assembly, Revision of the International Health Regulations, WHA, 58.3 (May 23, 2005). The International Health Regulations was first issued in 1969 as an agreed code of conduct. It required to prevent and control health threats and provided for a public health response. World Health Report 2007.
the existing drawbacks, an effort has been made both by the government and judiciary to provide medical facilities to all, both urban and rural people so to create a justiciable ‘right to health’. The government has made considerable investment for expanding the health care infrastructure. Over the last several years in India there has been a dramatic change in the national government’s approach to the health sector. At the highest level that of the prime minister and union finance minister, there have been public calls for increasing government health spending. One stated goal of these national schemes is to increase total government health spending from its previous level of about 1 percent of gross domestic product (GDP) to a targeted 2-3 percent of GDP by 2012, the end of the Eleventh Five-Year Plan.4

National Rural Health Mission Programme (NRHM), as well as the establishment of more medical and paramedical educational institutions, has resulted in the enhancement of the scale of medical facilities. Still as compared to the increasing role of private health care sector which largely cater to urban patients with higher purchasing power, the rural poor sections of the society are being deprived of proper medical health care. As it is well stated that the healthy future of society depends on the health of the children of today and their mothers, who are guardians of the future. Each year, millions of children & mothers could be saved through improved access to basic health interventions.

It seems that more than 30 years after the brave declaration of Alma Ata, we are no closer to the goal. The findings of the third National Family Health Survey (NFHS-3), a household survey

4 Peter Berman, Rajeev Ahuja, “Government Health Spending in India”, Economic and Political Weekly, at 209 (June 28, 2008).
carried during 2005-06, should put the political class to shame. The infant mortality rate (IMR), the number per 1000 children before one year of age is 57, which means over one in 18 infants die before they are one year old. The same is true for children under five, wherein the child mortality rate (CMR) is 74 (one in 13) as compared to 92 of NFHS-2. This is far cry from the Millennium Development Goal (MDG) of a CMR of 42 by 2015. Clearly, the IMR target of 30 by 2010 set by the 2002 National Health Policy (NHP-2002) is unlikely to be achieved. Much of these deaths are preventable through childhood immunization. But the reach of the country's Universal Immunization Programme (UIP) continues to remain low, which is the result of a weak public health care system. The NFHS-3 data show no significant improvement in immunization coverage between 1998-99 and 2005-06: 42 percent coverage in NFHS-2 and 44 percent now.

The objective of introducing the Pulse Polio Programme (PPP) over and above the routine immunization programme was to make India polio free. That goal has not been achieved because the PPP is being done at the cost of routine immunization, in terms of deployed resources.

There have been repeated changes in the definition of polio cases – out of the thousands of cases of acute flaccid paralysis (AFP) now reported only those with wild polio virus detected in their stools are classified as polio cases. This leaves out a large number of cases of paralysis that would qualify to be classified as polio by the older definition based on clinical signs. Secondly, there has been an unacceptably large increase in the number of AFP cases in the country since 2000. It has steadily increased

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from 8,103 in 2000 to 41,401 in 2007 (35,552 upto October 2008). The non-polio AFP rate had increased from 1.99 to 9.40 in this period.

The government of India and WHO are ignoring these increasing numbers of AFP cases, and the fact that a significant proportion of children with confirmed wild poliovirus paralysis are immunized children who have received 12-15 doses of OPV. Such an epidemic of paralysis while there is an ongoing “elimination programme”, is “explained away” by WHO to be due to “excellent surveillance”, instead of undertaking a comprehensive epidemiologic investigation into the steady increase. Parents are not informed that they should not allow intramuscular injections in children with fever during the polio-virus season or after receiving OPV.

India has one of the highest levels of child malnutrition in the world, higher than most countries in Sub Sahara Africa. It was calculated that 80% of Indian Population was living on less than two dollar per day. The UN Special Rapporteur Mr. Jean Ziegler on the right to food, reported over 250 cases of starvation deaths from many parts of India, and in particular, from the tea gardens in West Bengal. He found hunger rampant among the dalits and tribals. He concluded that India was not currently on track to achieve the goals set in relation to malnutrition and under nourishment in the UN millennium development goals.

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6 Indira Chakravarthi ‘Role of the World Health Organisation’ Economic and Political weekly at 41 (November 22, 2008).
7 Non-Polio AFP rate is defined as number of cases of paralysis per 100,000 population which is not due to polio. It is between one and two in most countries, whereas it is the highest in India (8.5 in 2008) www.polioeradication.org. (accessed on April 25, 2009).
Infact, the burden of disease on the population continues to be high and takes a heavy toll of life. Recent years have witnessed a resurgence of various communicable diseases such as tuberculosis (TB), malaria, chikungunya, dengue, kala-azar, encephalitis and leptospirosis. India which is among the 22 high burden countries, has 3.8 million tuberculosis (TB) patients. According to the Directorate General of Health Services, two deaths occur every three minutes from the disease. The Directly Observed Treatment Scheme (DOTS) is the World Health Organisation’s (WHO) effort to fight the disease across the world. The health ministry has planned to manage multidrug resistant tuberculosis (MDR-TB) with the DOTS plus programme, but this involves a costly treatment regimen.9

The number of malaria cases remains at around two million annually, but the disturbing aspect is the increasing trend of drug resistant falciparum malaria (nearly half of the cases), which causes the highly fetal cerebral malaria.10

According to the country representative of water aid in India, 50 percent of villages in India do not have protected drinking water. Annually, 37.7 million people are affected by water borne diseases, 1.5 million children are estimated to die of diarrhoea and 62 million people are at the risk of suffering from fluorosis due to excessive fluoride in ground water.11

The mass level campaign known as “Total Sanitation Campaign – TSC” promotes the ending of open defecation, safe disposal of human excreta, better hygiene practices, solid and

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10 supra note 5 at 23
11 Dr. Harender Raj Gautam, ‘Concerted Efforts Vital to Provide Safe Drinking Water in Rural Areas.’ Kurukshetra, at 3 (March 2009).
liquid waste management as well as rural environmental sanitation. It aims at achieving Total Sanitation by the year 2012. Following the success of TSC program, the Government of India introduced the Nirmal Gram Puraskar (clean village award) in October 2003. Villages are eligible to apply for this award on achieving collective outcomes such as universal coverage of toilets and free from open defecation, school sanitation coverage and the maintenance of a ‘clean environment’.

Notwithstanding the controversy in the number of HIV/AIDS cases and the prevalence rate of infection in the country, and the recent downward revision of estimates for these, they are still significant with the latest estimate of 25-31 lakh cases, India has the third largest number, after South Africa and Nigeria. 4 million HIV Positive are on treatment of ART (anti retroviral treatment) globally.

Against the WHO’s recommendation of 10 to 15 percent caesarean deliveries, today in urban India 45 to 50 percent of childbirths are by caesarean. This situation is attributable to profit motive, which has also led to an undesirable growth in “medical tourism” with indirect government support for patients from West Asia and the developed world who have the money to pay.

Despite the substantial increase in the number of CHCs, there is staff and resource shortages. As many as 80% PHCs have no doctor, 1,188 PHCs and 1,647 subcentres function without electricity or without regular water supply. According to the rural

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12 ‘Rural Sanitation in India’, Kurukshetra, at 40 (March 2009).
13 Ibid.
14 supra note 5 at 23.
15 The Tribune October 1, 2009.
16 supra note 5 at 25.
Health Statistics of the Ministry of Health and Family Welfare (MOH & FW), 50 percent of subcentres, 24 percent of PHCs and 16 percent of CHCs function out of rented or temporary premises. More than one fifth of the sanctioned posts for doctors are vacant, while over 40 percent of the PHCs have no laboratory technicians and nearly one fifth have no pharmacists. Only 20% of the medical professionals are available for 70 percent of the country’s population, in rural India.17

There is no clear medical education policy which will produce the manpower needed to provide appropriate medical care. In recent years the government has began operating on the principle that medical education is best provided by the private sector. As the motive of the private sector is profit, this means high fees which only a small section of society can pay. It also means that this high investment has to be recovered, and this can only be done if the doctor works in private sector, preferably in urban areas. This is one of the causes of highly skewed distribution of medical manpower, with about 80% of doctor working in urban areas.18

In infrastructure too, the government has withdrawn and is following a deliberate policy of encouraging the private sector. On 5 September 2008, Prime Minister Manmohan Singh inaugurated Apollo Reach, an initiative of the corporate Apollo Group to provide medical care in semi-urban and rural areas. Speaking on the occasion he said:

“The challenge of providing health care in a country like India is complex. Good health outcomes are not simply a matter of availability of healthcare providers. They depend on a number of

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17 supra note, 5 at 24.
concomitant factors like water supply and sanitation, education, and infant nutrition. The intricate connection between poverty and ill health is obvious and as Jawaharlal Nehru said, “a war on disease and ill health is therefore essentially a war on poverty and all its evil brood.” The challenge of providing affordable quality health care to our people cannot be left only to the state. The private sector has always played a dominant role in the provision of healthcare services in the country.”

Today not only medical education has become private sector dominated but even the Medical council of India (MCI), responsible for maintaining standards in medical education and in the medical profession, has increasingly become subservient to the interests of private enterprise. Over the years, with the increase in the number of private medical colleges, the MCI’s powers have grown greatly. In November 2002, the Delhi High Court ordered its president, to step down on various charges including corruption. Despite the court’s observation, the centre has done nothing to correct the irregularities within the MCI.

While the country’s private health sector booms with corporate multi-speciality hospitals extending their reach, importing state of art technology to serve a growing middle class and “foreign tourists”, the public health system remains skeletal and government spending on health is abysmal. Though now the government has involved the private health sector to treat poor patients approaching them e.g. in Gujarat, Chiranjeevi Scheme and in Delhi, Mamta Scheme for betterment of maternal health in relation to SC, ST and BPL families but still there are only 60 doctors for every 100,000 people in India, compared with 275 in Australia and 257 per 100,000 in America.

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19 Ibid.
20 supra note 5 at 25.
21 ‘Quacks Make Merry: Health Care at a Discount’ Business Economics, at 50 (Aug. 15, 2008).
According to unofficial sources, there are about 40,000 quacks in the city. Another estimate put the number of quacks in the country at over 1 million, and the total turnover per month for them would amount to (per month) Rs.5 billion and Rs.60 billion (per year).

Quacks flourish because proper health care is often unreachable. There is “doctor”, Amit Kumar, who had run a flourishing organ racket for nearly a decade amassing huge wealth including houses and accounts abroad. He was not even qualified to write a prescription.\textsuperscript{22} It revealed how lax the laws against practicing medicine without a degree are. Amit Kumar’s kidney racket has given a wake up call to the government for considering laws against quacks. But a top Indian Medical Association office bearer said the government does not seem to be serious about bringing in a law to curb quacks.

In 1997 Delhi state government drew up an “Anti Quackery Bill”. Subsequently it was referred to a select committee. Finally, the committee submitted its report in 1998, suggesting a few changes in the Bill. Meanwhile the Bill lapsed. Since then, no action has been taken on quacks.\textsuperscript{23}

The Delhi Medical Council has launched proceeding against quacks in the courts and issued showcase notice to more than 100 quacks. It has been requested through government to appoint special magistrates to put cases against quacks on fast track. The Delhi Government is also considering giving more teeth to DMC to tackle quacks.\textsuperscript{24}

\textsuperscript{22} \textit{id}, at 49, 
\textsuperscript{23} \textit{id}, at 51. 
\textsuperscript{24} \textit{Ibid.}
Unfortunately, at present there is a lack of regulatory framework and the sector attracts sub-standard private health care providers and quacks, there is slow implementation of accreditation process that impacts the quality of health care, penetration of health insurance to larger population, shortage of adequately trained health professionals leading to poor quality of service delivery.

Further, in an environment of private sector dominated health care, irrational treatments abound. It is estimated that in India two-thirds of the money spent on medical treatment goes towards buying unnecessary drugs because of irrational prescriptions by private practitioners. Such an environment has enabled the pharmaceutical industry, which comes under the Ministry of Chemicals and Fertilizers to thrive. There is a proliferation of brand names in India, with as many as 80,000 brands around. Even so, only 20 to 40 percent of people have access to all essential drugs they need. Thus essential drugs are beyond the reach of the common man. The prices of drugs have grown at a disproportionately high rate when compared with the wholesale Price Index (WPI). Policymakers are reluctant to impose any price control because the industry lobby prevailing over politics. The existing price control regime is far from effective as most essential medicines are outside its purview.

As seen in the study there is also the issue of the spurious drug market, which the Drug Controller General of India (DCGI) appears ill equipped or unwilling to tackle. Therefore, a national drug authority under the Health Ministry becomes necessary. These days pharmaceutical companies have found innovative

\[25\] supra note 5, at 25

\[26\] Ibid.
ways to escape government’s price control regulations, and raise medicine prices by four to five times, jacking up the consumer medical bill.\textsuperscript{27} The Drug Controller should take action against these companies so that this kind of misuse is prevented.

The spending on health has dropped to 2.9\% from 3.4 percent.\textsuperscript{28} In addition to this is the fiscal management pressure from the centre on the states, resulting in massive budgetary cuts in the socio-economic sectors including the already deprived health services. The overall health expenditure by states declined from 4.5 percent in 1999-2000 to 3.6 percent in 2008-09.\textsuperscript{29}

Some of the Indian health policies and programmes also attempt to eliminate deprivation in the provisioning of healthcare and achieve the objective of health equity. Still it is important to steer policy making through timely and systematic assessment of prevailing health inequality.

There is no health without mental health. The future of the country, therefore depends on the mental health and strength of young people. WHO wishes to engage schools in providing children with a better appreciation of mental health: it is made clear that this will have little to do with providing factual information, since the intent of the lesson should not be to provide in-depth discussion of various disorders and the emphasis is not on providing detailed scientific knowledge of the illnesses to be discussed, but on how the youngster experienced caring and/or reduced exclusion.\textsuperscript{30}

\begin{enumerate}
\item \textsuperscript{27} ‘\textit{Pharma cos take dietary route to evade price cap}’, The Times of India, 2 May 2009.
\item \textsuperscript{28} \textit{supra} note 5, at 25. The fund allocated for health sector in 2009-10 union budget is Rs. 22,641 Crores (2.2\% of the total), The Times of India, July 7, 2009.
\item \textsuperscript{29} \textit{Ibid}.
\item \textsuperscript{30} Vijay N. Ghormade, ‘\textit{Lectures on Human Rights}’ at 174 (2007).
\end{enumerate}
The government is talking big about rural health, it seems to have no strategy for urban health also, the health indices for urban poor have been consistently bad and becoming worse over years, in some cases even worse than those of rural India. The child mortality rate among the urban poor too is quite similar to rural rates. A draft of the strategies for urban health care, submitted as far back as May 2006, continues to remain just a draft.\textsuperscript{31} In the absence of uniform organizational structure, the bulk of increase in urban population was likely to happen through migration, resulting in slums without infrastructure support. The government appointed the Krishnan Committee in 1982 to address the problems of urban health. On the basis of recommendations of Krishnan committee, the health post scheme, similar to the primary health centre in rural areas, was devised for urban areas also.\textsuperscript{32} But nothing concrete has been done to cater urban health care.

Today’s highly mobile, interdependent and interconnected world provides myriad opportunities for the rapid spread of infectious diseases, and radio nuclear and toxic threats. Infectious diseases are now spreading geographically much faster than at any time in history. It is estimated that due to fast increase in air travel, an outbreak or epidemic in any part of the world is only a few hours away from becoming an imminent threat somewhere else. There are now nearly 40 diseases that were unknown a generation ago. WHO has verified more than 1100 epidemic events world wide.\textsuperscript{33} Cholera, yellow fever and epidemic meningococcal diseases made a comeback in the last quarter of the 20th century.

\textsuperscript{31} ‘No prescription for ailing urban poor’. The Times of India, January 14, 2008.
\textsuperscript{32} Ibid.
\textsuperscript{33} \url{http://www.who.int/whr/2007/overview/en/print.html} (accessed on May 6, 2008).
and call for renewed efforts in surveillance, prevention and control. Severe Acute Respiratory syndrome (SARS) avian influenza, and now Swine flu in humans has triggered major international concern, raised new scientific challenges, caused major human sufferings, and imposed enormous economic damage. Bio-terrorism in the form of the anthrax letter in the United States etc. are the new health threats that have emerged in the 21st century.

Further, the Global Outbreak Alert and Response Network (GOARN) was set up as a technical partnership of existing institutions and networks to pool human and technical resources for the rapid identification, confirmation and response to outbreaks of international importance. ChemiNet is also designed to mitigate chemical incidents and outbreaks of illness of chemical etiology that are concerned with international public health. It is a source of intelligence by informing WHO of chemical incidents.34

Health care as a right is indeed considered desirable universally. In a country like India; where three fourth of the population still live in the villages, providing universal access for health care has become even more difficult. The empirical study by the researcher has been carried out to make an assessment of the ground reality amongst different categories of people in the UT Chandigarh. The objective of this study was to make an evaluation of the perception and awareness about right to health. Though the field study was limited to Chandigarh yet it is representative of a fair cross section of people in general. The study indicates that awareness about health laws is quite less. Surprisingly even the legal experts were also found to be lacking the basic knowledge

about recent scientific developments in the field of health like PNDT Act, human cloning, surrogacy etc. The majority of interviewed, students, doctors etc have shown to possess little knowledge of the technicality of law leave alone the intrinsic legal provisions of the same.

**SUGGESTIONS**

Overall, public health facilities are found to be grossly inadequate for the vast population of country like India. Thus, for transforming the concept of health as a 'Right' into reality and for overcoming the obstacles to its realization, we may adopt the following measures:

1. Since the management, funding, and an implementation of health and education programme has been decentralised to panchayats. In order to reach household levels, integrated and coordinated delivery should be provided at village levels, for basic reproductive and child health services. A vast increase in the number of trained birth attendants is necessary to universalise coverage and outreach of ante-natal, natal and post-natal care. An equipped maternity hut in each village should be set up to serve as a delivery room, with functioning midwifery kits, basic medication for essential obstetric aid and indigenous medicines and supplies for maternal and newborn care. Each village should maintain a list of community midwives and trained birth attendants, village health guides, panchyat sewa sahayaks, primary school teachers and anganwadi workers who may be entrusted with various responsibilities in implementation of integrated service delivery.35

2. The complex socio-cultural determinants of women’s health and nutrition have cumulative effects over a life time. Discriminatory child care leads to malnutrition and impaired physical development of the girl child. For this, a holistic approach to women’s health which includes both nutrition and health services should be adopted and special attention should be given to the needs of women, and the girl at all stages of the life cycle. Women’s traditional knowledge about health care and nutrition should be recognized through proper documentation and its use should be encouraged.

3. Sex selection and abortion of the female foetus is big business with big players. Almost all the major manufactures of ultrasound machines are active in India. Home test kits are openly advertised and available through the internet. The message needs to go out to the offending medical professionals and bureaucrats in charge of implementing the PNDT Act, that female foeticide will be treated as the very serious crime and be effectively punished accordingly.

4. Special efforts should be made to tackle the problem of macro and micro nutrient deficiencies especially amongst pregnant and lactating women as it leads to various diseases and disabilities.

5. In both rural and urban areas, there continue to be unmet needs for contraceptives, supplies and equipment for integrated service delivery, morbidity of health providers and patients, and comprehensive information. It is important to strengthen, energise and make accountable the cutting edge of health infrastructure at the village, sub centre and primary health centre levels to improve

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36 Editorials, “Saving the Girl Child”, at 7, Economic and Political weekly, (February 16, 2008).
facilities for referral transportation, to encourage and strengthen local initiatives for ambulance services at village and block levels.

6. It is pertinent to mention here that the ongoing promotion of morning after pills as an emergency contraceptive measure through advertisements should be immediately regulated by issuance of directives by Health Ministry for inclusion of statutory warning in such ads that these pills must be taken only on the doctor’s advice. Because, today use of such pills has not only been increased but also has given rise to various health problems amongst its users.

7. Nearly 100 million people live in urban slums with little or no access to potable water, sanitation facilities and health care services. This contributes to high infant and child mortality, which in turn perpetuate high TFR and maternal mortality. Basic and Primary health care needs to be provided. Coordination with municipal bodies for water sanitation and waste disposal must be pursued and communication campaigns must spread awareness about the secondary and tertiary facilities available in this regard.

8. The fundamental step a country can take to promote health equity is to move towards universal coverage: universal access to the full range of personal and non-personnel health services they need, with social health protection whether the arrangements for universal coverage are tax based or are organised through social health insurance, or a mix of both, the principles are the same pooling prepaid contributions collected on the basis of ability to pay, and using these funds to ensure that services are available,

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37 supra note 35.
accessible and produce quality care for those who need them, says WHO report 2008.

Therefore, it is necessary to embed universal coverage in wider social protection schemes related to health care and to complement it with specially designed, targeted forms of outreach to vulnerable and excluded groups of the society.

9. It is time that knowledge about health inequalities can only be translated into political proposals if there is organized social demand. Since, the amount of grassroot advocacy to improve the health and welfare of population in need has grown enormously in the last years, the mobilization of groups and communities to address what they consider to be their most important health problems and health related inequalities is a necessary complement to the more technocratic and top down approach to assessing social inequalities and determining priorities for action.\textsuperscript{38} For instance, more recently, HIV/AIDS programmes have drawn attention of providers and policymaker to the importance of counselling, continuity of care, the complementarily of prevention, treatment and palliation and critically, to the value of empathy and listening to patients.\textsuperscript{39}

10. In 2007-08, the Jan Swasthya Abhiyaan (JSA) and the people's Rural Health watch, citizen fora that raise health issues, conducted a survey in the high focus states to analyse the impact of NRHM on rural health care. The survey found that the incentives under the Janani Suraksha Yojana (JSY) needed to be reviewed as they were leading to conflict and corruption between

\textsuperscript{38} The World Health Report 2008. \url{http://www.who.int} (accessed on April 6, 2009)

\textsuperscript{39} \textit{Ibid.}
auxiliary nurse midwives (ANMs), ASHAs, dais and anganwadi workers.

11. As already discussed that India has the most privatised health care system in the world as a result, of which, people bear over 80% of medical expenses through "Out of pocket" expenses, pushing the already poor to below-poverty line status. There is an urgent need not only to regulate private sector in this direction but it must also be integrated into the public health system where possible and in certain situations be required to perform the role of the public health system.

12. There is also the issue of the spurious drug market, which the Drug controller General of India (DCGI) appears ill equipped or unwilling to tackle. Therefore, a National Drug Authority established under the Health Ministry must perform its role strictly to combat the spurious drug market.

13. Further as under the Doha Declaration 2001 vital exception to the TRIPS agreement is made under the aegis of the WTO, whereunder developing countries retain the right to grant compulsory licences to their pharmaceutical companies for manufacturing otherwise patented drugs in instances of emergencies such as health epidemics (For instance, Swine Flu), life saving drug must be made available in a cost-effective manner. Because we must remember, that in an environment of open competition, it is the Consumer who should be ultimately benefitted from wider choice and better pricing.

14. We need regulatory measures to ensure that human organ transplants are kept within the realm of legitimate surgical procedure and do not degenerate into criminal butchery.

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medical profession should co-operate with administrative and legal efforts to tackle problems like organ trade, spurious drugs sale and quackery.

15. In relation to the other new scientific developments such as GM foods, an effective regulatory mechanisms to check, contamination of fields due to open field trial of GM crops should be established by the government on priority basis. Because gene pollution said to be worse than nuclear radiation. Hence, field trials of GM foods should be restricted to green houses only.

16. Moreover there is also need for establishment of regulatory body to regulate and monitor the use of mobile phones, microwave ovens, use of computers etc. which today are emerging as cause for various health problems.

17. Mental disorders threaten to become a serious problem in India and the treatment facilities remain woefully inadequate. It is reported that by 2020 depression will become the single largest killer in the world and India will lead the list. Unless the country has mentally sound people, who can we talk of being an economically strong nation? So, there is a need to re-strategised National Mental Health Programme, which should be integrated with the general health care programme. In this direction, recent attempt of the government to integrate mental health with physical health by way of common examination of the mental health patients with other patients, if implemented, will go a long way in creating uniform ‘right to health’ for all.

18. The law existing in relation to ban on public smoking is not being carried out in letter and spirit. Therefore, to make its implementation effective, need is to increase the amount of fine

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41 Purnima S. Tripathi, 'Depressing Scene', Frontline, at 113 (April 10, 2009).
from existing Rs. 200/- to Rs. 2000/- along with simple imprisonment up to 6 months.

19. Our government should adopt, implement, and periodically review, health policies, strategies and plans of action, on the basis of epidemiological, sociological and environmental evidence, addressing the health concern of the whole population. It should include methods such as right to health indicators and benchmarks, by which progress can be closely mentioned; and evaluate them on the basis of outputs.

20. Every user should be given the right to information about health care facilities, goods, services, programmes conditions and technologies, how best to access, use and enjoy them, and such information must be made available to the public by the Government in the most effective manner, in order to reach out to all sections of society.

21. Further, every user should also have right to access to complete medical records and data pertaining to his/her case containing the health status, diagnosis, prognosis, all the details of the health care provided therein including the line of treatment etc.

22. Every user should also have a right to autonomy, right to prior free consent as a pre requisite for health care proposed for him/her. Every user should also have right to choose and change his/her doctor and health care establishment.

23. People should have collective right to represent and participate within health care institutions at each level of health care in matters pertaining to the planning and evaluation of health care services, quality and functioning thereof.

24. Wherever the user feels that their rights pertaining to health have not been respected they should be empowered to lodge a
complaint before appropriate medical authority in addition to recourse to courts or any other quasi-judicial body. The Draft National Health Bill 2009 does provide for this and suggest for redressal of grievances through in house complaints forum at the institutional level.

25. The nature of hierarchical health governance, administratively, financially and technically, also contributes to the poor state of the public health sector. Further, "Public Health and sanitation hospitals and dispensaries" are state subjects. Health should be brought under the "Concurrent list" in the Constitution, which gives a role to both the centre and the states.

26. Last but not the least, there should be enacted Public Health Law which should act as an umbrella legislation to regulate implement, monitor various health legislation. 'Right to health' should be given the status of fundamental right in the chapter of fundamental rights through amendment in the Constitution as has been done in the case of 'right to education'42.

A healthy nation is a prerequisite for social and economic development. To make the public health care system work requires determined political leadership, adequate investment and appropriate policy instruments rooted in ground realities. Therefore, Public health must be brought to the top of the political agenda of our government. We know that already our Constitution of India has placed an obligations on the government to ensure protection and fulfillment of right to health for all without any discrimination and this is further given impetus by the Hon'ble Supreme Court of India in several judgments as discussed in this study. Even the National Human Rights Commission has also

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42 There is provision of free and compulsory education from the age 6-14 years children under article 21A of the Constitution.
directed the Government of India to enact a separate health law. Therefore, National Health Bill 2009 should be passed on priority basis so that people’s health could be accorded top priority along with education and food security. As rightly said by the present WHO’s Director-General Dr. Margaret Chan that:

“.....Doing better in the next 30 years means that we need to invest now in our ability to bring actual performance in line with our aspirations, expectations and the rapidly changing realities of our interdependent health world. United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all”43

To conclude, ‘right to health’ cannot only be conceived as a traditional right enforceable against the state, rather it has to be acknowledged as a positive right at a global level, as said by our Hon’ble Chief Justice of India K.G. Balakrishnan44.

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Questionnaire for General Public, Parents and Students

Dear Recipient

You are requested to spare valuable time to go through the questionnaire and put your answer accordingly. The central idea of my research is to analyze various health issues particularly pertaining to women & children in the light of health laws in India. In spite of having bulk of legislation still we are facing the problem of female foeticide, highest number of maternal deaths and undernourished children, anemia, HIV/AIDS, malaria and other diseases, poor supply of clean drinking water, sanitation etc. India bears 21% of global disease burden on its shoulders. This questionnaire will be basically used for collecting the viewpoint of people involved in different fields. The information given by you will be purely used for research purposes. It will not be made public nor will it be used for taking legal action. Please feel free to add any comments at the end of this form.

Name (optional) :

Occupation :

Qualification :

Any legal background :

Whether your name can be mentioned in the thesis:

1. Are you aware of Health Laws?
   - [ ] Yes  [ ] No  [ ] Can't say

2. Are there any gender differentiation between male and female children's health care?
   - [ ] Yes  [ ] No  [ ] Can't say

3. Is there any effect on fertility with maternal educational level?
   - [ ] Yes  [ ] No  [ ] Can't say

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4. Does son preference affect women's desire for children?
   □ Yes  □ No  □ Can't say

5. Do you know about family planning methods?
   □ Yes  □ No  □ Can't say

6. How many methods of family planning do you know?
   □ 2 methods  □ 3 methods
   □ 4 methods  □ Can't say

7. Do you know health hazards of I-Pill (Emergency Contraceptive Pill)?
   □ Yes  □ No  □ Can't say

8. How many visits for Antenatal care do women take during pregnancy?
   □ 2 visits  □ 3 visits
   □ 4 visits  □ >4 visits

9. Do the deliveries in your locality are conducted by
   □ Doctor  □ Paramedical Staff like (nurse, ANM etc.)
   □ Dai  □ Untrained person

10. Do you think early post natal care for a mother helps in
    Safeguarding the life and health of mother
    □ Yes  □ No  □ Can't say

11. How many ultrasound examinations in pregnancy are required?
    □ Two ultrasonography  □ Three ultrasonography
    □ Four ultrasonography  □ No ultrasonography

12. Are married women subjected to more domestic violence?
    □ Yes  □ No  □ Can't say

13. Do you know how to prevent HIV/AIDS?
    □ Yes  □ No  □ Can't say
14. Are you aware of contraceptive methods like condom, contraceptive pills etc. to prevent sexually transmitted diseases, (AIDS), and unwanted pregnancies?
   □ Yes □ No □ Can't say

15. Do you know that smoking and any other type of environmental pollution is harmful for the health of foetus and expectant mother?
   □ Yes □ No □ Can't say

16. Are you satisfied with the legislative provisions made for the protection of health of the children? How for these provisions are effective?
   □ Effective □ Not effective □ Can't say

17. Children have been given certain rights under various legislation. But there does not seem to be any uniform definition of 'child'. In your opinion which of the following should come under definition of child.
   □ Below 12 years □ Below 14 years
   □ Below 16 years □ Below 18 years

18. Do you know about child immunization schedule for < 1 year?
   □ Yes □ No □ Can't say

19. Is breast feeding within 1st hour of delivery beneficial?
   □ Yes □ No □ Can't say

20. Children between age of 6-9 months should receive.
    □ Solid diet only □ Semi solid food
    □ Breast milk only

21. Do you know about PNDT Act 1994 related to prohibition of sex determination in India?
    □ Yes □ No □ Can't say
22. Are you aware of healthy food habits?
   □ Yes □ No □ Can't say

23. Do you think that sex before marriage by young children is detrimental to their health?
   □ Yes □ No □ Can't say

24. Do you think that sex education should be made part of school education as a measure to improve all round health of teenage children?
   □ Yes □ No □ Can't say

25. Today, drug abuse amongst children/youth is on rampant. Do you think that society has a responsibility to educate and raise awareness amongst children regarding ill effects of drug addition?
   □ Yes □ No □ Can't say

26. If so, which methods do you think can be more effective in raising awareness in this direction?
   □ Counselling by parents
   □ Counselling in schools
   □ Through print and electronic media
   □ With the help of NGO's/Social Workers
   □ All

SPECIAL COMMENTS, if any

Thanks
Anu

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Questionnaire for the Medical Professionals

Dear Recipient

You are requested to spare valuable time to go through the questionnaire and put your answer accordingly. The central idea of my research is to analyse various health issues particularly pertaining to women & children in the light of health laws in India. In spite of having bulk of legislation still we are facing the problem of female foeticide, highest number of maternal deaths and undernourished children, anemia, HIV/AIDS, malaria and other diseases, poor supply of clean drinking water, sanitation etc. India bears 21% of global disease burden on its shoulders. This questionnaire will be basically used for collecting the viewpoint of people involved in different fields. The information given by you will be purely used for research purposes. It will not be made public nor will it be used for taking legal action. Please feel free to add any comments at the end of this form.

Name (optional) : 
Occupation : 
Qualification : 

Whether your name can be mentioned in the thesis:

1. Are you aware about health legislation that exist in India?
   ☐ Yes ☐ No ☐ Can’t say

2. Whether Prenatal Diagnostic Techniques and Preconception Act 1994, (Amended Act 2002, 2003) is being effectively implemented for control of sex determination in India?
   ☐ Yes ☐ No ☐ Can’t say

3. Does Medical Termination of Pregnancy Act, 1971, is being misused in India?
   ☐ Yes ☐ No ☐ Can’t say
4. Do you think informal education of rural community regarding anaemia and nutrition is going to have positive impact on the health of mother and child in future?
   ☐ Yes ☐ No ☐ Can’t say

5. Do you think 2 years rural posting of doctor be made compulsory for the better care of health of rural population?
   ☐ Yes ☐ No ☐ Can’t say

6. In the present scenario children are involved in drug abuse (like cough syrup abuse, smoking etc.) Are they aware of health hazards of various drugs abuse?
   ☐ Yes ☐ No ☐ Can’t say

7. Children in the age group of 6-17 years are involved in various drug addictions. In your opinion which of the following factors contribute to this:
   ☐ Peer group pressure ☐ Domestic breakups
   ☐ Poverty/illiteracy ☐ All

8. In your opinion what kind of population come forward to undergo rehabilitation treatment after drug addiction?
   ☐ High income group ☐ Middle income group
   ☐ Lower strata

9. Do you think adolescent health education be made compulsory in high school curriculum for healthy adulthood?
   ☐ Yes ☐ No ☐ Can’t say

10. Do you think yoga/meditation be made integral part of our education system right from the primary level?
    ☐ Yes ☐ No ☐ Can’t say
11. Is surrogacy in India affecting mother child relationship in future?
   □ Yes  □ No  □ Can't say

12. Is surrogacy causing high mother morbidity and mortality in India?
   □ Yes  □ No  □ Can't say

13. Do you think registration and monitoring of IVF clinics be made mandatory under law so that infertile couple don't get exploited?
   □ Yes  □ No  □ Can't say

14. Do you think insurance companies should cover infertility treatment like IVF, surrogacy etc.?
   □ Yes  □ No  □ Can't say

15. Do you think child born out of surrogacy/IVF etc. should have right to access information about his/her genetic background?
   □ Yes  □ No  □ Can't say

16. Do you think that reproductive cloning be allowed?
   □ Yes  □ No  □ Can't say

17. Do you think budget allocation on health system by Govt. of India is sufficient to provide quality health care to the public?
   □ Yes  □ No  □ Can't say

18. Do you think National Rural Health Mission (NRHM) is going to make changes in health status of rural population in India?
   □ Yes  □ No  □ Can't say
19. Do you think consulting a clinical psychologist/psychiatrist for coping with modern life style generated stress disorders is still perceived as a stigma by the society?

☐ Yes  ☐ No  ☐ Can't say

SPECIAL COMMENTS, if any ________________________________

________________________________________________________________________

Thanks
Anu