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DIMENTIONS

A SOCHARA – SOPHEA NEWSLETTER **March, 2014**

…….Walking the Path towards Health For ALL

Editorial

The call to work towards 'Health for ALL' (HFA) by 2000 AD, underpinned by a social justice ethic and with comprehensive primary health care (CPHC) as an approach to the development of health systems, was a prophetic moment in history in 1978. HFA was a social goal acknowledged and adopted by 134 member countries at the Alma Ata Conference, jointly organized by WHO and UNICEF, reflecting the aspirations of people globally. Bridging the health divide was the essence of the goal and approach. Halfdan Mahler the then Director General of the World Health Organisation has on record noted the key contribution of NGOs and civil society in pressing the HFA agenda forward through work on the ground which showed that health gains were possible over fairly short periods of time with the right mix of methods in which the role of communities in decision making and linking health with development was important. This work experience by NGOs in different continents has been captured in the book "Health by the People" based on a study undertaken on behalf of WHO. NGOs had been proactive in advocating the cause of reaching the unreached with WHO and with governments, and this set of negotiations, struggles and partnerships led to Alma Ata. HFA and CPHC built also on the United Nations Universal Declaration of Human Rights (1948), the Constitution of WHO, the UN International Covenants of 1966 on Economic, Political, Social and Cultural Rights and on several thought currents. The HFA goal captured the minds and hearts of people across the world committed to the primary health care (PHC) movement.

Actualising the HFA goal has been quite a different matter. Constant analysis of progress is necessary. The dominant medical model for the development of health systems was firmly in place at that time. The control of communicable diseases was seen as paramount and vertical health programmes developed their own structures, hierarchies and mechanisms. The basic principles of PHC of social justice, community participation, intersectoral coordination, and appropriate technology which came from the ground up were revolutionary and demanded a complete paradigm shift in approach. Health departments could not understand the need to change. A variety of interests were quick to resist the approach right from the beginning. UNICEF among others developed the selective primary health care approach in 1979. The Health Promotion movement commencing with the Ottawa Charter (i986), the decadal meetings (1988) of the Alma Ata Conference, with reflections and efforts to encourage governments to articulate health policies and develop indicators to measure

progress were part of the HFA processes that ensued. Experimentation in community health continued and provided rich experience in the training of community health workers, in working through village health committees, in using innovative educational approaches to training socially relevant community oriented health professionals, in developing rational therapeutics etc. Practitioners developed community health approaches to public health problems with community organization and participation etc. Members of the SOCHARA team were inspired by HFA and actively experimented with and interrogated many initiatives.

It was realized that community health approaches and networking, while necessary and effective at the level of small populations, were not sufficient to bring about larger change. Barriers to achieving health for all were complex and closely linked to societal processes and structures linked to macro policies. Socially embedded hierarchies and mindsets needed transformation. Efforts addressing gender issues and disparities reveal that this is to be a long haul struggle. Similarly other issues of race, caste, class, language have their own struggles. Their interface with health systems is minimal. The drivers and consequences of globalization add layers of further complexity.

In the 1990s like-minded organizations from diverse backgrounds worked towards the first People's Health Assembly in Savar, Bangladesh in 2000 as a counter to the annual World Health Assemblies of WHO in order to revitalize HFA. As part of this process the *Jan Swasthya Abhiyan* (JSA) was launched in India at the first *Jan Swasthya Sabha* in Kolkota in December 2000, and the global People's Health Movement (PHM) soon after in Savar. National and global People's Charters for Health were adopted. The PHM and JSA subsequently engaged proactively from local to global levels. State chapters evolved and dealt with different issues around a common cause. Realising the HFA goal is still work in progress

Articles in this issue of Dimentions highlight key processes in the Health Promotion movement right up to the Helsinki Declaration of 2013. Universal Health Coverage, currently on the agenda across several countries, has varied proponents with differing interests. These issues were discussed in a National Workshop reported here. While commercialisation of the health sector is rapidly deepening, corruption in the sector is also widely reported. The first announcement of the 5th National Bioethics Conference (NBC) has been made in this issue. The NBC from 11th to 12th Decemebr
2014 to be held in Bangalore will focus on "Integrity in Health Care Services and Research" followed by a one day International Symposium on Corruption in Health Care. Articles on the needs of migrants; the situation of burns among women and efforts towards tobacco control from community to policy level highlight the need for detailed attention that is required in addressing complex issues as part of the efforts towards HFA.

Reflective learning from experience, being in touch with ground realities and working in solidarity is essential as we continue to work towards HFA.

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Social Justice in Health and Universal Health Coverage: Challenges, Possibilities and Pathways

Sochara Team

(A detailed report is also available)

Over the years, SOCHARA has been involved with various initiatives in community health, public health, health policy, and health movements as part of larger collective, inclusive efforts within India towards equity in health. Building on work done through its teams in Bangalore, Chennai and Bhopal a 'Social Justice in Health' (SJH) initiative was undertaken. Two consultations were organized. The first was a one day dialogue on 'Health of the Urban Poor in Bangalore'- with a focus on people with mental illness, disability and the elderly, on 18th December 2012 and a National Workshop titled. 'Social Justice in Health and Universal Health Coverage Challenges, Possibilities and Pathways' on 10th and 11th September 2013. This article covers key points from the

national workshop.

About the Social Justice in Health initiative

'Social Justice in Health, Research, Advocacy, Training and Action on Realizing Health Rights' is an initiative building on the history of the Community Health Cell since 1984 and of SOCHARA from 1991. It worked to strengthen efforts towards realizing the "Health for All" (HFA) goal. A historical and contextual approach was adopted with dimensions of research, documentation, communication, dissemination and critical engagement with communities at different social levels. This included work in Madhya Pradesh with the Community Health Fellowship Program building up a critical mass of young enthusiastic community health practitioners in the state through the Centre for Public Health and Equity (CPHE), a SOCHARA resource centre for public health in Bhopal; the Community Action for Health initiative in 14 Blocks of 6 districts in Tamilnadu together with a range of campaigns of the Makkal Nazhvahyu Iyyakam (People's Health Movement in the state) through the Community Health Cell Extension Unit (CEU) which reaches its tenth year in 2014; the Community Health Learning Program and several other initiatives by the Community Health Cell (CHC) in Karnataka; the Community Health Library and Information Centre (CLIC) and a variety of involvements at national and global levels. SOCHARA as part of its commitment to support the health movement embarked on a process of critical reflection of the movement in an effort to distil from the collective experiences lessons that we may take forward in walking the path towards health for ALL. Multiple pathways contribute to the realization of inter-connected rights leading towards the HFA goal. These need to be understood, refined and used strategically with a sense of solidarity among the variety of groups and persons working for HFA.

'Social Justice in Health and Universal Health Coverage Challenges, Possibilities and Pathways' – a national workshop – Day One

Reflecting on aspects of work done, the workshop shared experiences and identified gaps in policy, practice and social action; and charted out possible directions for the future. Ninety seven participants from health and social science disciplines participated. Deliberations built on theoretical, historical and contextual frameworks, with a focus on specific themes such as equity, urban health, mental health, environmental health and privatization of health care which are inadequately reflected in current UHC debates. Approaches used to address the social determinants of health in different parts of the country were discussed.

Social justice, a concept linked to fairness and opportunity, is a very old and deep quest that has moved people across the centuries through approaches such as spirituality, ethics, philosophy, politics, development, alternative methods of governance, social movements and new evolving social arrangements. It is not a technical or managerial fix. The debate on Universal Health Coverage, needs to keep social justice in health at the heart of its thinking and strategies. UHC requires leadership from the bottom up, together with democratization of the health system, with mechanisms for widespread public participation in health and development to move towards comprehensive primary health care and HFA. This is a time for critical reflection on the multiple pathways that have evolved over decades towards achieving this goal. This includes study of the changing roles and power dynamic of the state, the voluntary sector, different systems of medicine, social movements, private enterprises and communities, with a focus on how each relates to the other and with outcomes in health of people. The predominance of a biomedical frame continues and influences both public health policy choices being made, as well as peoples' preferences.

Technical session1: 'Towards Social Justice in Health and Universal Health Coverage' – a Contextual Overview

The speaker of this session, shared that though India was an enthusiastic signatory of the Alma Ata Declaration in 1978 and is debating and planning Universal Health Coverage, the health crisis continues in India and globally, together with emerging health challenges. The Bhore Committee in 1946 reflected the same core principles as the Alma Ata Declaration. After much experimentation and thought the idea of strengthening an alliance for health emerged. Important elements in the evolution of the Peoples' Health Movement (PHM) and the Jan Swasthya Abhiyan (JSA) were recounted.

Three important policy initiatives have evolved with PHM and JSA positioned as a countervailing power.

- In 2004, around 300 Jan Swasthya Abhiyan activists dialogued with political parties in Delhi as a pre-election strategy discussing a policy brief and orienting manifesto writers to the challenges of

health for all in India.

- The National Rural Health Mission was influenced particularly the communitization component, giving people voice. This was followed actively through a process of engagement spanning a decade (2004-14)
- The PHM-WHO advocacy circle engaged with delegates during every World Health Assembly after 2000 AD with evidence based pressure on the World Health Organisation to bring comprehensive primary health care back on the agenda as an approach to strengthening public health systems. PHM activists were invited to present the People's Health Charter in the World Health Assembly, organise in-house seminars and finally participate in the planning and review of the World Health Report 2008 – Primary Health Care: Now More Than Ever. The WHO Commission on Social Determinants of Health (CSDH) 2005-8 also saw a strong engagement with the PHM in its establishment and functioning. One of the commissioners was from PHM. PHM members were also part of the CSDH Knowledge Networks. PHM facilitated civil society participation in different regions and also prepared an alternate civil society report. However, since the first People's Health Assembly in 2000, while health is much higher on the political and public agenda disparities continue and eternal vigilance and action is needed.

Technical session 2: Reflections on Pathways, Challenges and Possibilities in the Journey towards Health for All in India

A participatory assessment for network strengthening (PANS) process took place in JSA in 2010-11. Acknowledging the strengths of networking, engagement with communities and the state, ability for collective advocacy and action with a diverse inclusive network, capacity building at different levels and consistency; the feedback also identified challenges in communication, decision making, conflicting opinions, non inclusion and difficulty in taking and working with feedback. A balance is needed between local, state and national level concerns. The transition of focus from HFA and CPHC to universal health coverage and the existing divergent views were discussed. While the PHM and related movements have moved forward on campaigning for employment, food, education, information, and working strenuously on community action for health, there has been fragmented and inadequate focus and progress on public health system strengthening and medical care. Different approaches to financing and provisioning of healthcare were discussed. Dilemmas and influences in making choices, accountability and ethical processes in the discourse were raised. Market logic and expansion fails to recognize inherent inequalities and does not address health as a public good. The market is fixated on the powers of biomedicine as a solution to ill health which has its roots in the social determinants. Commercial entities including insurance companies co-opt human rights language in healthcare to facilitate flow of governmental funds towards private healthcare.

Technical session 3: Understanding the process of social change towards Health for ALL – Issues and challenges

Facilitators shared the experience of *Makkal Nalavazhvu Iyakkam* (MNI) (Tamilnadu chapter of PHM). The Tamil Nadu government reversed the decision on shifting immunization from communities to PHCs and revoked the central government order to close three public sector vaccine production units as a result of a sustained campaign carried out by MNI. Sensitization of the public and groups was done systematically through multiple-level meetings. The campaign adopted several approaches including: research to gather evidence, public communication through post cards, telegrams, and protests forming human chains etc. As a result of the campaign the department of health set up a commission to review the entire issue. Media, used effectively, was able to reach people and kept the issue alive through the campaign. Indirect support was also was received from those working within the health system and governance levels.

Parallel Sessions- Day Two

Urban Health – Parallel session-I

Health of the urban poor (comprising 25-,30% of the urban population) is neglected, despite apparent greater access to health care available in private, tertiary and specialized institutions in cities, small and medium towns and peri-urban areas. Health policy focus has been skewed with greater emphasis on mother and child health, reproductive health and rural health. Adequate data on the burden of ill health and health systems information is lacking about the urban poor. Advocacy for health of the urban poor is relatively weak. Within urban settings, the policy focus on displacement of slum dwellers, pollution, mental health, domestic violence, alcohol abuse, and accidents is minimal. Slums have increased in number,

as growth has outpaced development of urban infrastructure including health facilities. There is consequent overcrowding; poverty; poor sanitation, waste management and access to water; environmental pollution (air, water and noise); increasing expenses and health problems such as infectious diseases, NCDs, psychiatric disorders, and accidents.

Other issues affecting health of urban poor that were identified included: inadequate inter-sectoral coordination, health system gaps, and privatization. The National Urban Health Mission (NUHM) and the long delays in its commencement was discussed. There were detailed interactions with reference to Bangalore. There is an ongoing process of engagement with the NUHM especially from the perspective of vulnerable communities. As yet there is nothing on the ground.

Mental Health - Parallel session-II

Big gaps in access to services, gross neglect of mental health in policy and planning, exclusion of persons with mental illness (PWMI) and their caregivers were major areas of concern identified by the group. The facilitator shared the Basic Need India's (BNI) experience with community mental health and development work in deprived rural settings and urban slums in 30 districts across 6 states - currently covering 18,000 PWMI. Social exclusion, stigma and human rights violations of PWMI occur in many settings, even within the family. The support by family members was also recognized. BNI has focused on increasing the productivity and earning capacity of the individual PWMI and the formation of care givers groups and federations. A stakeholders model is used, developing programmes with users and carer's according to need, based on solidarity, skill sharing and consistency, and building on inherent capacities of PWMI. Policy changes were supported through partnerships at taluk and panchayat level.

Suggestions by the group for future action ranged from:

- Need for mental health promotion adopting a life cycle approach;
- school based mental health programmes;
- prevention of self harm;
- addressing mental health consequences of other diseases eg adolescents living with HIV;
- Developing solidarity mechanisms for inclusion of PWMI in the community, as a basis for community mental health work;
- Mental health should form an integral part of all health programmes eg Karuna Trust is integrating mental health with primary health care
- Need for greater funding for the District Mental Health Programme (DMHP) with coverage of all districts,
- Need to address the exclusion of mentally ill from other governmental programmes.
- The legacy of laws and practices to be changed.

Environment and Health – Parallel Session III

An effort was made to use case studies to understand approaches for the health movement to address E & H issues. Case studies included a) the Bhopal Gas Tragedy and the research, legal and social networking aspects of the campaign; b) the experience with the CHESS (community health environment skill-share) network, collaborations and c) experience from Tamilnadu with the 'smell index in Cuddalore and Lay Epidemiology in Mettur.

Environmental health relates both to impact of environmental pollution/degradation on human health, and the health of the environment itself. Environmental health problems were understood at three levels:

a) Biomedical challenges – i.e. adverse health outcomes such as cancers or developmental anomalies.

b) Public health challenges – cleaning up contamination, providing safety against exposure.

c) Socio-political, economic and cultural aspects – why is the environment degraded, why are communities deprived of access to resources, why is pollution continuing unabated?

Reflections and suggestions for the future include:

- So far there has been a focus on research support with low involvement in policy advocacy and governance mechanisms.
- Need for a platform for sharing, planning, and strategizing.
- Creation of a knowledge centre for environmental and social movements.
- A multidisciplinary approach bringing and keeping diverse people together.

- Shift from a victim mode to becoming active agents for change.
- Use the environmental health section of the Peoples Charter for Health.
- Larger scale sensitisation of students and youth.

Privatization of Health Care - Parallel session IV

The facilitators said that India suffers from a 'Mixed Health Systems syndrome' and delineated the following areas of concern:

A weak public health system complemented by an unregulated private medical sector is not meeting the medical and health needs of people. Evidence from the public private partnerships (PPPs) in the recent health insurance schemes in Andhra Pradesh and other states suggest limited access to health care by vulnerable sections of people; greater focus on secondary and tertiary care rather than primary care; no reduction in irrationality in health service provision; cream skimming and supplier induced demand. The high level expert group (HLEG) and medico-friend circle (mfc) suggested strengthening the

public health system, with contracting in of private providers where necessary for achieving universal access to health care. The Planning Commission however suggests managed care to attain UHC which increases expenditure as well as moral hazard.

There are other challenges: Government provided subsidies for land to private health care providers in several cities across states, but the poor could not get treatment in these hospitals despite agreements and legal stipulations. Grading of hospitals, empanelment guidelines, regulation of the pharmaceutical industry, exclusion of communicable diseases in health insurance coverage, lacunae in the Clinical Establishment Act and identification of skill requirements are some of the other challenges in the health sector that need to be addressed. Evidence based treatment, skill based education/training, models for cross-subsidy, internalization of a value system and ethics in health care settings need greater focus.

Health rights and equity: Health is a fundamental human right. The burden of non-communicable diseases is increasing, alongside shortage of health care professionals. In addition, there is a large disparity in urban-rural services. The strategy for coordinated healthcare services is unclear – there is a need for a strategic vision by the state with greater focus on availability, accessibility, affordability and participation.

Suggestions for the future include:

- Globally the PHM advocates a move away from neoliberal market oriented policies in health care.
- The Alma Ata CPHC approach to health system strengthening based on principles of social justice is most relevant for us.
- Effective regulatory mechanisms for the health sector are needed with quality assurance, price regulation and accountability.
- Vigilance against commercialization of health care.
- A central role for the government in development of the health sector
- Government should promote AYUSH in the public sector.
- The understanding of the public on the services offered by the public and private sector should be strengthened.

The Role of Academia and Research towards achieving Health for All- Plenary

Facilitators of the session shared experiences and a situation analysis from a research encounter called 'Research for People's Health', held at the Second global People's Health Assembly, Cuenca (July 2005) which brought together researchers from all over the world committed to people's health. The Global Forum for Health Research, COHRED, and an international Inter-Ministerial Conference held in Bamako, Mali, on Research for Health, Equity and Development have also reflected on these issues over the past decade. SOCHARA has participated in all these efforts. An overview analysis indicates that medical and health research has not focused adequately on fundamental issues, themes and strategies that improve the health of the citizens of the world. Medical and health care has become increasingly commodified. Globalization with its lack of regulation has produced more inequities than solutions. The majority of the population does not have access to health or health care or access has been substantially limited covering vulnerable populations with very small 'packages'. Suggestions included:

- Health research to be taken as one of the methods for social transformation.

- Rethink the relationship between researchers and the community, with the community/ participants as active subjects, not objects.
- The distinction between scientific and social need must be addressed.
- Research findings to feed into policies, practice and social action in a dynamic continuum through dissemination and knowledge translation and with a sense of time or urgency in addressing problems
- The difference and gap in language between researchers and communities to be bridged.
- Build real and virtual networks of researchers from local to global levels. Link between and across institutions.
- Share research findings with communities and all who participate in the study.
- Promote research on social determinants of health and comprehensive primary health care.
- Build research skills at different levels.
- Build interdisciplinary research teams.
- Integrate biomedical and social research for health, using qualitative and quantitative methods

The important role and functions of academic institutions such as medical colleges in contributing to the HFA goal were shared and discussed. The speaker said teaching/training, service provision, advocacy and research and its translation are important parts in institutions such as the St. John's National Academy of Health Sciences. The outreach work of the Dept of Community Health and its evolution over the years was shared. This included: teaching medical and nursing undergraduate and postgraduate students, trainees, paramedical and community health workers, NGO program personnel, government officials and others. There are a range of rural and urban programmes. Consultancies and evaluations are undertaken. Other departments also have outreach programmes and inter-departmental collaboration occurs. Alumni from the institution also are actively involved with HFA related work across the country.

Suggestions for the future included:

- The development of a public health movement would be a support in the HFA journey.
- In teaching health professionals it is important to have a mix between theory, practice which is in touch with social realities and a focus on community needs and community processes.
- It is important to evaluate innovations and interventions in academic settings against the objectives of academic programs. One method was the community acceptance of a young doctor as 'our doctor" rather than "your doctor' at the end of a field posting.

Final session: A consolidation of learning – evolving consensus, issues for further debate, and the way forward

Five key strategies among the many discussed were highlighted for organisations and persons working in community health or the people's health movement, namely:

- a paradigm shift from a biomedical to a societal or social approach;
- Communitization of the health system;
- Adoption of a social vaccine approach;
- Globalization of Solidarity from below;
- and a SEPC analysis in research and academia.

The concept of social vaccine and SEPC analysis also need deeper understanding. Reflecting on the session on "Pathways, Challenges and Possibilities in the Journey towards Health for All in India" the speaker highlighted the need to broaden our vision to include health care and health in our discussion. Finally, rather than just being defensive about the system, there needs to be a balance with creating alternative systems which the movement is not focusing on adequately at the moment.

From the parallel sessions, key learning's were recalled: the issue of urban health with attention to health of the urban poor is critical. This has received inadequate attention in government policies and programmes so far. The National Urban Health Mission was anticipated and has been delayed for long. Mental health needs priority attention in policy, practice and by all sectors, with social exclusion, and carers needs receiving high focus. Learning from the Basic Needs India approach, and the integration of mental health in primary health would be part of the way forward.. On privatization of healthcare points such as unregulated practice leading to poor quality of service delivery, unethical practice, PPPs, the need to strengthen the public health care system and the politics behind the healthcare system were consid-

ered as most important. On environmental health the importance of creating a healthy environment was highlighted.

some thoughts on the way forward……

As a health movement we must continue and increase our mindfulness, enquiry and action regarding the key underlying determinants of health. Urgent attention needs to be paid to address commercialization and privatisation of health care, and on private sector regulation. It is also important to move away from the debate of private versus public, and look at healthcare for all under a universal umbrella with new mechanisms so that all sectors are primary health care and social justice oriented .

There is a need for interdisciplinary research for social change – including the study of the impact of social movements to strategise better. Deeper ongoing processes of reflection within social movements and health systems would be helpful – on how decisions are made and other dynamics. Awareness and skills of people within the movement should constantly be kept updated. A reflection on how to partner with nursing and other professionals effectively in the health movement and for universal access to health care is needed. There is also a need for regulation of the health system and ethical practice by professional the participants where enthusiastic had energised by the two days spent together. New linkages were created giving strength to existing networks. One out come is the co-organisation of the 5th National Bioethices Conference (NBC) in Bangalore!

Source: Community Health Cell

INDIAN JOURNAL OF MEDICAL ETHICS

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Indian Journal of Medical Ethics (www.ijme.in)

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Dates:

December 11, 12 & 13, 2014

Venue: St. John's National Academy of Health Sciences, Bangalore

THEME :

Integrity in health care practices and research

SUB-THEMES:

- Integrity and upholding trust of patients in medical care
- Ethical imperatives of integrity in public health practices and health system
- Integrity in health care research (including misconducts-plagiarism, data fabrication/falsification, etc)
- Conflict of Interest in health care practices and measures needed

And on December 13, 2014
An International Symposium on
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Conference Hosts and Collaborators

St. John's National Academy of Health Sciences;

Society for Community Health Awareness, Research and Action SOCHARA;

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- (International Symposium in collaboration with MEZIS – "No Free Lunch", Germany)
- More information on the conference will be made available later in March 2014. Any query regarding the conference may be sent by email to:

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Health and Rights of Migrant Workers in the Informal Sector in India

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Worldwide the population living in urban areas is increasing, both in developed and developing countries.[1] However the growth rate of rural urban migration is much higher in less developed countries (ibid). Internal and international migration is associated with diverse factors such as economics, trade, climate change and environmental degradation.[2] Internal migration, defined as migration within a country can be seen as occurring due to a search for better lifestyles, better economic prospects and better lives as a whole.[3] Processes that drive migration will continue to do so in an accelerated manner in the coming years, and it is estimated that by 2050 more than two-thirds of the world's population would live in urban areas.[1]

Recent global estimates indicate that there are nearly 214 million international migrants and 740 million internal migrants.[4] In India internal migrants are estimated to be more than 300 million, nearly 30 per cent of its population. In India three types of internal migration are seen, voluntary, forced and distress migration. While voluntary migration is self-explanatory, forced migration refers to migration as result of development programmes, disasters, and conflicts; and distress migration results from failure of crops and can be seen as migration for survival.[2,5] More women than men are internal migrants in India, with the major reason for migration of women being marriage.[6] The caste distribution of migrants indicates that those belonging to socio-economically backward sections of society undertake short term or seasonal migration compared to long term migration undertaken by those belonging to higher socio-economic status.[7,8]

In the Indian context, amongst men the main reason for migration is employment which is most commonly sought and found in the informal sector.[9] Though data regarding the number of migrants joining the informal sector is not available, given that more than 90% of India's workforce is employed in the informal, the numbers in this sector would be large.[10] Based on the sectors which absorb migrant workers this can be estimated and then substantiated. The major sectors into which migrants join the workforce include construction, domestic work, textile, brick-kilns, transportation, mines, quarries and agriculture which are also the major sources of informal sector employment.[11]

While migration potentially can enhance economic prosperity, social cohesion and

urban diversity, it is the factors or conditions into which an individual migrates which determine the social outcomes of migration. Rural urban migration has led to an increased urban population size, but there has not been a proportionate increase in infrastructure, civic and otherwise to support the increase leading to a mushrooming of slums with poor or limited access to water, sanitation, garbage disposal, health care and so on.[12] While the urban population in India grew by approximately 75% between 1991 and 2011 there was only a 10% increase in the population having access to improved sanitation during the same time period.[13,14] Due to the nature of work, and their working and living conditions migrants face several health hazards.

Exposure to various biological, chemical and physical agents; lack of provision of personal protective equipment; lack of drinking water and sanitation facilities are some of the hazards to which migrant workers in the informal sector are exposed to.[15] Further these workers do not have any or have poor access to occupational safety and health measures. This is because of the poor bargaining power migrant workers have which is in part contributed by the absence of trade unions fighting for the rights of migrant workers (ibid). Migrant workers in the informal sector living in urban areas are also exposed at home to poor environmental conditions- housing, water, sanitation, overcrowding, poor nutrition, poverty and pollution.[16]

Apart from these risks, migrants face multiple barriers, including language, lack of knowledge of administrative and legal structures, stigma, discrimination, social exclusion, separation from family, lack of social support networks and a sense of alienation.[7,15] Migrants carry with them certain value and belief systems which reflect the socio-economic and cultural profile of the place of origin.[2] Migrants are discriminated in not being able to avail social security measures including health, education and nutrition.[15] These factors interplay and interact with each other resulting in adverse health outcomes, further impacted by caste, gender, religion and class leading

to health inequalities.[2,15] Evidence exists that migrant workers may not seek care for their health problems and that utilisation of public health facilities is poor due to inconvenient timings, distance from work and a sense of alienation from public services. Treatment is sought mostly from informal health care providers.[15,17]

Several laws have been constituted internationally and nationally for protection of the rights of migrants. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families which came into force in 2003, though mainly directed at international migration provides pointers to areas in which the rights of migrants have to be protected. This Convention calls for responsibility by countries that have ratified it to protect migrants against enslavement and violence; ensure access to emergency medical care and education for children; ensure equal treatment as nationals in regard to working conditions; according to this convention migrants have the right to join trade unions and other organizations defending their interests; and also have rights to cultural identity, freedom of thought and of religion.[18] India is not a signatory to this Convention.[19]

In India the Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act (1979) (ISMWA) is directly related to the rights of migrant workers. This Act has provisions for equality in terms of pay for migrant workers and others, travel allowance for travel from state of residence to state of work, displacement allowance, provision and maintenance of suitable accommodation, providing prescribed medical facilities and compensation for any expenditure incurred on health, issuance of passbooks to workers, provision of protective clothing, and notification of accidents and deaths to specified authorities and kin in both state of work and residence. The contractor is responsible for ensuring that the various entitlements under the Act reach the workers.

Apart from the Inter-State Migrant Workmen Act, other Acts applicable to migrant workers in the informal sector include the Minimum Wages Act, Contract Labour (Regulation and Abolition) Act, Equal Remuneration Act, Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, Workmen's Compensation Act, Payment of Wages Act and Factories Act. These Act's lay down stipulations for minimum wages; provision of safe drinking water, latrines and urinals, washing facilities, first aid facilities and crèches; equal remuneration for men and women; provision of free temporary accommodation; compensation in case of death or disease; prompt payment of wages; adequate safety measures and promotion of the health and welfare of workers.

Though Article 19 of the Constitution gives all citizens the right to move freely throughout the territory of India; to reside and settle in any part of the territory of India there is absence of a provision in the Indian Constitution to ensure the right of migrants to access various social security measures, including health care. In India internal migration is not given priority attention in policy or practice and does not figure in any central or state sponsored social security measures like the Public Distribution System with the exception of the *Rashtriya Swasthya Bhima Yojana* (the benefits of which can be availed in any part of the country).[7,15] This excludes migrants, leading to their discrimination and marginalization. Lack of data regarding short term migration further leads to exclusion of such migrants at the time of policy making in the states where they migrate into.[7]

With regards to the various Acts directed towards migrants there are policy and implementation gaps.[20] The ISMWA is applicable only to migrants between states and not within states thereby excluding a large proportion of intra-state migrants. The ISMWA has no provision for crèches; it does not deal with access to social security measures; and there are no guidelines for inter-state cooperation. Various research studies, reports and newspaper articles reveal poor implementation of the ISMWA.[15,21-25] These highlight the role of the contractor, concerned authorities and lack of trade union support for migrants leading to poor enforcement and non-implementation of legal and legislative protection. The stipulation that a worker has to be certified by the employer together with lack of awareness and knowledge regarding their entitlements and language barriers further limits the number of migrant workers being able to register and avail benefits of the various Acts directed at them. The fact the migrant workers do not have any formal contracts and are dependent on the contractor for wages increases their vulnerability and prevents them from organising themselves and demanding for their rights.[7,15]

The above mentioned factors including poor working and living conditions, absence of social support structures, socio-economic and cultural factors, lack of access to social security measures and poor implementation of laws directed at migrants result in

migrants working in the unorganised sector to have poor health outcomes. These factors match with the Social Determinants of Health (SDH) framework put forward by the World Health Organisation Commission on SDH.[26]

Migrants suffer from high burden of both communicable and non-communicable diseases including occupational and mental health problems compared to the native population.[27] Among women the prevalence of reproductive tract infections is higher than the host population; poor antenatal coverage results in malnutrition and anaemia; and experience of violence is higher than the native population.[28] Children suffer from under nutrition and have low immunization coverage mainly due to frequent shift of location of work by parents (ibid). Behavioural patterns, together with no or poor access to HIV information, prevention and health services increases the risk and vulnerability of migrants to HIV/AIDS.[29]

In India, as Universal Health Coverage is being planned and piloted, there is a need for integrating the rights of migrants into the proposed initiatives. Though the 12th Plan definition clearly mentions that all Indian citizens residing in any part of the country can access equitable health care, the mechanisms through which this would be achieved have not been spelt out. In the context of migrants not being aware of their rights, having been excluded from social security measures in many schemes being implemented by state governments it becomes important that the rights of migrants in terms of access to health services are protected.

While migration is a means of social and economic development, there is need to protect the health of migrants because it is not migration that leads to poor health outcomes but the social, economic, political and cultural conditions into which migration takes place.[2] There is need for inter-sectoral coordination between ministries and departments to ensure that migrant workers' rights are protected so that migrants do not experience disparities in health outcomes.[5]

In the Indian context this requires better enforcement of laws with provisions that benefit migrants, particularly their working and living conditions, to ensure access to social security measures both in the state of origin and host states through coordination between state and central governments, organization of migrant workers through trade unions, and by having true universal health coverage where in migrant workers are able to access health services irrespective of their state of origin, income level, social status, gender, caste or religion as envisaged by the High Level Expert Group on UHC.

References:

1. United Nations. World UrbanizationProspects: The 2011 Revision. New York: Population Division, Department of Economic and Social Affairs, United Nations; 2012.

2. World Health Organization. Health of migrants: the way forward: report of a global consultation, Madrid, Spain, 3-5 March 2010.

3. Trebilcock, A. Decent Work and the Informal Economy. Discussion paper No 2005/04, UNU-WIDER, Helsinki; 2005.

4. United Nations Development Programme. Human Development Report 2009—Overcoming Barriers: Human Mobility and Development; 2009.

5. Deshingkar P, Grimm S. Internal migration and development: A global perspective. United Nations Publications; 2005.

6. Migration [Internet]. [cited March 01, 2014]. Available from: http://censusindia.gov.in/Census_And_You/migrations.aspx

7. Srivastava R, Sasikumar S. An overview of migration in India, its impacts and key issues. Regional Conference on Migration, Development and Pro-Poor Policy Choices in Asia; 2003: p.22–4.

8. Deshingkar P, Start D. Seasonal migration for livelihoods in India: Coping, accumulation and exclusion. Overseas Development Institute London; 2003.

9. Mitra A, Murayama M. Rural to Urban Migration: A District-Level Analysis for India. International Journal of Migration, Health and Social Care. 2009;5(2):35–52.

10. India. Report On Conditions Of Work And Promotion Of Livelihoods In The Unorganised Sector. National Commission for Enterprises in the Unorganised Sector, Government of India, New Delhi; 2008.

11. Migration in India 2007-2008, Report No.:533, NSS 64th Round. New Delhi: National Sample Survey Office, Ministry of Statistics & Programme Implementation Government of India; 2010.

12. Barten F, Santana VS, Rongo L, Varillas W, Pakasi TA. Contextualising workers' health and

safety in urban settings: The need for a global perspective and an integrated approach. Habitat International. 2008;32(2):223–36.

13. WHO / UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation [Internet]. [cited March 16, 2014]. Available from: http://www.wssinfo.org/data-estimates/table/

14. Tabulations Plan of Census Year - 1991 [Internet]. [cited March 16, 2014]. Available from: http://www.censusindia.gov.in/DigitalLibrary/TableSeries.aspx

15. Kumar NA. Vulnerability of Migrants and Responsiveness' of the State: The Case of Unskilled Migrant Workers in Kerala, India. Working Paper No. 26. Kochi, Kerala: Centre for Socio-Economic and Environmental Studies; 2011.

16. Piu Mukherjee, Bino Paul, G D Pathan J.I. Migrant Workers in Informal Sector: A Probe into working conditions, Discussion Paper 9, Adecco TISS Labour Market Research Initiatives (ATLMRI). Mumbai: Tata Institute of Social Sciences; 2010.

17. Ghosh R. Health Insecurities of Workers in Informal Employment. Labour &Development.2010;17:1-13.

18. UN General Assembly. International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 18 December 1990, A/RES/45/158.[Internet]. [cited March 10, 2014]. Available at: http://www.refworld.org/docid/3ae6b3980.html

19. International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families [Internet]. [cited March 10, 2014]. Available from: https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-13&chapter=4&lang=en

20. Overview of Internal Migration in India. Geneva, Switzerland: United Nations Educational, Scientific and Cultural Organization; 2012.

21. Basheer KPM. Migrant workers in city get a raw deal. The Hindu [Internet] Kochi. October 9, 2007; Available from: http://www.hindu.com/2007/10/09/stories/2007100960020300.htm

22. Malarvizhi J. Migrant workforce builds up city pulse. The Hindu [Internet] Chennai. February 26, 2008; Available from: http://www.hindu.com/2008/02/26/stories/2008022659340400.htm

23. Moving tale of sweat and blood far from home. The Hindu [Internet].Chennai. July 7, 2008; Available from: http://www.hindu.com/2008/07/07/stories/2008070758550300.htm

24. Basu M. India has no room for its wandering builders. The Hindu [Internet]. Bangalore. May 1, 2012; Available from: http://www.thehindu.com/opinion/oped/india-has-no-room-for-its-wandering-builders/article3371330.ece

25. Sekar S, Dahat P. They are changing the way Chennai lives. But.The Hindu [Internet].Chennai. June 11, 2012; Available from: http://www.thehindu.com/news/cities/chennai/they-are-changing-the-way-chennai-lives-but/article3512755.ece

26. World Health Organization. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Commission on Social Determinants of Health Final Report. World Health Organization, Commission on Social Determinants of Health; 2008.

27. Srivastava R. Internal Migrants and Social Protection in India: The Missing Link. Vol. II: Workshop Papers- National Workshop on Internal Migration and Human Development in India Workshop Compendium. New Delhi, India: United Nations Educational, Scientific and Cultural Organization and UNICEF India Country Office; 2012. p. 166–93

28. Chatterjee CB. Identities in motion: migration and health in India. Mumbai: Centre for Enquiry into Health and Allied Themes; 2006.

29. International Organization for Migration, World Health Organization, Center for Disease Control. Health and Migration: Bridging the Gap. United Nations Publications;2005.

Source: Community Health Cell

THE BURNING QUESTION OF WOMEN'S RIGHT TO LIFE AND DIGNITY

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When the Bangalore based women's group Vimochana studied cases of unnatural deaths among women in 1997-98, they encountered a shockingly high number of "burnt wives" (Menon, 1999a). This led to their involvement in the Victoria Hospital burns ward since 1998, and to consistent efforts towards preventing violence against women as well as improving the quality of burns care (Menon, 1999b; Vimochana, 2013). The Victoria Hospital burns ward is one of the largest in South Asia with a capacity of 54 beds (Vimochana, 2013). The hospital is a teaching hospital of the government Bangalore Medical College and Research Centre.

Women victims contributed disproportionately to the burns burden. While they accounted for 40% more admissions than men, the average severity of cases was also found to be much higher (over 40% higher body surface area involvement than for admitted men). A combination of these factors (higher number and higher severity) resulted in admitted women contributing to around 70% of all deaths occurring in the ward (not including mortality of female children) (Vimochana, 2012). It was also noted that the number of admissions of burnt women was increasing with time, by an average of 28 cases each year (Sophie, 2011).

Burns can occur as accidents, as it reportedly does for a majority of burns cases, or as a result of attempted suicide or homicide. Data of women admitted to Victoria Hospital suggested that 32% cases were of attempted suicides and 5% were attempted homicides (Vimochana, 2012). These figures includes those women who reported accidental burns but later disclosed that they had suffered intentional burns (amounting to at least 19% of those reporting accidental burns) (Vimochana, 2012). They confessed about the real reasons only to Vimochana after bedside counselling by the activists (Vimochana, 2013). However, these figures may also be underestimates as the burns intent was not elicited for 11% of admitted cases. The women choose to hide the history of intentional burns for several reasons, largely related to family honour, pressure from in-laws and concern for the future of their children and fear of conviction for attempting suicide (Sophie, 2011; Vimochana, 2013). Though reasons for attempting suicides and homicides were diverse, a significant number were related to the underlying situation of violence faced regularly by women. Intentional burns usually occur as the culmination of such systematic violence. The main causes were poor interpersonal relationship with the husband or marital family, alcoholism, dowry related arguments and lack of trust between the spouses (Gururaj, 2005; Sophie, 2011). Over 10% of all suicidal burns and almost all homicidal burns among women were attributable to dowry (Jatti, 2006; Vimochana, 2007). It is because of these reasons that burns stand as the number one cause of mortality among women aged between 15 and 34 years. Based on official national level statistics, suicides per se are far more common among men as compared to women (1.8:1), but suicide by burns was far more common among women (1.8:1), a situation that needs further investigation with insight from anthropology and psychology.

Violence against women transpires in many forms. It ranges from verbal abuse to murder. It is perpetuated and sustained by a patriarchal society. Despite the presence of several legislations attempting to protect women, such cases are increasing. Among dowry burns victims, it was also noted that women with a single girl child were disproportionately affected (Jatti, 2006; Nuchhi et al., 2012). The combination of dowry and a girl child created a much higher risk, again demonstrating the systematic violence against the female gender.

Vimochana is not a group that works on healthcare issues. The primary concerns and campaigns have been with addressing violence against women through various support programmes including counselling, legal assistance and rehabilitation. Campaigns and protests have been used as tools to address systemic and procedural inertia towards women's issues (IANS, 2009a). But following their study of unnatural deaths, and based on insights from family members of burns victims during their "campaign to safeguard a woman's life", they pressed the health department in 1997-98 to provide space for two activists to work alongside the staff in the burns ward (Sophie, 2011). This would give them a unique opportunity to meet and interact first hand with burns victims, and in turn understand the size of the problem and the underlying issues. Several other demands had been made during the 1997 campaign, and the activists placed

in the ward were in a good position to encourage the implementation of these demands. Through advocacy and consequent reforms, the situation of hygiene and corruption in the wards has reportedly improved over the years. Through appropriate lobbying, funds were secured from non-governmental sources for infrastructural development in the wards such as an air conditioning system (Sophie, 2011).

Health system reforms are related to the right to life. In this situation, it also related to women's right to equality and freedom from oppression. There is a need for governmental hospitals to focus further on burns treatment, rehabilitation and counselling as these are not priorities in private hospitals.

Vimochana also tried to identify areas in Bangalore where these occurrences were found to be relatively common. Based on their findings, they made community level interventions to strengthen women's support groups for local problem redressal. These reportedly reduced violence against women in those areas. There is a need to document such efforts systematically to be able to learn from them.

Besides Vimochana's work in the burns ward, their continued pressure led to the development of a Joint House Committee on Atrocities against Women towards improving investigation of violent deaths and preventing such occurrences in future (Menon, 1999a). Inadequate systemic support towards documentation of violent deaths of women was a major issue due to which several perpetrators of violence remain scot-free. The right to justice for women who suffered was being undermined. The need for strengthening case documentation, investigation and judicial enquiry was identified. Gaps in the investigation process were recognized based on site visits made by activists. Interactions with families of victims led to documentation of case studies from across the state. These were presented as a part of a Truth Commission organized with the National Law School India University in 1999 (Riti, 1999). Similar campaigns have been held over the past years as well (IANS, 2009a, 2009b). Sensitisation of various persons involved in the documentation, judicial redressal and care process of victims was also an important part of the agenda (Menon, 1999a). Some innovations included constituting a forum called "Parihar" under the police department for women facing crisis situations and creation of a manual for the police on gender and violence (Menon, 1999a; Sophie, 2011).

Vimochana has recognised that there is a lifelong stigma attached with burns victims, which differentiates them from most other victims of violence. There is a need to understand this stigma and disadvantage faced by these women to be able to support them appropriately. Currently processes are underway to identify avenues for improving support to burns victims, such as governmental jobs and disability pensions. The larger issue of stigma may take longer to address.

References

Gururaj, G., 2005. Injuries in India: A national perspective. Burd. Dis. India 325.

IANS, 2009a. Harrowing stories at Bangalore "dowry court" [WWW Document]. Sify News. URL http://www.sify.com/news/harrowing-stories-at-bangalore-dowry-court-news-national-jh2t4dbgcca.html (accessed 3.12.13).

IANS, 2009b. Suffering and surviving dowry: a "court" convenes in Bangalore - Thaindian News [WWW Document]. Thaindian News. URL http://www.thaindian.com/newsportal/health/suffering-and-surviving-dowry-a-court-convenes-in-bangalore_100223592.html (accessed 3.12.13).

Jatti, V.B., 2006. Evaluation Of Dowry Deaths In Bangalore City In Two Years Period From Nov 003 To Oct 2005 (Thesis). RGUHS, Bangalore.

Menon, P., 1999a. "Dowry deaths" in Bangalore. Frontline 16.

Menon, P., 1999b. Inside the burns ward [WWW Document]. indiaterrorism.bravepages.com. URL http://indianterrorism.bravepages.com/burnsward.htm (accessed 10.1.13).

Nuchhi, U., Gannur, D., Yoganarasimha, K., 2012. Evaluation of Dowry Related Crimes in Bijapur City. Indian J. Forensic Med. Toxicol. 6, 209–13.

Riti, M., 1999. Tales of women and wanton cruelty [WWW Document]. Rediff Net. URL http://www.rediff.com/news/1999/aug/18riti.htm (accessed 3.12.13). Sophie, A., 2011. Domestic Violence in India: a ten-year study of burnt women in Bangalore. Vimochana, Bangalore.

Vimochana, 2007. Database of burns admissions in 2007. Vimochana, 2012. Database of burns admissions in 2012.Vimochana, 2013. Interview with Vimochana activists.

A REVIEW OF THE WORLD HEALTH ORGANIZATION (WHO) FRAME WORK CONVENTION ON TOBACCO CONTROL (FCTC) IN INDIA

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Introduction to the WHO FCTC

The WHO Framework Convention on Tobacco Control (FCTC) is an international treaty on public health which was negotiated under the auspices of the World Health Organization. It became the first WHO treaty and was adopted under Article 19 of the WHO Constitution[1]. The treaty was initially adopted at the 56th World Health Assembly on 21 May 2003 and it entered into force on 27 February 2005. This was done in accordance with Article 36 of the WHO FCTC which stated that the Convention would enter into force 90 days after it was acceded to or ratified by the fortieth State which wished to become a Party to the Convention[2]. As of November 2013, there are 168 States who are signatories to the WHO FCTC The FCTC is an evidence-based treaty which was formulated in response to the increasing number of health issues and deaths which resulted from the consumption[3] of tobacco-based products. The effects of globalization and the resulting tobacco epidemic further increased the necessity for an internationally

binding legal framework for effective tobacco control. The FCTC is considered as a major

breakthrough with regard to the promotion of public health and it marks the first time that the WHO has used its internationally-applicable legal powers to address the problem of tobacco consumption. The FCTC is also one of the first legally-binding multilateral agreements regarding a chronic, non-communicable disease.

The main provisions of the FCTC include:

1. The reduction of demand for tobacco and tobacco-based products (contained in Articles 6-14 of the FCTC);
2. The reduction of the supply of tobacco (contained in Articles 15-17 of the FCTC).

Both these provisions are not limited and they cover a number of important issues related to tobacco and smoking.

Since its introduction, the WHO FCTC has become one of the most widely accepted and ratified treaties in United Nations history and because of the remarkable inclusion of non- governmental organizations in the negotiation and drafting process, the Convention is considered as an excellent example of a collaborative effort between governmental and non-governmental organizations.

History of the WHO FCTC

The World Health Organisation, before the formulation of the FCTC, was largely concerned with the prevention and control of communicable diseases. However, the increasing effects of globalization and the resulting interconnectedness of the global economy led to a huge upsurge in the number of preventable deaths and health issues arising from the consumption of tobacco. The WHO took notice of this upward trend in the mortality rate and sought to utilise its legal powers as an intergovernmental body so as to facilitate a practical solution to the tobacco epidemic.

The initial idea for an international treaty in order to reduce and regulate the demand for tobacco products was set forth by tobacco activists Ruth Roemer and Allyn Taylor in 1993[4]. They conceptualized the idea of a framework convention-protocol approach in order to control the usage and circulation of tobacco[5]. They also advocated that the WHO should utilize its was adopted as one of the first resolutions of the conference. constitutional authority in order to formulate international conventions with the aim of promoting and preserving public health[6].

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1. Adoption of Framework Convention on Tobacco Control, 97, The American Journal on International Law, 689, 689 (July 2003)

2. Framework Convention on Tobacco Control (FCTC), Art. 36.

3. TAYLOR, Allyn L. and BETTCHER, Douglas W. WHO Framework Convention on Tobacco Control: a global good for public health. Bull World Health Organ [online]. 2000, vol.78, n.7 [cited 2014-01-19], pp. 920-929

4. Roemer, Ruth, Allyn Taylor, and Jean Lariviere, "Origins of the WHO Framework Convention on Tobacco Control." American Journal of Public Health 95.6 (2005): 936–38. American Public Health Association, 22 June 2004.

5.Ibid.

6. Ibid.

They presented the idea of an "international instrument" for tobacco control at the Ninth World Conference on Tobacco or Health in Paris, France in 1994[7]. The proposal turned out to be successful gaining widespread approval and itwas adobted as one of the first resolutions of the conference.[8]

In 1996, the 49th World Health Assembly voted and authorized for the development and formulation an international framework convention, in accordance with Article 19 of the WHO Constitution, in order to facilitate global tobacco control [9,10]. In continuance of a resolution taken at the 48th WHA in 1995[11] , the WHO had also tasked Taylor and Roemer with drafting a paper highlighting the various mechanisms which the WHO could employ in order to effectively control tobacco use globally[12]. The background paper also provided concrete reasons for the implementation of a framework convention as opposed to any other form of international legal action.

In 1998, following the election of Dr. Gro Harlem Brundtland as the Director-General of the WHO, the path for preparing a framework convention for tobacco control gained an impetus. Dr. Brundtland, a Norwegian medical doctor, listed tobacco control as one of her main priorities during her term and she established the Tobacco Free Initiative (TFI) project as a special cabinet project under the Directorship of Dr. Derek Yach, who was the head of the Policy Coordination Committee at the WHO. Dr. Yach led the development of the FCTC up until its adoption in 2003. Following this, the WHO started to seriously undertake the process of establishing a framework convention to control tobacco usage.

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7. Ibid.

8. Ibid.

9.World Health Assembly (WHA) Resolution WHA49.17

10. A.L.Taylor, The World Health Organization and a framework convention-protocol approach to global tobacco control, in TOBACCO: THE GROWING EPIDEMIC, p.422, p.422 (Rushan Lu, Judith Mackay, Shiru Niu, Richard Peto ed., 2000).

11. World Health Assembly (WHA) Resolution WHA48.11

12. Roemer, Ruth, Allyn Taylor, and Jean Lariviere, "Origins of the WHO Framework Convention on Tobacco Control." American Journal of Public Health 95.6 (2005): 936–38. American Public Health Association, 22 June 2004.

At the 52nd WHA in 1999, the WHA set up:

1. An Intergovernmental Negotiating Body (INB) to negotiate and draft the proposed framework convention; and

2. A technical Working Group which was tasked with preparing the "proposed draft elements" of the treaty.

In 2000, the WHA paved the way for starting the official negotiations on the framework convention. It took three years, between 2000 and 2003, for the INB to negotiate an agreement on the FCTC between all the stakeholders and to conclude the formal drafting of the FCTC. On 21

May 2003 the 56th WHA adopted the WHO Framework Convention on Tobacco Control.

The Convention was made open for signatures in June 2003 and it entered into force on 27 February 2005, ninety days following the fortieth ratification. In 2006, the principal treaty bodies, the Conference of the Parties (COP) and the Convention Secretariat, were established.

Implementation of the WHO FCTC in India

India was one of the first countries to sign and ratify the WHO Framework Convention on Tobacco Control. India had signed the treaty in September 2003 and had ratified in February 2004 after which it entered into force from 27 February 2005. India was also one of the main countries at the forefront of the FCTC negotiations. However, effective implementation of the FCTC in India has been and remains questionable.

The Cigarette and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA) is the main legislation which controls and regulates tobacco distribution and usage in India. This national law for tobacco control was enacted in May 2003, during the then ongoing FCTC negotiations. The development of the COTPA was concurrent with the FCTC negotiations and it presented a stark improvement to the Cigarette (Regulation of Production,

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13. World Health Assembly (WHA) Resolution WHA52.18(1)

Supply and Distribution) Act of 1975, which was the first legislation regarding tobacco control in India.[14]

While the Cigarette Act, 1975 mandated the display of statutory health warnings on cigarette packs, the COTPA, 2003 represented a much more concentrated effort towards tobacco control by bringing together all forms of tobacco products under legislative control. The 2003 legislation also contained many other provisions which curbed the production and distribution of tobacco.

The COTPA, 2003, similar to the FCTC, lays an emphasis on public health. The Indian legislation for tobacco control, for the most part, contains adequate provisions and guidelines for meeting the intended objectives of the WHO FCTC[15]. However, a law is only as good as its implementation and the effective implementation of the COPTA, in line with the objectives of the FCTC, has been compromised due to a number of weaknesses.

There are four main provisions of the WHO FCTC which include:

1. Protection from exposure to Second Hand Tobacco Smoke (Article 8)
2. Ban on Advertising, Promotion and Sponsorship (Article 13)
3. Prohibition on access of tobacco products to minors (Article 16)
4. Packaging and labelling of tobacco products requiring depiction of pictorial health warnings (Article 11)

To comply with these main objectives of the FCTC, the COTPA has adopted similar provisions in its corresponding Sections.

Although most of the Indian laws exceed the minimum expectations under the FCTC, their implementation has been far from what is necessary in order to effectively control and reduce tobacco usage[16].

Some of the main problems include the concessions given to airports, hotels and other such public spaces to have smoking areas, the failure of the authorities to effectively check the sale of tobacco products to minors and ineffective pictorial health warnings on tobacco products[17].

On 2 October 2008, smoking in public places was banned nation-wide under the Prohibition of Smoking in Public Places Rules, 2008. This law prohibits smoking in public places such as restaurants, hospitals and government offices. The enforcement of these rules lies at the State level[18].

Also, the fine for smoking in public is only Rs. 200 and this does not serve as a sufficient deterrent to prevent restaurant owners from prohibiting smoking due to the fear of losing business[19].

Sections 4 and 6 of the COPTA, 2003 deal with the prohibition of smoking in public places[20] and the prohibition of the sale of cigarettes and other tobacco products to minors & sale within 100 yards of any educational institution[21] respectively. But the proper enforcement of these two provisions of the COPTA have been inadequately implemented by the official authorities, especially the check on the sale of tobacco products to minors and near educational institutions.

Section 7 of COTPA mandates the display of pictorial health warnings on all tobacco products. This provision corresponds to Article 11 of the WHO FCTC but its implementation was long delayed by amendments and overdue court cases. It came into force only in May 2009 following an order by the Indian Supreme Court. However, litigation concerning this rule still continues till date.

With respect to Article 13 of the FCTC, the Cable Television Network (Regulation) Amendment Bill, which came into force in September 2000, completely bans

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14. A Comparative Analysis of WHO Framework Convention on Tobacco Control and the Indian laws regulating tobacco, (July 2008), produced by the Public Health Foundation of India in collaboration with the Ministry of Health and Family Welfare, New Delhi.

15.Ibid.

16. Implementation of the Framework Convention on Tobacco Control (FCTC) in India (A Shadow Report – 2010), Published by HRIDAY

17. Ibid

18. Rachel L. Schwartz, Heather L. Wipfli, and Jonathan M. Samet, World No Tobacco Day 2011: India's progress in implementing the Framework Convention on Tobacco Control, Indian J Med Res. 2011 May; 133(5): 455-457.

19. Pandey G, Indian ban on smoking in public, BBC News, Oct 2, 2008 [accessed on April 29, 2011].

20. Section 4 of COPTA, 2003

21. Section 6 of COPTA, 2003

any advertisements promoting cigarettes and alcohol. Advertisements by the Health Ministry

discouraging the use of cigarettes and other tobacco products are displayed frequently in order to raise awareness about its harmful effects.

Despite the number of measures taken to control tobacco usage, the poor enforcement and the numerous cases filed in courts by tobacco producers and companies undermine the authority of the Indian legislation as compared to certain other developed countries such as Australia, where the anti-tobacco laws are strictly and rigidly enforced. Also, since the COPTA, 2003 entered into force before the ratification and implementation of the WHO FCTC, there have been concerns regarding false starts in the area of tobacco control by India which has led to weaknesses in the legislation[22].

The WHO, building on the FCTC, released its first 'Report on Control of the Tobacco Epidemic' titled "MPOWER" in 2008. The MPOWER stands for a set of six tobacco control measures which build upon the policy approaches detailed in the FCTC. These six measures include:

1. Monitoring the epidemic;
2. Protecting non-smokers from exposure to Second Hand Smoke (SHS);
3. Offering help to quit tobacco use;
4. Warning smokers of the health effects of smoking;
5. Enforcing advertising bans;
6. Raising the price of tobacco products.

These six components of MPOWER are intended to assist the parties to the FCTC in the country-level implementation of tobacco control measures. The WHO also assembles an annual Global Tobacco Control Report (GCTR) to gauge the status of tobacco control by its parties against the MPOWER framework.

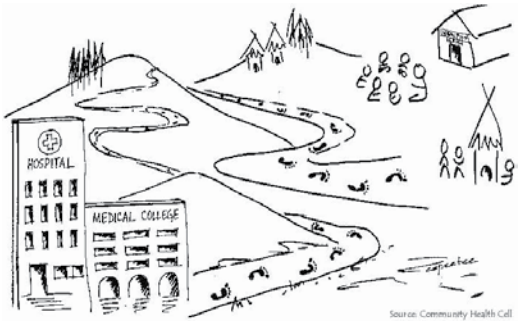
While the enforcement of advertising bans on tobacco products has been strong, there has been little progress with regard to the policy on smoke-free environments. In 2007, the Union Territory of Chandigarh became the first city in India to become smoke-free due to its successful implementation of smoke-free policies. India, like most other developing countries, does not have adequate infrastructure for successful rehabilitation of people who want to quit smoking, as called for under Article 14 of the FCTC. India also

lags behind in setting up of infrastructure for educational and training programmes for spreading awareness about the dangers of tobacco usage (stated in Article 12 of the WHO FCTC).

India's size, socio-economic structure and heterogeneous picture of tobacco usage, due to the gap between the rural and urban areas, makes the problem of tobacco control even more challenging. In order to overcome these obstacles and meet its FCTC obligations, India should take the initiative to set up a comprehensive and sufficiently funded national program for tobacco control[25]. Measures should be taken to curb the demand for tobacco by increasing taxes on all tobacco products and maintaining stringent checks on smuggling and unauthorized advertising[24]. Enforcement agencies must also be strengthened by investing sufficient resources to monitor the implementation of the anti-tobacco laws in India.

Another requirement which would go a long way in curbing tobacco usage would be the collaboration between policy-makers and health professionals to discourage and curb tobacco use. This cooperation between policy makers and health professionals is still

lacking in India when it comes to problem of tobacco control. The implementation of the anti-tobacco laws in India is not entirely uniform and there are many regions which lag behind in implementing the required measures for tobacco control. It is imperative that the legislation for tobacco control be integrated with raising awareness and promoting cooperation between the Centre and the States in order to effectively combat the tobacco epidemic in India.



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22. Rachel L. Schwartz, Heather L. Wipfli, and Jonathan M. Samet, World No Tobacco Day 2011: India's progress in implementing the Framework Convention on Tobacco Control, Indian J Med Res. 2011 May; 133(5): 455-457.

23.WHO report on the global tobacco epidemic, 2008: the MPOWER package, Geneva: World Health Organization; 2008. World Health Organization.

24. Implementation of the Framework Convention on Tobacco Control (FCTC) in India (A Shadow Report – 2010), Published by HRIDAY

25. Ibid

References

I. Journal articles

1. Adoption of Framework Convention on Tobacco Control: The American Journal on International Law (22 June 2004)
2. World No Tobacco Day 2011: India's progress in implementing the Framework Convention on Tobacco Control by Rachel L. Schwartz, Heather L. Wipfli, and Jonathan M. Samet (published in the Indian Journal of Medical Research, May 2011)
3. The World Health Organization and a framework convention-protocol approach to global tobacco control by A.L.Taylor in TOBACCO: THE GROWING EPIDEMIC
4. WHO Framework Convention on Tobacco Control: a global good for public health by Allyn L. Taylor and Douglas W. Bettcher
5. Origins of the WHO framework convention on tobacco control by Roemer R, Taylor A, Lariviere J (published in the American Journal of Public Health, June 2005)

II. Reports

1. A Comparative Analysis of WHO Framework Convention on Tobacco Control and the Indian laws regulating tobacco (produced by the Public Health Foundation of India in collaboration with the Ministry of Health and Family Welfare, New Delhi)
2. Implementation of the Framework Convention on Tobacco Control (FCTC) in India (A Shadow Report – 2010) (published by HRIDAY)
3. WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL
4. HISTORY OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL
5. CONSTITUTION OF THE WORLD HEALTH ORGANIZATION

III. Websites & urls

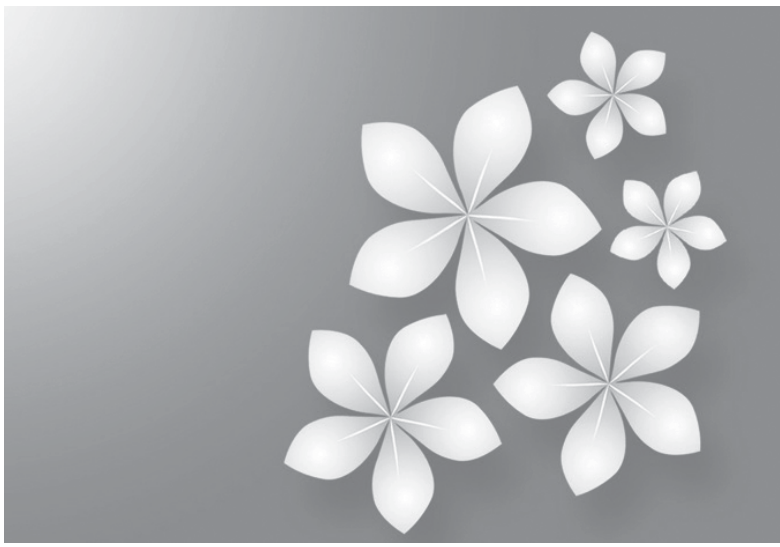
1. http://www.who.int/fctc/
2. http://whqlibdoc.who.int/publications/2009/9789241563925_eng.pdf
3. http://whqlibdoc.who.int/publications/2003/9241591013.pdf
4. http://www.who.int/governance/eb/who_constitution_en.pdf
5. http://www.hriday-shan.org/hriday/FCTC_SHADOW_REPORT_INDIA-2010.PDF

SOCHARA AND IT'S OBJECTIVES

The Society for Community Health Awareness, Research and Action (SOCHARA) is a professional resource group in community health and public health, rooted in civil society. It has spearheaded community health action; innovative training; and policy action research in community health and public health since its inception in January 1984. The Community Health Cell (CHC) is the functional unit of Society for Community Health Awareness, Research and Action (SOCHARA), which is a registered Society. (see website www.sochara.org)

The objectives of SOCHARA are:

- To create awareness regarding the principles and practice of community health among all people involved and interested in health and related sectors
- To Promote and support community health action through voluntary as well as government initiatives
- To undertake research in community health policy issues, particularly in areas of :
  - Community health care strategies
  - Health personnel training strategies
  - Integration of medical and health systems
- To evolve educational strategies that will enhance the knowledge, skill and attitudes of persons involved in community health and development
- To dialogue and participate with health planners, decision makers and implementation of community oriented health policies
- To establish a library, documentation and interactive information centre in community health.



S. J. Chander, Team Member, SOCHARA-SOPHEA, Bangalore

The former UN Secretary General Mr. Kofi Annan characterized the civil society as the world's 'new super power' in his address to the McGill University in June 2005. He said *''After decades of undemocratic and ineffective global governance on key global issues -- ranging from development and environment to human rights, trade, and security -- now is the time to privilege and highlight the visions and views of civil society leaders around the world,''*1 It is estimated about 40,000 international NGOs and many national level NGOs have contributed to addressing many socio political, health and environment issues. The role of civil society in tobacco control, particularly in the FCTC process was very significant. Various civil society networks across the globe have contributed positively and worked with WHO towards developing and ratifying the FCTC. The other networks that have contributed significantly towards tobacco control are Frame Work Convention Alliance (FCA), GLOBALink is managed by the Union for International Cancer Control, GLOBALink members include individuals, information centres, news editors, cancer societies, health educators, project officers, congress organizers and international organizations like WHO.

Since 1993, GLOBALink has been involved evolving a global tobacco control network through individuals, institutions and networks since 1999. It has over 5,000 members from health, education, law, journalism word wide who are committed to reduce the tobacco health problems arising out of tobacco.

The Frame Work Convention Alliance (FCA) was created in 1999 and formally established in 2003. FCA has over 350 organizations as its members from over 100 countries. The FCA was created to work towards the development, ratification and implementation of the international treaty, the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) . Several national civil society networks contributed significantly towards tobacco control. Canadian civil society organizations played the following roles in the FCTC process; monitoring, lobbying, technical expertise, brokering and fostering inclusion.

SOCHARA is a member of FCA since 1999. On 30th June 1999 Dr. Thelma Narayan spoke at the NGO Forum held in Geneva. The forum for nongovernmental organizations was the first of its kind that took place Key tobacco control experts gave presentations on topics such as smoke-free places, illicit trade, funding, health warnings and tobacco advertising and sponsorship etc. In May 2000, SOCHARA made a written submission to the first public hearing on tobacco organized by the World tHealth Organization in Geneva. Dr. H Sudharshan represented SOCHARA at this hearing.

In India, the Advocacy Forum for Tobacco Control (AFTC) brings together over sixty organizations across various states since 2001. The key focus areas of AFTC are advocacy, awareness and research related to tobacco control in India. The same year SOCHARA, NIMHANS, Bangalore Institute of Oncology and other health care and cancer care organizations formed the 'Consortium for Tobacco Free Karnataka (CFTFK). Since its inception the CFTFK has grown in membership and carried out numerous advocacy and awareness programs in various districts of the state, using a range of innovative methods.

As result of the role of civil society organizations, and leadership by the WHO, the FCTC became one of the most quickly ratified treaties in United Nations history. Tobacco consumption gained social acceptance over many years while its harmful effects were not known. Besides the legal measures, social disapproval has to emerge for elimination of tobacco for which a strong civil society role is required.
Therefore it is pivotal to strengthen the role of civil society in tobacco control at various levels.

References:

1. http://www.commondreams.org/headlines05/0604-02.htm
2. http://ceche.org/mol/Winter-05/features-2.html
3. http://www.fctc.org/about-fca
4. Raphael Lencucha, Anita Kothari and Ronald Labonte, The role of non-governmental organizations in global health diplomacy: negotiating the Framework Convention on Tobacco Control, Health Policy and Planning 2010;1–8
5. http://tobaccocontrolblog.wordpress.com/2007/07/01/ngo-forum-bringing-fctc-to-life/
6. http://www.aftcindia.org/about_us.htm

INNOVATIVE INSTRUMENTS OF CIVIL SOCIETY ENGAGEMENT WITH HEALTH FOR ALL

Dr. Ravi Narayan, Community Health Advisor - SOCHARA - SOPHEA

"The people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare."

The Alma Ata Declaration, 1978 (2)

"For too long the medical profession and the medical education sector have been directed by professional control and debate. It is time to recognize the role of the community, the consumer, the patient and the people in the whole debate. …… What is needed is a strong countervailing movement initiated by health and development activists, consumer and peoples' organizations that will bring health care and medical education and their right orientation high on the political agenda of the country. All those concerned about 'peoples needs' and 'peoples health' will have to take on this emerging challenge as we approach the end of the millennium."

SOCHARA , VHAI, 1998 (26)

"The participation of people and people's organization is essential to the formulation, implementation and evaluation of all health and social policies and programmes. Strong people's organizations and movements are fundamental to more democratic, transparent and accountable decision making processes."

The People's Charter for Health - 2000 (1)

"An overview of all the above roles played by civil society and social movements in the engagement towards catalyzing Health in All Policies led to the identification of some innovative instruments of engagement, some of which are now finding place even within government and international planning and strategy documents.

Six such innovative instruments have been selected for this paper from many others.

1.1 SOCIAL WATCHES

The idea of monitoring and analyzing closely the emerging trends in situation analysis, data, statistics, and performance outputs and impacts by civil society groups outside the formal public health system, at all levels has been gaining ground over the years, providing space and opportunity for trend analysis and comment which is different from the official reports.

The Global Health Watch of the People's Health Movement which is brought out every few years as

*This is a brief extract from a larger paper by the author entitled 'Countervailing Power : the Role of

Civil Society and Social Movements in Catalysing Health In All Policies' presented at the 8th Global Conference on Health Promotion in June 2013 at Helsinki, Finland.

an alternative World Health Report has been described earlier. At regional level with a focus particularly on Africa, the EQUINET and the Global Equity Gauge Alliance has also been recognized. At country level a good example of a Watch is the People's Rural Health Watch which was a civil society monitor of the National Rural Health Mission in India in its initial years. The most innovative website based on data regarding access to health and development and indices from UN sources is 'Gapminder' which focuses primarily on Equity and related trends between regions and country. Today it has become a major teaching and training tool.

1.2 PEOPLES' TRIBUNALS & CITIZEN JURIES

Another instrument of engagement which has been developed in many regions by civil society, is the idea of people's tribunals and right to health hearings. In this innovation an informal jury of legal officials is set up and representatives of the community or patients/citizens at large are invited to share their experiences of the health services and programs, in the presence of health and

development officials of the Government. This platform provides people a platform to air their concerns and invites government officials to respond to this concerns in generic ways. In India the Right to Health hearings organized by the People's Health Movement at regional and national level in collaboration with the National Human Rights Commission has been a good example of this approach. A people's tribunal on the World Bank Policies in Health and Development has also been organized. In some countries these are also called citizen juries. The Indian National Rural Health Mission strategy document has internalized this instrument providing space for Jan Sunwai's (people's hearings) The Ministry of Environment in India has also recently included this instrument in the Health and Environmental Impact Assessment (HIA and EIA) which is mandated as part of emerging state and national environmental policy to mitigate the health and development hazards of unplanned development, migration and displacement. As part of this process the local community is also invited to assess the needs and develop plans through a participatory process.

1.3 HEALTH ASSEMBLIES

In the last decade regular, often annual assemblies of health and development activists have been organized at state level, country level, and internationally to bring civil society and social movement representatives together to share experiences, analyse the impact of campaigns and plan strategies locally, nationally, and globally in a spirit of solidarity. The most significant of such assemblies have been the people's health assemblies organized by the people's health movement in Savar Bangladesh, 2000 AD; in Cuenca, Ecuador in 2005 and in Cape Town, South Africa in 2012 leading to the People's Charter for Health, the Cuenca declaration and the Cape Town statement. Additionally the well known World Social Forum (WSF) process started in Porto Allegre, Brazil which has also developed into country level, regional and global annual fora have included health as a key theme within the forum and often also as a satellite activity leading to various consensus declarations and documents. The Mumbai declaration of 2004 which evolved from the international health forum associated with WSF, Mumbai 2004 is well known.

1.4 CAMPAIGN INNOVATIONS

Campaigns have always been the sheet anchor of civil society action on health issues. Starting from the orthodox trade union type of protest /solidarity marches – and red flag demonstrations, campaigns have begun to innovate other forms of expressions of solidarity including human chains, candle light vigils, and in many parts of Latin America into all sorts of carnival oriented activities which helps to innovate a new popular culture of protest and solidarity through music, street theatre, and other art forms. Groups like Greenpeace have taken this further through various forms of symbolic and creative action to get the message to decision makers and policy makers.

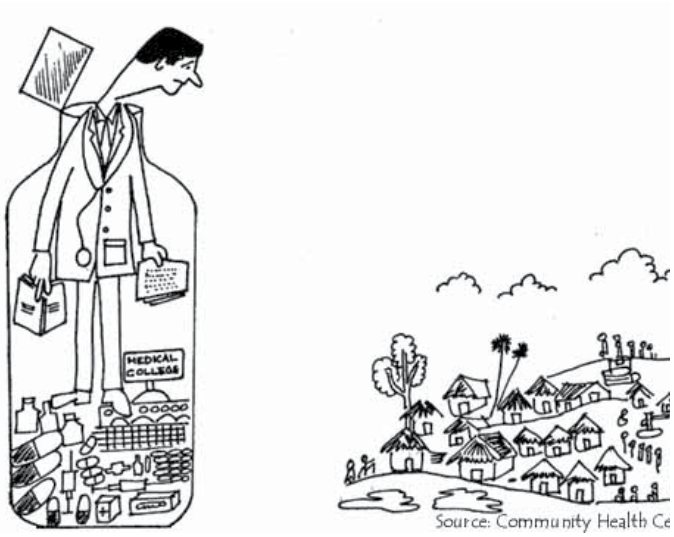
1.5 HEALTH MANIFESTOS

As part of the political process it is not uncommon for civil society and social movement groups to dialogue with formal political parties before state and national elections. This has been going on for years with different civil society organizations raising issues and facilitating dialogue with different groups. However with increasing recognition that Health in All Policies requires also the All for Health approach and the evidence that Health for All requires action on Social, Economic, Political and Cultural determinants that go far beyond ideologically determined action, there is increasing effort to evolve health manifesto's, policy briefs, and charters that are then distributed to all political parties with a message that Health is too important to be left to one group or the other. This approach which has now begun to be applied by the People's Health Movement in India by the development of a Health Policy news brief in 2004 before the national elections and a people's health manifesto in 2009 before the national election, as well as manifesto's before state elections has begun to increase the importance of health on the political agenda of the country. (42) In 2004 the process contributed along with other factors to the reorientation of the emerging National Rural Health Mission towards the policy of communitization even more emphatically, which was sustained by civil society participation in task forces and advisory groups of NRHM. This trend has now begun to emerge at state and district level before elections at this level. It is too early to demonstrate the impact but perhaps the increasing public dialogue on universal health care in the country is at least one obvious impact of such engagement.

1.6 HEALTH POLICY PROCESSES

Sustained policy engagement and dialogue – both in the "confrontational " or "engaging in consensus development mode" is another process instrument which needs to be identified as an increasingly ef-

fective tool. The evolution of community monitoring and community action for health in the National Rural Health Mission (NRHM) in India: the development of the National Health Act and the concept of National Health Assembly in Thailand and the changes in distorted childhood immunization policies in state of Tamilnadu in India are three examples of such sustained processes in three very different situations and levels. The World Health Report 2008 on Primary Health Care records this role of civil society and social movements in its section on Mobilizing the Communities by noticing this instrument of engagement in India, Bangladesh, Chile, Western Europe and Mali, demonstrating that this is now an increasing global trend and experience.



Additional information:

a. People's Health Movement:

www.phmovement.org ;

b. Global Health Watch : www.ghwatch.org ;

International People's Health University:

www.phmovement.org/iphu;

c. Community Health Wikipedia- India:

www.communityhealth.in

d. medico friend circle :

www.mfcindia.org

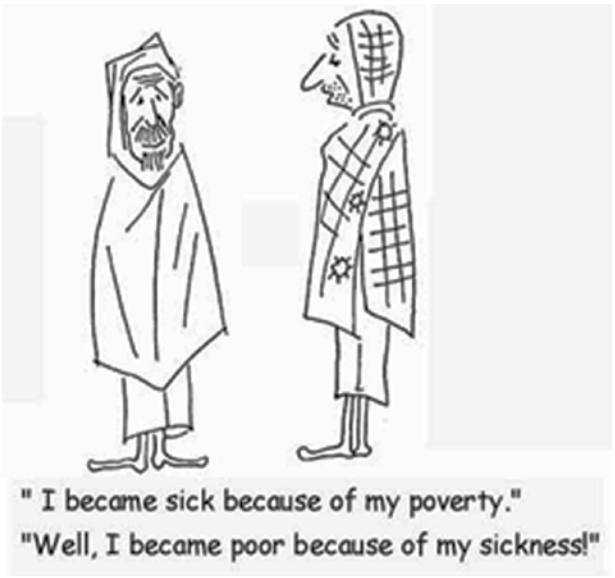
e. Public health Resource Network :

www.phrnindia.org

f. Global Equity Guage Alliance :
www.gega.org.za

g. Gapminder : www.gapminder.org

h. Community of Practice on Accountability and Social Action in Health: www.copasah.net



To access the whole paper with references and the power point, as well as a video clipping of the presentation, please go to the following links- Conference website -http://www.healthpromotion2013.org/

Participants at the National Workshop, Bangalore, September 2013

Work undertaken by SOCHARA team members in all the units and by all members of the solidarity networks and donor partners is gratefully acknowledged. Participants of the national workshop shared their time, thoughts and reflections. Members of SOCHARA and the Executive Committee are a source of support and guidance. Thank you! The commitment to Health for ALL by all mentioned here and many more fellow travelers provides hope and energy for continued efforts. This newsletter is published with support from the Ford Foundation

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