

**Health Panel- People's SAARC**  
**19<sup>th</sup> August 2008**  
**2.00-4.00pm**  
**Colombo, Srilanka**

**Introduction**

Access to basic health services was affirmed as a fundamental human right by the Declaration of Alma-Ata in 1978. The reality is that, in 2008, many people in resource-poor settings still do not have equitable access to even basic services. In many places this gap is widening. The SAARC region has one of the poorest health indicators in the world—it houses the largest number of people with micronutrient deficiencies and diabetes; carries 40% of the world's tuberculosis burden, and has a high burden of cardiovascular diseases and one of the worst indicators for reproductive health in the world. The under-5 child mortality places the rates in the region among the highest in the world with almost 40% of the total global burden of deaths occurring in four countries of South Asia alone. According to the most recent estimates of WHO, UNFPA, UNICEF and World Bank, in 2005, 99% of the 536,000 maternal deaths occurred in developing countries, 36% in South Asia including Afghanistan (figures for S.E. Asia and West Asia are much better). India had the largest number of maternal deaths at 117000, followed by BD and Pakistan in that order. Rather worryingly maternal mortality decreased at less than 1% annually between 1990 and 2005 and at this rate is unlikely to meet the MDG target of 75% reduction in MMR by 2015. It is also estimated that almost 70% of the entire global burden of low birth weight occurs in South Asia and enormous inequities exist in the provision of health care and services. These issues of high burden of maternal and child mortality are also associated with the rising burden of diseases of development such as diabetes, cardiovascular diseases and urban obesity. The region has also experienced much tumult and conflict.

In Most South Asian developing countries, excluding Srilanka, the private medical sector outperforms the public sector. Access to medical care is determined not by need, but by the ability to pay. The introduction and/or expansion of user fees has been the most common reform in health care financing. Alternative financial reforms involved the introduction or revitalisation of prepayment schemes aimed at universal coverage and promotion of private health insurance. Out-of-pocket expenditure on health care has increased not only because of the introduction of user fees, but also as a result of the promotion of the role of the private sector in health, given the absence of widespread coverage of the population by health insurance schemes.

There is a Collapse of Public Health System, The Systemic failure of the public health system has been defined by many activists as a form of structural violence, a violation of both individual and group rights which leads to following:

- A kind of differentiation of the health care system- one for the rich and other for the poor leading to further polarisation of the two groups
- Declining or stagnant budgets, deterioration of quality of care in public health system that has lead to *systemic weakening*
- Emergence of a exploitative, profit making private sector that the poor can hardly afford, leading to further indebtedness
- Negative impact of Globalisation-Liberalisation-Privatisation policies on various social sector services
- Trend towards a gradual withdrawal of the state from investments in public health services, selective primary healthcare provisions
- Proliferation of an unregulated private medical sector: The failure to support public sector personnel to perform their duties in the skeleton comprehensive programs inevitably created a very big 'market' for the private sector.

All these issues must be viewed in the backdrop of enormous developments in many fields and the rapid growth of enterprise. India leads most of the world in information technology, both Pakistan and India boast nuclear weapons and sophisticated missile delivery systems and have been on the brink of nuclear conflict on several occasions. These incongruities and misplaced priorities lie at the heart of the South Asian dilemma, where overt developments in technology and industrialization have failed to bridge the urban rural divide and remove pervasive poverty and social inequity. In particular the status of women in south Asia, especially among its rural populations, is of great concern. Poverty and gender inequity are not the only social issues that impact health in South Asia. The rapid growth of religious intolerance and feuds in the subcontinent in recent years, have all brought much focus to bear on the determinants of such change. The genesis of such upheaval has many dimensions including macroeconomic policies that fail to benefit the poor and lack of investments in human development. The recent growth of religious intolerance and obscurantism in the region has enormous implications on the physical and mental health of its population.

This panel aims to bring together social scientists and activists together from the public health and social science domains in South Asia and discuss ways of making SAARC governments accountable for providing Health for All and on the various health issues and concerns in the region.

## **TOWARDS HEALTH FOR ALL- SOUTH ASIAN DILEMMA"**

The Health panel in Peoples SAARC was introduced by Deepa from SAMA, and she explained the objectives of the Panel, which was to come out with concrete recommendations for the Peoples SAARC declaration which can be taken forward in influencing the official SAARC summit. The main objective of the panel being to learn from each other on the health status of our respective countries, coming together for working towards right to health and also to highlight and fight against any discrimination within various South Asian Health Systems. The Health Panel was attended by about 150 participants from various south asian countries.

### **Session 1 (a) - Conflict and Health-Srilanka**

Sirimali from the peoples health movement, made the presentation on **Conflict and Health in Sri Lanka**. He pointed out that Conflicts can be divided into two parts, such as micro and macro levels. We can identify domestic violence as a micro level conflict. Cast conflicts also come under this category. But religious, ethnic and class conflicts might start as micro level, but it can go up as macro level conflicts. Almost in all South Asian countries, predominantly conflicts go hand in hand with everyday life. Some of them are ethnic issues while some are political issues. However, any issue can create more and more health problems.

Highlighting the Sri Lankan Health scenario in context of conflict, Sirimali informed that Sri Lanka has lost nearly 100,000 young people due to the war. It is also reported that nearly 25,000 have been disabled in the war. These are official sources, but the actual figures could be much more. It has been found difficult to obtain the actual strength of the armed forces serving in the operational areas. Accordingly, even rehabilitation of the disabled has become a health issue, he pointed out.

A survey done at Vaddukkodai has revealed that 43% of the children have become victims of mental disabilities of varying nature due to the war.(Health Study – 1994). Destitution and displacement are the other social consequences of the war. With the loss of the husband, the wife becomes a widow. Widows are confronted with a host of problems. When the

Sirimali pointed out that we should assess the health impact by the damage caused to families, inclusive of service personnel, through destitution and displacement as a result of the on-going civil war. At least 135,000 to 210,000 people sought refuge in India, and those who in Government-run camps are being assisted by the Government of India, and approximately 410,000 people are internally displaced. Due to this unsettled state, health programmes are being disrupted as seen by the following statistics on human resources.

### Human Resources in the Jaffna Health Sector

Category	Approved Cadre	In Position	Vacancies
Specialists	32	10	22
Consultants	17	00	17
Medical Officers	421	219	202
Registered Medical Officers	58	20	38
Nursing Officers	841	103	738
MLTs	39	16	23
Radiographers	21	08	13
ECG Recordists	06	01	05
Physiotherapists	15	02	13
Hospital Midwives	89	40	49
Pharmacists		11	-11
Public Health Midwives	262	119	143
Minor Employees	463	353	110
<b>Total</b>	<b>2264</b>	<b>902</b>	<b>1362</b>

Source : District Secretariat, Jaffna  
Sunday Times – 20 April 2008

Intensive health campaigns are essential for the development of the health of a Nation. In a war torn country, priority is given to expenditure related to the war. As a result, financial provision for the development of the health services is reduced. Therefore, a breakdown in the health services is unavoidable. Shortage of personnel, drugs and clinics will directly impair the functioning of the health services. The following statistics gives a comparison prevalent in the SAARC region.

Country	No. of Military personnel/ million	Average Military expenditure as % GDP (2004)	Military Holdings Index
Bangladesh	1,000	1.5%	198
Nepal	2,700	2.5%	160
India	1,300	2.5%	142
Pakistan	4,000	3.5%	144
Sri Lanka	8,000	4.1%	926

Source : Cost of Conflict in Sri Lanka Strategic Foresight Group – 2006

The following are some of the health challenges.

- Landmines
- Malnutrition
- Psycho-Social Trauma
- STI/HIV/AIDS
- Communicable Diseases
- Non-Communicable Diseases
- Reintegration of Combatants/child soldiers
- Re-settlement of displaced persons
- Rehabilitation Programme for disabled persons
- Create Peace

Sirimali pointed that the most important health problem in Sri Lanka is the war. A person who is against peace cannot function properly as a health worker nor is he a health developer. So is the war entwined with health. Therefore, the time has come for all health workers who consider peace as the first component of health to rally round in ushering peace.

### **Session 1 (b) - Conflict and Health- Nepal**

The next presentation was made by Bina Pradhan from WHRAP on the **conflict and health situation in Nepal**. Laying down the political context of the conflict in Nepal she informed that a decade (1996-2006) of “People’s War” and its transition to peace process has been a unique experience in the history of Nepal opening up tremendous space and potential for all kinds of change, ending social oppression and discrimination and women’s historical subordination/servitude ,instituting health services system from people’s perspectives and needs and meeting people’s aspiration for new & prosperous Nepal. The key factor contributing to the Peoples War was awareness raised at the societal level -, that turned people’s dissatisfaction of the uneven development process and social/gender discrimination into an uprising against the oppressive regime , Discontentment and grievances of the people are indicative of hidden/latent conflict, albeit non violent, that existed within the country.

People’s drive to redress the grievance gave impetus to the Maoist movement against the state power and political hegemony of the ruling regime and allied parties and the Massive participation of women and the most deprived section of the population such as various ethnic groups and Dalits. Reflecting on the Conflict situation on Nepal Bina said that while the protracted violent conflict opened up enormous opportunities to determine Nepal’s future, and exhibited people’s immense “popular energy” and will in mobilizing against the old regime, it also had devastating immediate impact on the people’s lives, livelihood, health and wellbeing: Armed conflict between the Maoist rebels and the state security forces and the army has been unparalleled in the history of Nepal and perhaps in the region.

In Nepal with the exception of Manang and Mustang, the entire country was under seizure of conflict – changing people’s lives in fundamental ways, Destruction of the existing infrastructure, school establishments, law and order situation (rule of law), and the entire economy of the country was so wide spread that its impact on the people’s lives their health and well being have been catastrophic.

Stating the limitation of Data available she informed that the , extent of the damage and the cost of the bloody conflict have not been adequately and systematically documented or assessed, less so on women and their health (it is only recently that Ministry of Peace and Reconstruction, MOPR have just started to collect information. The information she collected was s from various sources -mostly media, and small study reports and INSEC report on violation of human rights.

### **Destruction of health infrastructure and health services**

According to Ministry of Health, approximately over 1,000 community health service centers destroyed since they are usually attached to buildings of village development committees. According to World Bank's Country Assistance Strategy Progress Report Nepal, 2003, escalation of violence destroyed one third of the country's 3,900 village development committee buildings. Delivery of health services has been completely disrupted in the far western regions and severely restricted in other parts of the country due to: absence of health workers in the health facilities because of abduction and threat to life by the Maoists, lack of regular medical supplies and equipments in the health facilities and frequent bandh/road blockade, destruction of bridges, airports towers and so on

Giving statistics on the Health delivery system she said that only 55.5 percent of targeted pregnant women are reported to have received TT2+ vaccinations in 2003. Apart from regular health initiatives, polio eradication and national immunization programs have also received a major setback. Vaccines against BCG, DPT, OPV (Oral Polio Virus) and measles could not cover 100 percent of targeted population. Reports show that EPI target were also not met in Bardia & Bhaktapur & in other districts .Reported mass resignation by Village Secretaries made logistic supplies difficult to be transported to the health center, so did the absence of skilled health workers in local health facilities

Giving an example of a small village Rukum, 300 miles west of Kathmandu, she said that the main hospital has minimal manpower and equipment. It does not even have an X-ray machine. It is reported that health workers are generally absent in the local health facilities as they have moved to the district head quarters. Out of 249 health workers' posts in Rukum, only 159 were occupied. According to the annual report of District Health Services, many rural health centers and hospitals do not have trained health assistants and lab technicians , has had a negative impact on the health services s.

Bina Pradhan, said that , health services during the conflict period were provided mainly by the community health workers - VHWs and MCHWs provided services at the PHC out reach clinics as In-Charge of health facilities were deputed to district HQs. Local

health Management Committee and VDC Secretaries mostly stayed in district HQ. In effect PHC outreach clinics were established as PHs and SHPs where VHWs & MCHWs from respective facilities visit specific areas to run clinics – one per month in 3 to 5 catchment areas in a VDC. The only government employees who still remain in the villages were local health volunteers, agricultural extension worker, police, and postmen have fled. Services provided included: health education, counseling and IEC, distribution of pills, and condoms, ante-natal care services, treatment for minor ailments, referrals and follow ups.



**Narjit Basnet's hand was chopped off by Maoist rebels. He still manages to teach the children at a community school. Credit: Naresh Newar/IRIN**

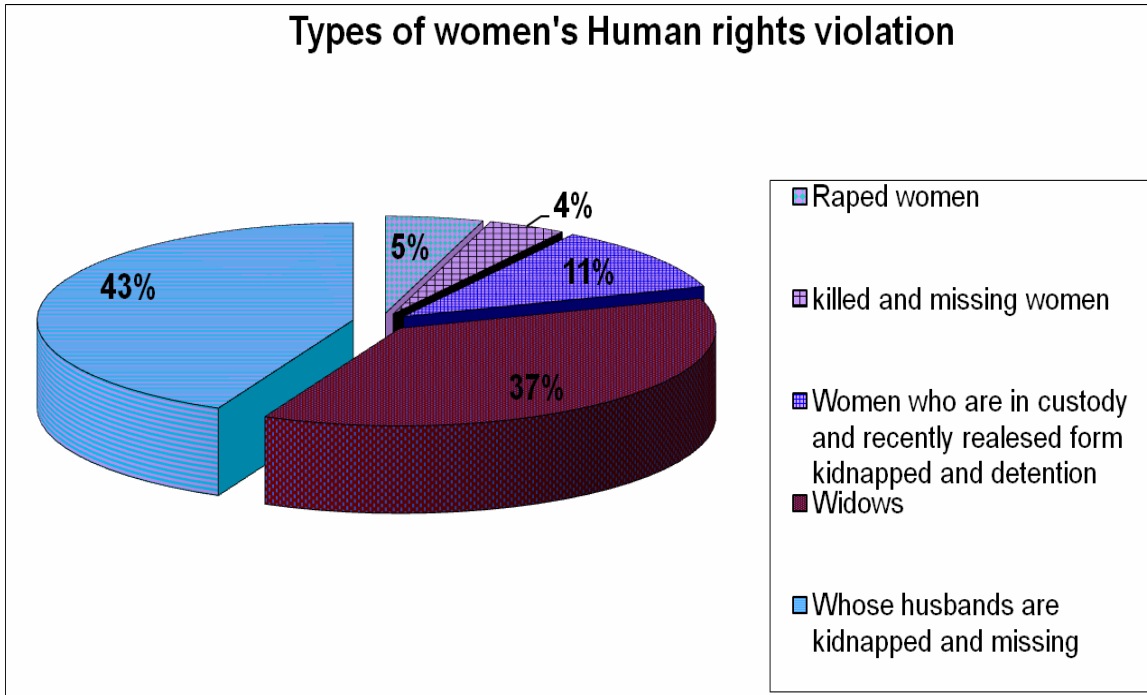
Teachers have been especially targeted in the conflict, allegedly by both rebels and the army. People in general have also been affected due to bandhs/blocades, and destruction of infrastructures

The Center for Victims of Torture (CVICT), Nepal, reported that some 16,000 people were subject to torture in Nepal every year; amounting to an estimate of 100,000 people being tortured including family members. Presence of torture from both sides – Maoist and the state – are reported by different sources. Long term consequences of such tortures and sexual violence on health and well being are considered to be devastating (although there are no records of the incidence of health consequences of such rape, torture and physical abuse of different types/nature). More than 70% of Nepalese prisoners claim to have been tortured while in custody, and sexual abuse is also reported on both sides of the conflict – by the security force and Maoist insurgents

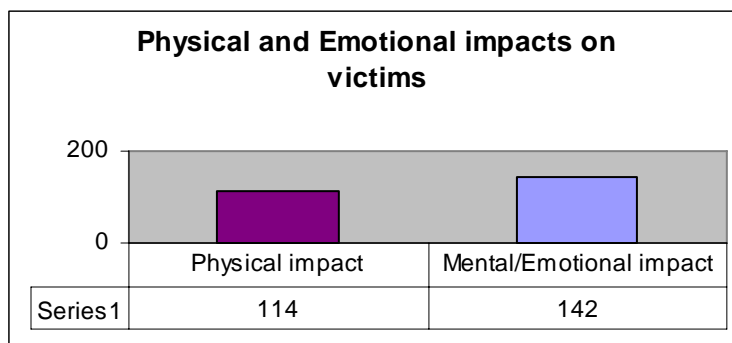
Referring to the Epidemic of HIV, Bina noted that there were some indirect effects of conflict on HIV/AIDS have also been reported although there has not been any in depth study. Migrant spouses upon return to their villages have been found to be HIV positive. This was found most notably in Maoist-controlled districts such as Accham, Kailali and

Doti, where around 6-10 percent of migrant laborers were reported to be HIV positive. Wives of such migrant returnees are also most vulnerable to the risks of HIV and AIDS infection

According to the study carried out by WOREC, an NGO, in 6 districts of Banke, Bardiya, Dang, Rolpa, Saalyan & Udaypur comprising of 142 case of women's human rights violations, conflict situation in the country has intensified women's destitution and has deprived them of their sustenance base + serious health problems



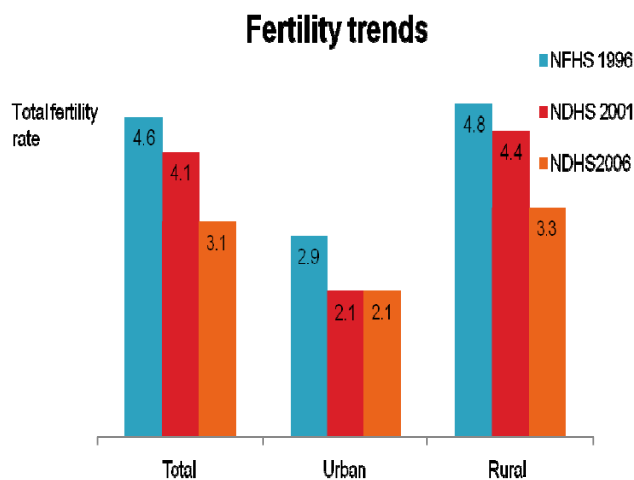
### Multiple consequences of health disorders



Among the physical consequences of Health among women was rape, torture, beating, prolapsed uterus, gynaecological problems, aching uterus, pregnancy complications, malnutrition, increased workload ,sickness, vomiting, irregular menstruation, sleeplessness, depression, fear of social stigmatization, dizziness, fainting, anxiety, Fear, Risks of committing suicide , grief, weeping, distress/depression

Different sources of data, collected between 2001 & 2005/6, covering the conflict period reveal a significant improvement in socioeconomic, demographic and health status of the people in Nepal despite the colossal loss of lives, massive displacement, destruction of livelihoods and physical facilities (including health and other basic services), virtual collapse of the economy (growth rate down to 1.9%) causing reduction in production of agricultural and manufacturing of goods and services, acute violation of human rights - women’s rights in particular and so on

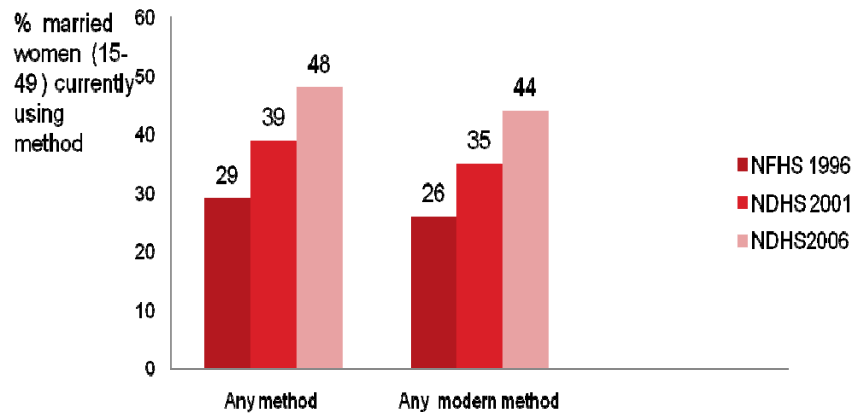
**Health indicators during the conflict period show reduction of fertility by one child within a period of less than 5 years**



More women using family planning – almost 44 % of the married women.

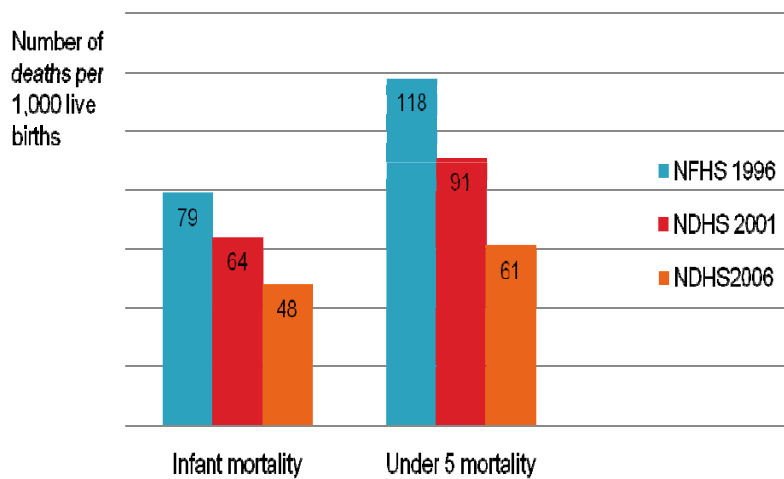
This represents 20% increase in the past 5 years alone

## Trends in contraceptive use



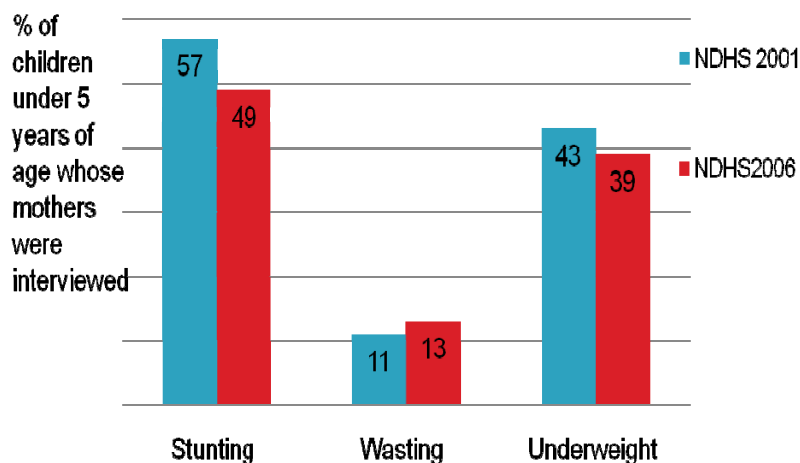
Both infant and child mortality show significant reduction. Percentage point reduction in child mortality is higher during the conflict period compared to pre conflict period

## Trends in childhood mortality



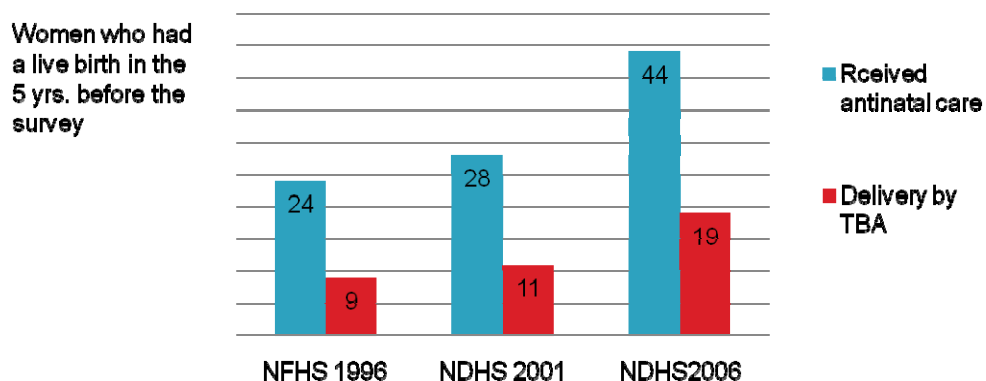
**Even during the most difficult of times people managed to feed their children**

## Trends in Children's Nutritional Status



Maternal mortality declined from 539 to 281 per 100,000 live births

## Trends in maternal health care



## Conclusions and implications for transformative change in health & health services

Emphasizing Women Health Rights Bina summarised that People's war in Nepal presents it self as a severe constraint in the lives of women and men as well in providing window of opportunities. On one hand at the root of the conflict are the persisting inequalities and the widespread destruction destabilizing people's lives and negatively impacting on their health and well being – particularly of women. On the other, it has brought about a wide spread consciousness of the structural control among women and in loosening the hegemony of the local elites and patriarchal controls. As a survival strategy women have come out of their traditional roles taking over men's work; taking up arms; protecting family welfare, resisting family and social pressures, and breaking age old social-cultural barriers.

Most people affected by conflict, survived by their own efforts and coping strategies rather than as a result of outside interventions or conventional health services system – it is the community voluntary health care provided by the FCHVs, CHWs and MCHWs

### Recommendations

- Aim of the post conflict health systems reform should not be “recovery” to return into the pre-conflict bio-medical model but transformation built on the initiatives and drives of the people
- Community based health care systems with strong participation of the people to provide health for all
- Strengthen such community based health care system building necessary skills and capacity of the local health workers/volunteers and quality of care
- Accountability of the state machinery to ensure necessary health infrastructure and supplies
- Conflict should not be viewed as negative and an obstacle to “development” but is an eye opener and critique of the failure of “development” to address the issues of chronic poverty, lack of long term access to health and health care resources, exclusion of women and social/ethnic groups, and seemingly benign but violation of their rights and equity by the system

### Session 2- Maternal Mortality : A human rights crisis

-	Maternal Mortality Ratio		
Country	2000-2006 Reported	Adjusted	Life time risk of Maternal Death 1 in
Bangladesh	320	570	51
India	300	450	70
Nepal	280	830	31
Pakistan	530	320	74
Srilanka	43	58	850

Source: The State of World’s Children 2008-UNICEF

Abhijit from Center for Health Rights and Justice and Health Watch Forum , India said Maternal Mortality was a huge human rights crisis is taking place in South Asia. Every year a very large number of women succumb to maternal mortality in this region. This number is close to 200,000 and is more than the number of people dying due to conflict

(internal and international) which is key area of concern for the South Asian community. The situation is similar in all countries of the region except for Sri Lanka. Maternal mortality is one issue where the region will not reach MDG indicators. In neighbouring Thailand ( in South east Asia) , he informed that they are talking of MDG +.Maternal Mortality continues to a major problem while the region is going through a unprecedented economic growth.

### **Maternal health : Nobody cares**

The poor status of maternal health in the region 60 years after the region stopped being a colony shows how little the new nations cared about their women.

Reflecting on the experience in India, he stated that t deaths are more among poor, among the socially excluded groups. According to technical sources the total number of women facing some life threatening complication can be upto 30 times the number of women who die. This means that a total of about 4 million women face some life threatening complication. It is not surprising that nearly 1 in 30 women die due to childbirth in India. And this is higher among the socially excluded groups

### **Changes taking place in India**

- A. India has started a new programme for improving rural health and maternal health is one its important components. Now institutionalized delivery is being made compulsory through a process of incentives – both for the woman and for a community volunteer. The irony of the situation is that women are dying because they are approaching health care. This is more among marginalized communities. Government wants to institutionalize deliveries without taking care there are adequate number of beds or health personnel available. No such mapping exercise was done in the country. Health providers are insensitive to the health needs of women and to issues of social exclusion and gender.
- B. In Uttar Pradesh, the most populous state of the country, nearly 40,000 women die of childbirth related reasons every year. Women in Uttar Pradesh have now decided that they will not be exposed to risk of maternal death. Across 10 districts of the state women have formed Women’s Health Rights Forums. This forum was started by women who either survived a near miss event or whose family members died. These women are now actively monitoring their local health providers and the local health services. They hold regular dialogue with the Chief Medical Officers in their districts, the health secretary and last month they also held a meeting with the health minister. Their demands are simple – They want that women from their communities receive the set of services that have been promised under the government policy. They want that each maternal death be investigated to find out what was the reason behind the death and not just the medical cause.
- C. The Government of India has also introduced a Community based monitoring system within the new national health implementation framework. In a pilot phase that is ongoing communities from 1600 villages are being trained to monitor their health service availability and maternal health services is one of the key areas they are investigating.

## **Recommendations**

- Each maternal death must be made cognizable event- reported, recorded and investigated
- Side by side system has to improve as well- allocation should be increased, training in technical skills should take place, health personnel must learn to value human death
- Indigenous knowledge has to be respected
- Community has to be made aware of the importance- so that they can demand and do audit, adverse outcome audit
- Health sector expenditure - we have to pressurize the government to pay more for the provision of service. Total health expenditure should be much more
- Compulsory public posting of doctors. Considering their career- work in periphery.
- Train more paramedics and nurses include Traditional Birth Attendants (TBAs) as a cadre of the health service by upgrading their skills, registering them and setting up local systems of monitoring their work
- Social Insurance mechanism to ensure maternal health services are free for all

## **Session 3- Healthcare Financing**

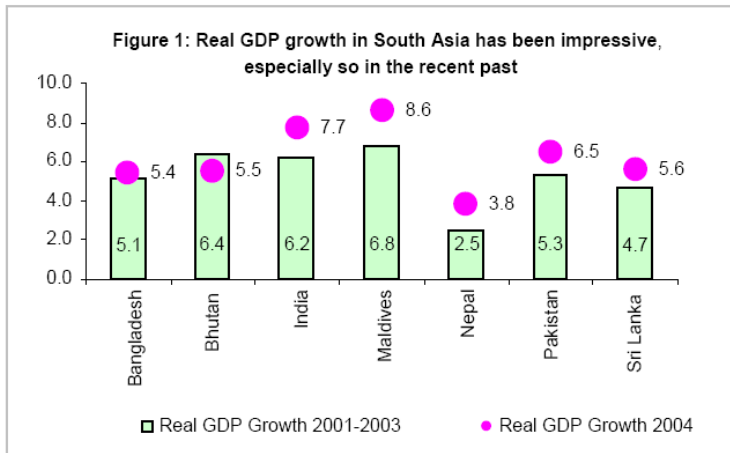
Abhijit informed that the **Health outcomes** in South Asia are among the poorest in the world.

- One out of every three child deaths occurs in South Asia
- Two third of the world's malnourished children live in South Asia
- Maternal mortality rates are the second highest in the world
- A poor child often will not be immunized or go to school, most likely will be malnourished, lack access to clean water and be prey to exploitative practices that jeopardize their wellbeing and most of them will be girls ( Dr Saleh, Dy Director UNICEF, July2005)

### **1. Economic growth is happening at a rapid pace –**

Despite obstacles such as conflict, corruption and high fiscal deficits in some countries, South Asia has achieved impressive economic growth and poverty reduction in the past decade, thanks mainly to economic reforms in the 1990s. ( WB report 2006, Economic Growth in South Asia: Promising , Un-equalizing, ...Sustainable?)

- Concerns raised by the report :
- Growing income inequality
- Persistence of conflict and corruption may be persistent
- Productivity, savings and investments are lower compared to East Asia



## 2. **Health related public investments** is very low:

WHO recommends that 5% of the GDP should be invested in Health

- In Bangladesh the Total Health Expenditure is 3% of GDP
- In Pakistan the Total Health Expenditure is lower at 2 % of GDP
- In India the Total Health Expenditure is nearly at the WHO recommended level at 4.9% of GDP but the Government's share of this expenditure is less than a fifth at 16.4%
- In Pakistan it is the same at 16.4% and in Bangladesh the Government share is a little higher at 29% .
- It is only in Sri Lanka the Government contributes nearly 50% to the 4.2 % of GDP that is spent on health.

It is not surprising that the health care indicators in Sri Lanka are the best in the region

( All figures from WHO National Health Accounts Series 2006)

## 3. **In equities in Healthcare**

The difference ( ratio) in availability of skilled attendance at birth, a basic health care facility, is vast among wealthiest quintile and poorest quintile in the different countries of the region and these are as follows;

Bangladesh 11.6 times ( 3.4% to 39.6%)

Nepal 12 times ( 4.8% to 57.8%)

Pakistan 12 times (4.6% to 55.2%)

India 4.6 times ( 19.4 to 88.4%)

Data ; World Health Statistics 2008

## 4. **Inadequate Health personnel and services**

The presence of health care personnel in the region is as follows:

Bangladesh – Doctors 3/ 10,000 pop Nurses - 3/ 10,000 pop; Beds – 3/ 10,000

Nepal – Doctors 2/ 10,000 pop - Nurses – 5 / 10,000 pop, Beds - 2/ 10,000

India – Doctors 6/10,000 Nurses - 13/ 10,000 pop; no data

Pakistan – Doctors 8/ 10,000; Nurses - 5/ 10,000 pop Beds 12/ 10,000

Srilanka – Doctors 6 / 10,000 pop; Nurses 17/ 10,000 pop Beds -29/ 10,000

Cuba – Doctors 59/ 10,000 pop; Nurses 74/ 10,000 pop – Beds - 49/ 10,000  
Egypt – Doctors 24/ 10,000 pop; Nurses 34/ 10,000 pop Beds - 22/ 10,000  
Data ; World Health Statistics 2008

## 5. Health care financing

Private out of pocket ( as part of private)– Bang- 88% Nepal 87% India 94% Pak 98% SI 86%

Private insurance (as part of private exp) - Bang 0.1% Nepal 0.3% India 0.8% Pak No data SI 9.6%

Social Security - Bang 0.0% Nepal 0% India 4.7% Pak 0% SI 0.2%

Government - Bang –29.1% Nepal 28.1% India 19% Pak 17.5% SL-46.2%

In all these countries except for SL the government is a minor contributor to healthcare expenditures and an overwhelming part of private expenditure is out of pocket.

Data ; World Health Statistics 2008

## 6. Changing patterns in Health care financing ( example of India – with the support of World Bank)

Increasing emphasis on Public Private Partnerships for provision of care – these include

- Insourcing of services in hospitals – from nonclinical services like laundry and canteen to clinical services like radiology to essential support services like pharmacy and laboratory. Experience shows that even if some services are free for those below a certain income bracket – there are unnecessary examinations and medicines prescribed and free services are seldom available
- Voucher schemes – where free services are provided by private providers against vouchers. There are evidences of additional expenditure and non compliance of quality standards in the most well known scheme – Chiranjeevi scheme in Gujarat state.

Insurance is also being promoted as a risk pooling mechanism for the poor. Indian medical insurance industry is very new. My personal experience and those of my friends has been poor with refusal being the norm. A global example of the insurance industry has been portrayed by Michael Moore in his film Sicko and it is really a very telling story.

Abhijit interestingly noted that now the Chambers of Commerce and Industry have started seeing healthcare as a growth sector. Earlier only the high income group and medical tourism was seen as the key growth area, but now the government is providing tax incentives for setting up hospitals in the second and third tier cities. There has been some increase in the overall outlay of the government but the expenditure and outlays for strengthening the system is being avoided and PPP is being seen as a route.

Medical education is increasingly shifting to the private sector with high tuition fees, capitation fees and doctors are primarily interested in private practice

Key Issues, he highlighted were as follows

- Health outcomes among the worst in the world despite economic growth

- Income inequalities are increasing with economic growth
- Government health care expenditure is far lower than the recommended by WHO for adequate health care
- Poor people have to make out-of-pocket expenditure for healthcare which compromises health care seeking as well economic status
- Status of health care services is poor; large inequalities in service provision between different economic groups
- Government policy is focusing on private health care provisioning with little thought of the experience of the private sector in providing public services and without any forms of regulations being in place
- Private sector looking at health care ( including government expenditure on healthcare ) as a growth opportunity.

Exception: Sri Lanka

## 7. Recommendations

- Health has to be seen as a regional emergency and tackled collaboratively and seen in the context of income disparity which is increasing in the region
- Healthcare has to be socialized service – ie. state has to ensure the provision and availability of quality affordable services
- The poor have to provided health care services free of cost either through state service delivery points or private service delivery points
- Health care cannot be seen as a profit-making sector. Private provision of services has to be through a not for profit mode.
- Regulation of private sector including private health care industry and insurance industry has to be ensured to ensure quality, as well as to regulate costs.
- National Ombudsman agencies must be set up for increasing accountability – financial and technical
- Health care has to be seen as a key area of regional cooperation and collaborative action
- Healthcare has to be seen as a important component of national growth and regional growth – areas of collaboration has to include the pharmaceutical industry where India has come to an position of global leadership.
- A regional technical task group/mechanism to be set up to provide technical direction based on local economic, political and cultural realities

## Session 4- Right to Health - Bangladesh

Prof Dr Rashid E- Mahbub, from Peoples health Movement, Bangladesh and past president of Bangladesh Medical Association said that in the south asian region, rising costs of living, drugs, and the fuel crisis impact health by reducing people's ability to empower themselves. In many countries, physicians are protected and held less accountable for bad medical practice. allocation of resources for health needs to be done in an equitable manner, and primary health care in particular is in danger of being privatised. while key indicators of maternal mortality rate and infant mortality rates are

used to assess the health status of countries, it must be understood that they do not provide a comprehensive assessment of the situation.

Across south asia the present health systems do not appear to be working adequately. people should be empowered to take the initiative for their own health. providing health care should ensure the absence of discrimination and be broad based through primary health care, and backed by political support. The issue of health insurance for the poor needs to be reviewed as health is a basic right and should be a state responsibility.

Almost half the population in Bangladesh is living below the national poverty line (UNDP). The fulfillment of their right to health is closely related to poverty reduction strategies and policies. Shortages of staff, hospital beds, medicine and equipment are severely limiting access to health care. Although the total number of hospitals and hospital beds doubled between 1980 and 2000, most of the increase occurred within the private sector which the poor cannot afford. Corruption and mismanagement, in both public and private health services, further limit access to health services especially for the poor.

The constitution and major policy documents of the Bangladesh government have recognized the health rights and development. Bangladesh has ratified most of the international treaties and covenants including ICCPR, ICESCR; and a signatory of international declarations including Alma-Ata, ICPD, Beijing declarations, and Millennium Development Goals. However the implementation of government policies and plans in the development of health institutions, human resources, accessibility and availability, resource distribution, rural-urban disparity, the male-female gap has put the health system in a dismal state. Neither the right to health nor the right to development has been established in the development of health system or in providing health care.

The development and service pattern of the health system have negative correlation with human rights and contributed to the underdevelopment of Bangladesh. The government should take comprehensive approach in prioritizing the health rights of the citizens and progressive realization of these rights.

### **Session 5- Indian Womens Heath Charter- towards South Asia**

Kamayani from WHRAP presented the Indian Womens Health Chartre on behalf of her colleagues of Indian Womens Heath Movement Sabla and Manisha. The English version of the Indian Women's Health Charter was released in the Second National Assembly of the People's Health Movement in Bhopal, India in March 2007. Thereafter, the Charter has been translated into seven Indian languages (Hindi, Marathi, Tamil, Telugu, Bengali, Assamese and Manipuri). Four of the above are now available in printed form as well. This document has had its genesis in the 10<sup>th</sup> International Women and Health Meeting (IWHM) which was held for the first time in South Asia, in New Delhi, in 2005. After the IWHM, the process of raising women's health demands was carried forward through the

National Dialogue on Women, Health and Development in 2006. Kamayani informed that it was during the preparation of the National Dialogue that the need for a 'Charter' of women's health demands was expressed. A drafting committee then wove together the health concerns raised by over 2500 women over four years and contextualised these within a feminist ideological and political framework as well as in the context of making the right to health care justiciable in India. The Charter has no individual authorship, out of due respect to the hundreds of women who raised their concerns over a period of four years.

Thus the Indian Women's Charter as you see it today has been a product of five years of reflection, consultation and dialoguing at various levels, ranging from the global to the local. This Charter is neither the beginning nor the end of raising issues from the grass root level on the one hand and advocating for health rights on the other. Ever since we started working on it, we have visualized it as a process of evolution, one that constantly includes the changing realities of various marginalised communities, both within and outside India.

The Indian women's health movement has always believed that health is dependent on age, class, race, caste, ethnicity, culture, location, physical or mental ability, marital status, sexual orientation and degree of homelessness. It is intrinsically linked to the productive and reproductive roles that women play within patriarchy as well as on the levels of exploitation and conflict prevailing inside and outside the home. Improvements in universal access and availability of quality health care services, irrespective of the capacity to pay, therefore need to go hand in hand with overall reduction and elimination of inequality, poverty, discrimination and all forms of violence, and with the creation of an enabling environment wherein women can access all their rights without fear or coercion. Hazardous work and living environments, wars, civil strife, global policies that exploit developing countries or further dispossess the resource poor and the indigenous people are therefore detrimental to the health of women and their communities. The loss of sustenance, livelihoods and increasing poverty in the period of neo-liberal globalization, increased militarisation and growing fundamentalisms have clear gender-specific impacts and have harmful outcomes on the mental health and sense of well-being of all people.

This Charter thus emerges out of the Women's Health Movement in India with its history spanning over three decades. The main highlights of the Charter are that it focuses on the social determinants of health, access to health care, rational therapeutics, regulation of the private sector and the politics of health. Secondly we have centre-staged the health rights of 'all women', including marginalized groups such as girl children, adolescents, single women, disabled women, sex workers, LBT women, women living in State custody, minority women, tribal women, Dalit women and so on. Thirdly violence against women has been emphasized as a public health and human rights issue. Last but not least, we have reiterated State obligations towards the full realisation of the health and well-being of its people by commenting on law, policy and ethical dimensions.

Kamayani also pointed out that during the past one year, the Charter is being used as an advocacy tool to dialogue amongst various movements and with the government. Commissions on women rights . Although the Indian Women's Health Charter is contextualised within the wide-ranging discussions amongst individuals, groups and movements in India, it will be a beginning at the South Asian level at the Peoples SAARC meet, to gain feedback on it from the friends from other countries and so that, without reinventing the wheel, they are able to adapt the Charter to the specific conditions of their respective countries in order to use it as a tool for lobbying and advocacy. It will be also be good if friend sin Sri naka can take it forward in Sinhalese, she concluded.

Kamayani flagged the issues of arrest of Dr Binayak Sen and urged the drafting committee of the SAARC People's Charter to ask for immediate release by the indian government of Dr Binayak sen who has been detained for treating an alleged maoist, without nay concrete evidence for more than one year in Chattisgarh.

Mr Narendra Gupta from PRAYAS, India suggested the development of a framework and alternatives, leading to the saarc people's charter., opned the floor for discussion and feedback on the presentations and if there were any questions.

## **Open Forum**

Ms Princy Mangalika - President – Organization of People Living with HIV/AIDS proclaimed that still they have social harassment in Sri Lanka and it seen in the Hospitals and in the Schools. Ms Kusum, on behalf of the Sex Workers of , Community Strength Development Foundation, said that Sex workers face a lot of social discrimination and ostracism and have multiple health issues. She also said that many are forced into the sex trade due to the lack of alternate employment. Tthey are especially vulnerable to abuse. and even in detention they maybe discriminated against.

An HIV patient herself she said irrespective of how hiv/aids was contracted every affected person has a right to treatment, to be free of discrimination, stigma and ostracism, to education and employment. Although there are funds allocated for hiv/aids related work, there is need for greater transparency. Not only a sex worker but each and every person is at risk of the disease.people living with hiv/aids tend to be ostacized in public places, schools and hospitals.

Dr Prasanna Cooray ,public health expert spoke on the state of health services in Srilanka and and stated that health is not synonymous with allopathic services. when we think of services, we think of allopathic healthcare services, but south asia is blessed with medical pluralism in that there are many types of health systems in practice. therefore, we should look at health from a south-asian perspective. Good health is multifactorial, he

pointed out. He put a question to the pane whether due recognition is given to services provided through the private and ngo health sectors.

Although overall, Sri lanka has good health indicators, the plantation sector is disadvantaged. the maternal and infant mortality rates in the plantation sector still remain higher than the national average. this is attributed to the poor living conditions, economic issues and lesser access to health care. Mr Mohan – On behalf of the Plantation Community – stated that the WHO and many other people think that Sri Lanka has a good health system, but it is has totally neglected the concerns of the plantation community. He further stated that they do not have proper housing facilities, proper education and health care services. Their health status is far below compared to an average Srilankan. Ms Kanthi Lanka - On behalf of the Savisthri Organization, emphasized about the plight of the plantation women and requested to work up to elevate their living standards. The extensive use of pesticides in south asia is a serious issue, she said adding that it is affecting the health of people. pollution from pesticides and other chemicals are responsible for a large amount mental fatigue, physical exhaustion and eye problems.

Mr Arumugam, a well known Activist in the Plantation Sector emphasized that all Sri Lankans have now become mental patients because of the war situation. He stressed the need to take necessary steps to stop the war.

Concluding the Recommendations Dr Narendra Gupta Concluded the session saying that as the speakers and the house have agreed that :

- Maternal deaths should be declared a health emergency and a cognizable event; should be allocated increased resources in national health systems; establish a south asian health resource centre as a clearing house for information and financial outlay.
- The public health sector should not be privatized; should be the responsibility of central governments.
- The private health sector should be subject to medical audit.
- The health systems should be gender sensitive, and address the needs of the girl child and adolescent, women of all ages, single women, those with disabilities, sex workers, those affected with hiv/aids, women living in conflict, war and disaster situations, women in custody of state institutions, women in the labour force, including external and internal migrants, lesbian, bisexual and transgender women, and women of caste, ethnic and religious minorities.

## The co-organizers of the Health Panel were as Follows

- **WHRAP- South Asia:**The Women's Health and Rights Advocacy Partnership is part of the vision shared by ARROW and her partners to move forward the sexual and reproductive health and rights agenda through advocacy across the region. WHRAP brings together women's organisations who are committed to strengthening civil society capacity to effectively advocate for sexual and reproductive health and rights (SRHR), especially safe motherhood and young people's SRHR at the local, national and regional levels.**Partners:** Chetna and Sahayog – India, Shirkat Gah- Pakistan, Naripokkhoo and Bangladesh Women Coalition- Bangladesh and Beyond Beijing Committee- Nepal .  
[www.arrow.org.my](http://www.arrow.org.my) <<http://www.arrow.org.my/>>
- **Peoples Health Movement- Srilanka:** has its roots deep in the grassroots people's movement and owes its genesis to many health networks and activists who have been concerned by the growing inequities in health over the last 25 years. The PHM calls for a revitalisation of the principles of the Alma-Ata Declaration which promised Health for All by the year 2000 and complete revision of international and domestic policy that has shown to impact negatively on health status and systems. [www.phmovement.org](http://www.phmovement.org)  
<<http://www.phmovement.org/>>
- **Health Watch Forum** is a network active in several north Indian states for advocacy and monitoring on reproductive health and rights. Healthwatch Forum maintains the Reprohealth Listserve which is used by advocates and concerned civil society members to communicate about maternal and reproductive health and rights across India. SAHAYOG is anchoring the secretariat of Healthwatch Forum. [www.sahayogindia.org](http://www.sahayogindia.org)  
<<http://www.sahayogindia.org/>>
- **Sama is** Resource Group for Women and Health is based in Delhi and was initiated by a group of women's health activists from different parts of India, who have been involved with women's empowerment and health for several years. Sama believes in confronting all forms of discrimination and emphasizes on equality, empowerment and rights of women, especially from marginalized communities, and perceives health from a gender, caste, class and rights perspective. [www.samawomenshealth.org](http://www.samawomenshealth.org)  
<<http://www.samawomenshealth.org/>>
- **Centre for Health Equity, Jaipur:** is an initiative focusing on issues of inequities and related topics in health sector. It mobilizes disadvantaged citizens to petition the government and demand what is rightfully theirs. Focusing primarily on health equity and accessibility, the Centre monitors issues such as access to primary health care, the Community AIDS Awareness Program, State level advocacy programs regarding coercive population programs.  
<<http://www.prayaschittor.org/salientf.htm>>