VULNERABLE GROUPS IN INDIA

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ABOUT THE DOCUMENT

A great majority of people in the developing nations are under the line of poverty. They are deprived of adequate access in the basic needs of life such as health, education, housing, food, security, employment, justice and equity. Issues of sustainable livelihood, social and political participation of the vulnerable groups exists as the major problem in the developing nations. Governments have failed to guarantee people's rights in the implementation level. People who belong to the vulnerable groups are unable to acquire and use their rights. In this background, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) have guaranteed the rights to sustainable livelihood, social, political and economic development for all especially those disadvantaged. Many countries have ratified these covenants. In 1979, the Government of India acceded to the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Article 12 of the ICESCR states that, "*The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*" In the year 2000, the Committee on Economic, Social and Cultural Rights offered explicit details of all the possible instances of violation that individuals and groups within a nation are likely to suffer from besides listing out obligations for the state to *protect* and *fulfill* the right of everyone to the enjoyment of the highest attainable standard of physical and mental health through the General Comment 14. Despite international commitment, individuals and groups experience differential access to food, education and health in India. The health rights of vulnerable groups remain detached from the state systems i.e. policy, programme and practice. The document identifies the vulnerable groups in India, their health and human rights concerns while exploring the degree and kinds of their vulnerability vis-à-vis their location and identity.

The document is based on the research on the vulnerable groups in India done through the project, *Establishing Health As A Human Right*. We would like acknowledge the help received towards the finalisation of the document. The Programme Development Committee of CEHAT, and the external experts patiently reviewed the draft, raised pertinent questions, and provided critical feedback and suggestions that were very useful. Mr Prashant Raymus, helped us enormously by cross-checking the data reported in the document by consulting the available relevant data sets on health status of vulnerable groups in India. Ms. Padma Deosthali, Coordinator of CEHAT, convinced us of the importance of such a document on vulnerable groups and strengthened it with her comments. Oxfam-Novib, Ford Foundation and Rangoonwala Trust Foundation supported the project through which the publication of this document has been possible. Editor Lina Mathais, went through the document with great dedication. Satam Printers handled the printing process with utmost patience providing several proofs of the document before the final go-ahead. We hope that this document will be useful for those involved in Research and Advocacy on Health and Human Rights in India.

Chandrima Chatterjee, Ph.D
Project In-Charge (Research)
Establishing Health as a Human Right

'The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time. To ensure it happens is the challenge facing the human rights community and public health professionals.'

Mary Robinson,
Former UN High Commissioner for Human Rights

Section 1

VULNERABLE GROUPS; THEIR HEALTH AND HUMAN RIGHTS

Human right applies universally to all. The process of identifying vulnerable groups within the health and human right generated from the pressing reality on the ground that stemed from the fact that there are certain groups who are vulnerable and marginalized lacking full enjoyment of a wide range of human rights, including rights to political participation, health and education. *Vulnerability* within the right to health framework means deprivation of certain individuals and groups whose rights have been violated from the exercising agency (Yamin, 2005). Certain groups in the society often encounter discriminatory treatment and need special attention to avoid potential exploitation. This population constitutes what is referred to as **Vulnerable Groups**. Vulnerable groups are disadvantaged as compared to others mainly on account of their reduced access to medical services and the underlying determinants of health such as safe and potable drinking water, nutrition, housing, sanitation etc. For example, persons with disabilities often don't get employment or adequate treatment or people living with HIV/AIDS, face various forms of discrimination that affects their health and reduces their access to health services.

- Right to health means the enjoyment of the highest attainable standards of health.
- Right to health includes the right to health for all.
- Right to health includes the underlying determinants of health, such as safe drinking water, adequate sanitation and access to health-related information.

Limitations on the exercise of certain human rights can only be justified under certain conditions established under international human rights law. These conditions, which are referred to as *Siracusa principles*, include following:

1. The restriction is provided for and carried out in accordance with the law;
2. The restriction is in the interest of a legitimate objective of general interest;
3. The restriction is strictly necessary in a democratic society to achieve the objective;
4. There are no less intrusive and restrictive means available to reach the same goal;
5. The restriction is not imposed arbitrarily i.e. in an unreasonable or otherwise discriminatory manner; and
6. The restriction is time-limited and subject to review.

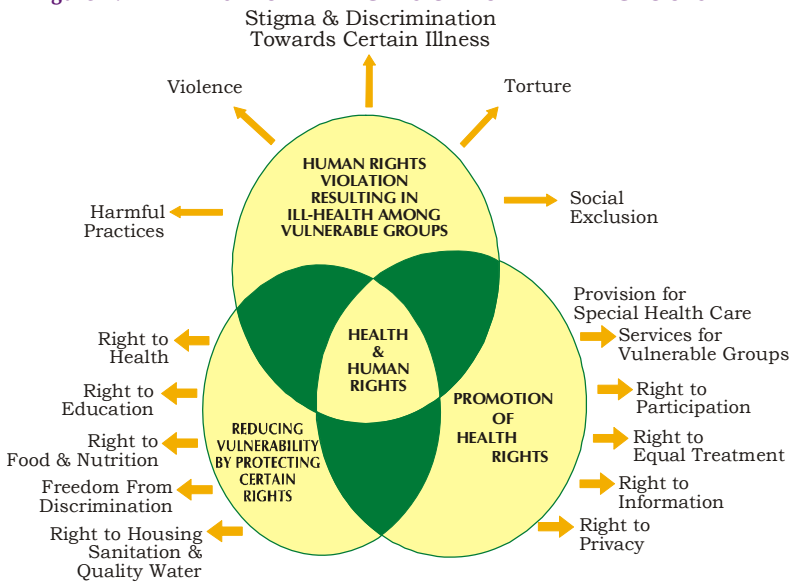
The issue of *participation* and *prevention* of violation is important for understanding the vulnerable groups; their health and human rights. The United Nations *Economic, Social and Cultural Rights Committee* (ESCR Committee) mentions that an important aspect of implementing the right to health "*is the improvement and furtherance of participation of the population in the provisions of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular in political decisions relating to the right to health taken at both the community and national levels*".[1] The *General Comment 14* of the *Article 12* (Right to Health) also proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that measures, such as the strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls *General Comment No.3, Paragraph 12*, which states that even in times of severe resource constraints, the vulnerable members of society must be protected. Protecting and fulfilling the rights of the vulnerable groups constitutes the *immediate* state obligations under the Covenant for Economic Cultural and Social Rights.

There are many and complex linkages between health and human rights of the vulnerable groups. Violations or lack of attention to human rights can have serious health consequences for certain groups (abuse, stigma and discrimination, harmful traditional practices, violence, torture, etc). The manner in which health policies and programmes are designed can either protect or violate human rights of certain groups (accessibility to service, provision of information, respect for integrity and privacy, cultural sensitivity, gender and age sensitivity). The chances of enjoying good health must not be unfairly disadvantaged because of sex, class, religion, age, sexual orientation, ethnic identity,

[1] ESCR Committee General Comment No 14, para 17

disability, health status (HIV/AIDS),civil, political, social or other statuses. All governments are obliged to protect and promote the conditions conducive for the enjoyment of the right to health.

Figure 1: HEALTH & HUMAN RIGHTS OF VULNERABLE GROUPS[2]



Participation of the vulnerable groups is essential for securing the public health goals. Human rights approach to health lays emphasis on the inclusion of the needs and concerns of diverse groups and communities. There are several interfaces between public health and human rights. While both the approaches have their separate spaces and adopt contrasting lenses of approaching health, there are innumerable instances where they compliment each other.[3] An important step towards increasingly coming closer to each other is

A rights-based approach to health refers to the processes of:

- Using human rights as a framework for health development.
- Assessing and addressing the human rights implications of any health policy, programme or legislation.
- Making human rights an integral dimension of the design, implementation, monitoring and evaluation of health-related policies and programmes in all spheres, including political, economic and social.

[2] Adapted from World Health Organisation (2002), 25 Questions and Answers on Health and Human Rights, Health and Human Rights Publication Series, Issue No 1,July, pg.10

[3] For details consult, Centre for Health and Human Rights Harvard School of Public Health and International Federation of Red Cross and Red Crescent Societies (1995), **AIDS, Health and Human Rights; An Explanatory Manual**, Section 4; *The Public health- Human Rights Dialogue,* pg. 39.

perhaps their recognition of the vital role of societal environment to both health and realization of human rights. Both the approaches recognize the fact that there is a complex relation between the individual and the society that impacts their health. For example, the health of an individual or groups may depend on the conditions such as sufficient income, living conditions, access to safe drinking water, etc., and all the above factors are heavily influenced by whether or not an individual belongs to a group that suffers discrimination.

Public health is assumed to seek the greatest good for the greatest number of people. Application of human rights principles to public health strategies has expanded the scope of the latter by going beyond averages and focusing attention also on those population groups in society which are considered most vulnerable. The focused attention on vulnerable and disadvantaged groups in the international human rights instruments reinforces the principle of equity. An ideal public health strategy would be the one which addresses the concerns for equity and justice in every society but in practical terms there are limitations of every health system. This necessitates the need to focus on the immediate service delivery by prioritizing the needs. Human rights norms and standards form a strong basis for health systems to *prioritize* the health needs of vulnerable and marginalized population groups.

Component of the public health system in rights-based framework

- Appropriate physical infrastructure at all levels of health care system.
- Adequate numbers of qualified human resources for accurate health care.
- Availability of specific services suitable to different levels.

Focus on the vulnerable group is very useful for human rights documentation. It allows review of context specific violations, identify the challenges faced by the specific groups and their access to healthcare, gather information on group-specific risk factors, cultural and social differences among groups and its impact on health and health-seeking behaviour, document the negative attitude of the health system resulting in denial, draws attention to how national legislation and development policies impact upon the status of such groups. This facilitates advocacy for Right to Health and empowers the disadvantaged groups by raising awareness about their rights and potential violations.

Different societies have different conditions/situations that generate and perpetrate vulnerability among certain individuals and groups. Hence identifying vulnerable groups within the right to health framework is an ongoing process.

Section 2
VULNERABLE GROUPS IN INDIA

In India there are multiple socio-economic disadvantages that members of particular groups experience which limits their access to health and healthcare. The task of identifying the vulnerable groups is not an easy one. Besides there are multiple and complex factors of vulnerability with different layers and more often than once it cannot be analysed in isolation. The present document is based on some of the prominent factors on the basis of which individuals or members of groups are discriminated in India, i.e., structural factors, age, disability, mobility, stigma and discrimination that act as barriers to health and healthcare. The vulnerable groups that face discrimination include Women, Scheduled Castes (SC), Scheduled Tribes (ST), Children, Aged, Disabled, Poor migrants, People living with HIV/AIDS and Sexual Minorities. Sometimes each group faces multiple barriers due to their multiple identities. For example, in a patriarchal society, disabled women face double discrimination of being a women and being disabled.

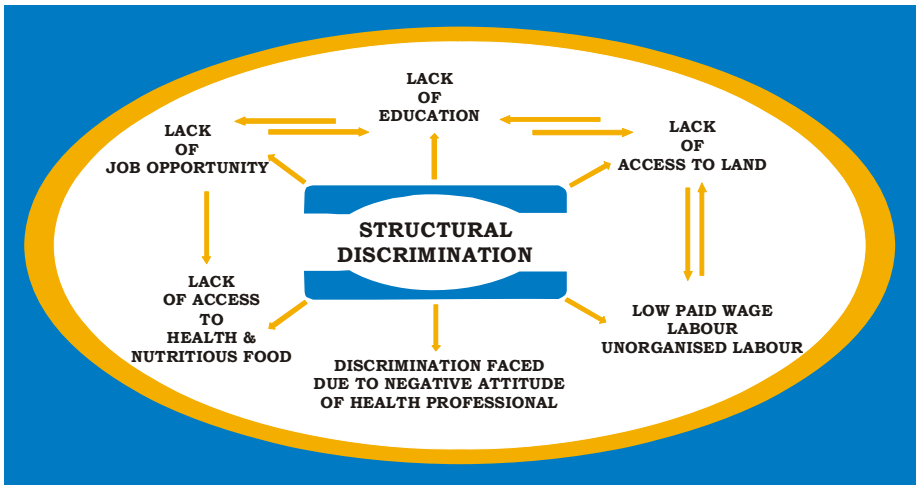
1. VULNERABLE GROUPS FACING STRUCTURAL DISCRIMINATION (Women, Scheduled Castes, Dalits, Scheduled Tribes)

Structural norms are attached to the different relationships between the subordinate and the dominant group in every society. A group's status may for example, be determined on the basis of gender, ethnic origin, skin colour, etc. The norms act as structural barriers giving rise to various forms of inequality. Access to health and healthcare for the subordinate groups is reduced due to the structural barriers.[4] In the next page, *Figure 2* explains the structural discrimination faced by the groups and their human right violations.

The right to health obliges governments to ensure that "health facilities, goods and services are accessible to all especially the most vulnerable group or marginalized section of the population, in law and in fact, without discrimination.

[4] Structural discrimination refers to rules, norms, generally accepted approaches and behaviours in institutions and other social structures that constitute obstacles for subordinate groups to the equal rights and opportunities possessed by dominant groups. Such discrimination may be visible or invisible, and it may be intentional or unintentional.

Figure 2: Structural Discrimination Faced by Groups



In India, social norms and cultural practices are rooted in a highly patriarchal social order where women are expected to adhere to strict gender roles about what they can and cannot do.

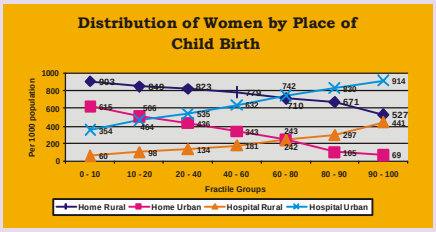
In India, members of gender, caste, class, and ethnic identity experience structural discrimination that impact their health and access to healthcare. **Women** face double discrimination being members of specific caste, class or ethnic group apart from experiencing gendered vulnerabilities. Women have low status as compared to men in Indian society. They have little control on the resources and on important decisions related to their lives. In India, early marriage and childbearing affects women's health adversely. About 28 per cent of girls in India, get married below the legal age and experience pregnancy (Reproductive And Child Health – District level Household Survey 2002-04, August 2006). These have serious repercussions on the health of women. Maternal mortality is very high in India. The average maternal mortality ratio at the national level is 540 deaths per 100,000 live births (National Family Health Survey-2, 2000). It varies between states and regions, i.e., rural-urban. The rural MMR (Maternal Mortality Rate) is 617 deaths of women age between 15-49 years per one lakh live births as compared to 267 maternal deaths per one lakh live births among the urban population (National Family Health Survey-2, 2000). In most cases the deaths occur from preventable causes. A large proportion of women is reported

to have received no antenatal care.[5] In India, institutional delivery is lowest among women from the lower economic class as against those from the higher class[6].

Women face violence and it has an impact on their health. During infancy and growing years a girl child faces different forms of violence like infanticide, neglect of nutrition needs, education and healthcare. As adults they face violence due to unwanted pregnancies, domestic violence, sexual abuse at the workplace and sexual violence including marital rape and honor killings. The experience of violence and its impact on health varies according to the women's caste, class and ethnic identity.

Caste also perpetrates inequality. Caste in Indian society is a particular form of social inequality that involves a hierarchy of groups ranked in terms of ritual purity where members who belong to a particular group or stratum share some awareness of common interest and a common identity. The caste system is linked to the possession of natural resources, livelihood resources and in the Indian context also to land economy and land based power relations.

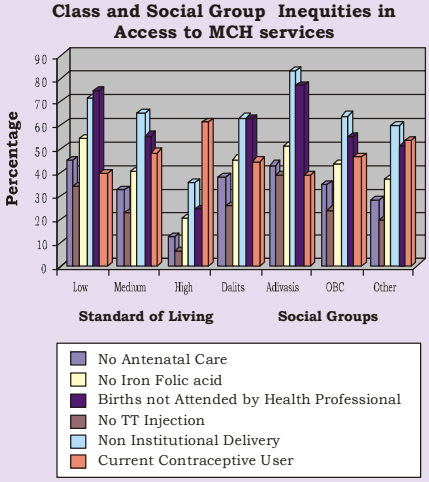
Traditionally, caste relations were based on the hierarchy of occupations where work related to leather, cleaning dead cattle from village grounds, work related to funeral ceremonies, etc were placed at the bottom. People or castes who were performing the task of eliminating the polluted elements from society were considered 'untouchables' vis-à-vis the Brahmins who were highest in the order based on the purity-impurity principle. Structurally the lower castes were economically dependent on the higher castes for existence. The **Scheduled Caste** (lower castes) remained economically dependent, politically powerless and culturally subjugated to the upper caste. This impacted their overall lifestyle and access to food, education and health.



Source: National Sample Survey, 1998, Report No.445, Maternal & Child Healthcare in India

[5] Only 16 per cent of the women in India received all the antenatal care i.e., at least 3 antenatal check-ups, and at least one tetanus toxoid injection and supplementary iron in the form of iron folic acid tablets/syrups daily for 100 days as recommended by the RCH Programme. (RCH-DLHS-3,2002-04)

[6] In India, the percentage of home delivery is highest (59 per cent), whereas institutional delivery (public and private health institutes) accounts for only 40.5 per cent. Home delivery assisted by skilled birth attendants accounts for 7.1 per cent. Institutional delivery by background characteristics shows that only 22 per cent childbirths of Scheduled Tribes women takes place in institutions as compared to 33 per cent births to Scheduled Caste women. (RCH-DLHS-3,2002-2004, pg 98)



Source: National Sample Survey, 1998, Report No.445, Maternal & Child Healthcare in India [6]

A major proportion of the lower castes and Dalits are still dependent on others for their livelihood. Dalits does not refer to a caste but suggests a group who are in a state of oppression, social disability and who are helpless and poor. They were earlier referred as 'untouchables' mainly due to their low occupations i.e., cobbler, scavenger, sweeper.[7]

In a caste-dominated country like India, Dalits who comprises more than one-sixth of the Indian population (160 million approx), stand as a community whose human rights have been severely violated. Literacy rates among Dalits are only about 24 per cent. They have meager purchasing power; have poor housing conditions; lack or have low access to resources and entitlements. In rural India they are landless poor agricultural labourers attached to rich landowners from generations or poor casual labourers doing all kinds of available work. In the city they are the urban poor employed as wage labourers at several work sites, beggars, vendors, small service providers, domestic help, etc., living in slums and other temporary shelters without any kind of social security. The members of these groups face systemic violence in the form of denial of access to land, good housing, education and employment.

Structural discrimination against these groups takes place in the form of physical, psychological, emotional and cultural abuse which receives legitimacy from the social structure and the social system. Physical segregation of their settlements is common in the villages forcing them to live in the most unhygienic and inhabitable conditions. All these factors affect their health status, access to healthcare, and quality of health service received. There are high rates of malnutrition reported among the marginalized groups resulting in mortality, morbidity and anaemia. Access to and utilization of healthcare among the marginalized groups is influenced by their socio-economic status within the society.

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[7] Dalits in India, are poor, deprived and socially backward. They have faced severe forms of human rights violation. They have been involved in a long struggle to abolish untouchability and caste discrimination.

[8] Fractile group constitutes of monthly per capita consumption expenditure (MPCE). Population is classified into seven fractile groups. 0-10 is the lowest consumption group while 90-100 is the highest consumption group.

Structural discrimination directly impedes equal access to health services by way of exclusion. The negative attitude of the health professionals towards these groups also acts as a barrier to receiving quality healthcare from the health system. In the case of women, discrimination increases by the complex mix of two factors-being a women and being a member of the marginalized community. A large proportion of Dalit girls drop out of primary school inspite of reservations and academic aptitude, because of poverty, humiliation, isolation or bullying by teachers and classmates and punishment for scoring good grades (National Commission Report for SC/ST, 2000). The scavenger community among the Dalits is vulnerable to stress and diseases with reduced access to healthcare.

The **Scheduled Tribes** like the Scheduled Castes face structural discrimination within the Indian society. Unlike the Scheduled Castes, the Scheduled Tribes are a product of marginalization based on ethnicity. In India, the Scheduled Tribes population is around 84.3 million and is considered to be socially and economically disadvantaged. Their percentages in the population and numbers however vary from State to State. They are mainly landless with little control over resources such as land, forest and water. They constitute a large proportion of agricultural labourers, casual labourers, plantation labourers, industrial labourers etc. This has resulted in poverty among them, low levels of education, poor health and reduced access to healthcare services. They belong to the poorest strata of the society and have severe health problems. They are less likely to afford and get access to healthcare services when required. [9] The health outcomes among the Scheduled Tribes are very poor even as compared to the Scheduled Castes. The Infant Mortality Rate among Scheduled Castes is 83 per 1000 live births while it is 84.2 per 1000 per live births among the Scheduled Tribes.[10]

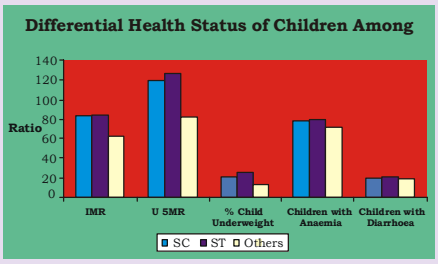
Domestic violence and health

1. According to a household level study on domestic violence in India, 50 per cent of married women reported facing spousal violence and among those reporting abuse, 50 per cent reported abuse during pregnancy.[11]

2. According to a community and hospital based study in Maharashtra, India, conducted during 1993-95, almost 16 per cent of deaths in pregnancy were caused by domestic violence.[12]

[9] Women's Health, Booklet for National Health Assembly II, Compiled by Sama Resource Group for Women and Health, New Delhi, October 2006.
[10] National Health Policy 2002, Government of India.
[11] Study quoted in, *Advancing Right to Health: The Indian Context,* by Sama: Resource Group for Women and Health, New Delhi, pg.26
[12] Ganatra B.R., Coyaji K.J., Rao V.N., 1996, *Community cum Hospital Based Case Control Study On Maternal Mortality: A Final Report,* KEM Hospital Research Centre, Pune, India.

Among the Scheduled Castes and the Scheduled Tribes the most vulnerable are women, children, aged, those living with HIV/AIDS, mental illness and disability. These groups face severe forms of discrimination that denies them access to treatment and prevents them from achieving a better health status. Gender based violence and domestic violence is high among women in general in India. Girl child and women from the marginalized groups are more vulnerable to violence. The dropout and illiteracy rates among them are high. Early marriage, trafficking, forced prostitution and other forms of exploitation are also reportedly high among them. In situations of caste conflict, women from marginalized groups face sexual violence from men of upper caste i.e, rape and other forms of mental torture and humiliation.



National Family Health Survey, 2000

2. VULNERABILITY OF CHILDREN AND AGED

Children and the elderly population face different kind of vulnerability. Mortality and morbidity among **children** are caused and compounded by poverty, their sex and caste position in society. All these have consequences on their nutrition intake, access to healthcare, environment and education. These factors directly impacts food security, education of parents and their access to correct health information and access to health care facilities. Malnutrition and chronic hunger are the important causes of death among children from poor families. Diarrhoea, acute respiratory diseases, malaria and measles are some of the main causes of death among children, most of which are either preventable or treatable with low-cost interventions. Tetanus in newborns remain a problem in at least five states: Uttar Pradesh, Madhya Pradesh, Rajasthan, West Bengal, and Assam (UNICEF, India).[13]

Poverty has a direct impact on the mortality and morbidity among children. *Neo-natal* mortality[14] is about two times higher among people with low standard of living while *Under-5 mortality*[15] among children from lower economic class is five times than that of households with high standard of living. 73.4 per cent of children have some form of anemia (National Family Health Survey-2, 2000).[16] In India, a girl

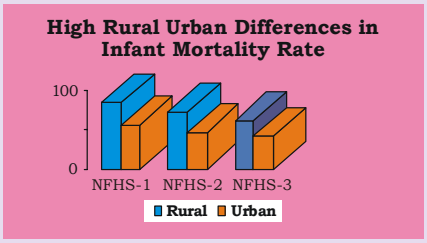
[13] http://www.unicef.org/india/children.html, accessed on 25th February, 2007
[14] Neonatal Mortality-The probability of dying in the first month of life
[15] Under Five Mortality-The probability of dying before the fifth birthday
[16] NFHS II, 1998-99, pp. 272

child faces discrimination and differential access to nutritious food and gender based violence is evident from the falling sex ratio and the use of technologies to eliminate the girl child. Among children the health indicators vary between the different social groups. High mortality and morbidity is reported among children from Scheduled Castes, Scheduled Tribes and Other Backward Classes as compared to the general population.

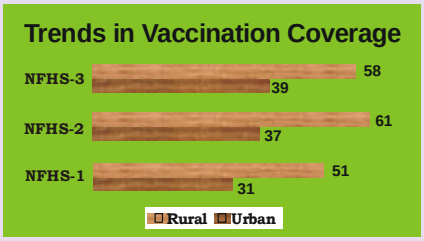
Infant morality is higher among the rural population (Rural-62, Urban 42 per one thousand live births in the last five years, National Family Health Survey 3, Fact Sheets). The vaccination coverage is very poor among children who live in rural India. Vaccination coverage among children between 12-23 months who have received the recommended vaccines is only 39 per cent in rural India as compared to 58 per cent in urban India (National Family Health Survey- 3, Fact sheets).

In India, children's vulnerabilities and exposure to violations of their protection rights remain spread and multiple in nature. The manifestations of these violations are various, ranging from child labour, child trafficking, to commercial sexual exploitation and many other forms of violence and abuse. With an estimated 12.6 million children engaged in hazardous occupations (2001 Census), for instance, India has the largest number of child labourers under the age of 14 in the world. Child labour in the agriculture sector accounts for 80 per cent of child labour in India and 70 per cent of working children globally (Jaswal, Patro, et al., 2006). In, Sivakasi, an estimated 1, 25,000 children make the child labour force, comprising 30 per cent of the entire labour force.[17] Those children working in the brick kilns, stone quarries, mines, carpet and zari industry suffer from occupation related diseases. In India, however there is a huge gap in the industry-specific and exposure-specific epidemiological evidence. Most of the studies are small-scale and community-based studies.

There is a large proportion of children in India who are living with HIV/AIDS. The most common sources of infection among children is the Mother-to-Child Transmission (MCTC), sexual abuse, blood transfusion, unsterilised syringes, including injectable drug use



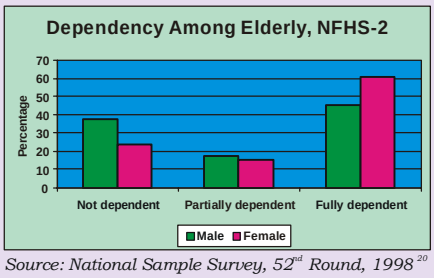
National Family Health Survey, India



National Family Health Survey, India

[17] Angnihotram RV. An overview of occupational health research in India. Indian Journal of Occupational Environ Med 2005;9:10-4,

(NACO,2006). Among children, there are some groups like street children and children of sex workers who face additional forms of discrimination. A large number of children are reportedly trafficked to the neighbouring countries. Trafficking of children also continues to be a serious problem in India. The nature and scope of trafficking range from industrial and domestic labour, to forced early marriages and commercial sexual exploitation. Moreover, for children who have been trafficked and rescued, opportunities for rehabilitation remains scarce and reintegration process arduous. While systematic data and information on child protection issues are still not always available, evidence suggests that children in need of special protection belong to communities suffering disadvantage and social exclusion such as scheduled casts and tribes, and the poor (UNICEF, India)[18].



Source: National Sample Survey, 52nd Round, 1998 [20]

In India, the population of the **elderly** is growing rapidly and is emerging as a serious area of concern for the government and the policy planners. According to data on the age of India's population, in Census 2001, there are a little over 76.6 million people above 60 years, constituting 7.2 per cent of the population. The number of people over 60 years in 1991 was 6.8 per cent of the country's population. The vulnerability among the elderly is not only due to an increased incidence of illness and disability, but also due to their economic dependency upon their spouses, children and other younger family members. According to the 2001 census, 33.1 per cent of the elderly in India live without their spouses. The widowers among older men form 14.9 per cent as against 50.1 per cent widows among elderly women. Among the elderly (80 years and above), 71.1 per cent of women were widows while widowers formed only 28.9 per cent of men. Vulnerability among the elderly also depends on their living arrangement since the elderly are less capable of taking care of themselves compared to younger persons and need the care and support of others in several aspects. About 2.9 per cent of elderly in India live alone. More elderly women (4.1 per cent) live alone compared to elderly men (1.8 per cent)[19]. The significance of the living

[18] http://www.unicef.org/india/children.html, accessed on 25th February, 2007
[19] National Sample Survey Organisation, 1991
[20] (Rajan,2006) The calculations have been done by author. For details of citation, see *Reference*. National Sample Survey in its 52nd round (July 1995-June 1996) focused on issues such as economic independence, chronic ailments, retirement and withdrawal from economic activity and familial integration among the elderly 60 and above. This was a large-scale sample survey conducted throughout the country. The elderly covered in the sample consisted of 16,777 males and 16,428 females

arrangement among the elderly becomes evident when seen in the context of their level of economic dependence (Rajan, 2006). Lack of economic dependence has an impact on their access to food, clothing and healthcare. Among the basic needs of the elderly, medicine features as the highest unmet need.

Healthcare of the elderly is a major concern for the society as ageing is often accompanied by multiple illnesses and physical ailments. Pain in the joints, followed by cough and blood pressure, piles, heart diseases, urinary problems, diabetics and cancer are the common ailments reported among elderly. (National Sample Survey, 52nd Round, 1998). One out of two elderly in India suffers from at least one chronic disease which requires life-long medications. Providing healthcare to elderly is a burden for especially poor households (Rajan, 2006). About 29 per cent of the elderly populations in India are reported to have received no medical attention before death (National Sample Survey, 42nd Round, 1991).

Among the elderly, the widows, poor and disabled constitute those who are more disadvantaged. Widows face structural disadvantages associated with gender and marital status. There is striking gender differential that exists in the ownership of property and assets and in the participation of their management. At all India level, aged women like those in other age groups suffer from lack of ownership of property and financial assets and participation in their management compared to aged men in both urban and rural India (National Sample Survey, 52nd Round, 1998). Lack of property ownership affects their access to resources like food, housing, health etc. [21] Visual impairment, hearing problem, locomotor problem (difficulty in walking) and problems in speech are common forms of disability among elderly. Senility and neurosis are common mental illness reported among elderly (National Sample Survey, 52nd Round, 1998).

[21] Rajan, S.I, Risseeuw, C.I, Pereira, M., *Care of the aged: gender, institutional provisions and social security in India*, The Netherlands and Sri Lanka, www.idpad.org/pdf/3.2.pdf, accessed on 20th February, 2007

3. VULNERABILITY DUE TO DISABILITY

Disability poses greater challenges in obtaining the needed range of services. Persons with disabilities face several forms of discrimination and has reduced access to education, employment and other socio-economic opportunities. In India, there is an increase of proportion of **disabled population**. The proportion of disabled population in India is about 21.9 million. The percentage of disabled population to the total population is about 2.13 per cent. There are two broad categories of disability, one is *acquired* which means disability acquired because of accidents and medical reasons the other is *disability since the onset of birth*. According to the National Sample Survey Organisation Report (58th Round), about one-third of the disabled population have disability since their birth. There are interstate and interregional differences in the disabled population. The disabled face various types of barriers while seeking access to health and health services. There are different types of disability and the needs of the disabled differ accordingly. Among those who are disabled women, children and aged are more vulnerable and need attention.

Mental illness is a prominent form of disability.[22] Five out of ten leading causes of disability and premature death worldwide are due to psychiatric conditions.[23] Depression and anxiety are the most common mental disorders. Psychotic disorders such as schizophrenia and bipolar disorder, although less common are profoundly disabling. The other area of concern is the mental health of women and the elderly. Neurotic and stress related cases are reportedly higher among women than men though among men there is reporting of higher number of cases of serious illness. Dementia and major depression are two of the leading contributors to mental diseases in older people. But inspite of such proportion of mental illness, the health care provisions for persons with mental illness are very poor in India. People with mental illness face severe forms of human rights violations. In Special Homes, Hospitals and Asylums, they are kept in chains, denied basic needs like food, clothing and face different forms of abuse. There is social stigma attached to mental illness. Women with mental illness are subjected to physical and sexual abuse both within families and the institutions.

Available Provision of Care for Mental Illness

Total psychiatric beds per 10,000 population	0.25
Psychiatric beds in mental hospitals per 10,000 population	0.2
Psychiatric beds in general hospitals per 10,000 population	0.05
Psychiatric beds in other settings per 10,000 population	0.01
Number of psychiatrist per 100, 000 population	0.2
Number of psychiatric nurses per 100,000 population	0.05
Number of psychologist per 100,000 population	0.03

Mental Health in India-An Overview, 2006

[22] 2001 Census reported on *Mental Illness* as a form of disability.
[23] World Health Organization, 2002.

There are 42 mental hospitals in the country with bed availability of 20,893 in the government sector and another 5096 in the private sector hospital settings to take care of an estimated 1,02,70,165 people with severe mental illness and 5,12,51,625 people with common mental disorders. Psychiatric medicines are supplied only in a few primary health centers, community centers and district hospitals. Services like child guidance and rehabilitative services are also available only in mental hospitals and in big cities. Several states do not have mental hospitals (Mental Health in India-An Overview, 2007).

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, commonly referred as the PWD Act came into force on Feb. 7, 1996. Mental illness has been considered in the Act, but there is no reference to any provision within the Act to be given or set aside for people with mental illness. The Act also does not assure the right to treatment.

Person suffering from mental disabilities are particularly vulnerable to discrimination. This impacts negatively on their ability to access appropriate treatment and care. There is also stigma associated with mental illness due to which they experience discrimination in many other aspects of their lives affecting their rights to employment, adequate housing, education etc.

4. VULNERABILITY DUE TO MIGRATION

Migrants and their denial of rights have to be understood from the existing contradictions within and across countries—from skilled and voluntary migrants at one end of the spectrum to the poor and unskilled migrant population on the other end destined to be excluded from the fabric of the host nation/areas. For the latter, the intersection of human rights and migration is a negative one, with bad experiences throughout the migratory 'life cycle', in areas of origin, journey or transit (in case of international migrants) and destination. The intersection of health and human rights becomes even more complex when irregular or illegal migration clashes with the interest of the area of destination. Cases of exploitation of migrants by employers, smugglers or traffickers in such cases never meet justice. All these directly impact the rights of individual migrants.

India has a large number of international migrants. About 5.1 million persons are *migrants by last residence* from across the international border in India (2001 census). Neighbouring countries are the main sources of origin of the international migrants to India with the bulk of these migrants coming from Bangladesh, followed by Pakistan and Nepal. But these are migrants who have entered the country legally.

Migrants and mobile people become more vulnerable to HIV/AIDS. By itself, being mobile is not a risk factor for HIV/AIDS. It is the situations encountered and behaviours possibly engaged in during the mobility or migration that increases vulnerability and risk. Migrant and mobile people may have little or no access to HIV information, prevention (condoms, STI management), health services.

Source: **International Organisation for Migration** (2005), Health And Migration: Bridging the Gap, Geneva: International Organisation for Migration

There are many who enter the country illegally. Those are the one who are most vulnerable to abuse and exploitation by employers, migration agents, corrupt bureaucrats and criminal gangs. In many situations, migrants do not know what rights they are entitled to and still less how to claim them, hence the cases of abuse go unrecorded. Another area where exploitation is rampant is forced labour which takes place in the illicit underground economy and hence tends to escape national statistics. Illegal migrants often live on the margins of society, trying to avoid contact with authorities and have little or no legal access to prevention and healthcare services. They face higher risks of exposure to unsafe working conditions.[24] Many often they do not approach the health system of the host countries for fear of their status being discovered.

Internal migration of poor labourers has also been on the rise in India. The poor migrants usually end up as casual labourers within the informal sector. This population is at high risk for diseases and faces reduced access to health services. In India, 14.4 million people migrated within the country for work purposes either to cities or areas with higher expected economic gains during the 2001 census period.[25] Large number of migrants are employed in cultivation and plantations, brick-kilns, quarries, construction sites and fish processing (NCRL, 2001). Large numbers of migrants also work in the urban informal manufacturing construction, services or transport sectors and are employed as casual labourers, head loaders, rickshaw pullers and hawkers. The rapid change of residence due to the casual nature of work excludes them from the preventive care and their working conditions in the informal work arrangements[26] in the city debars them from access to adequate curative care.

International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families

Article 43

1. Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to: e. Access to social and health services, provided that the requirements for participation in the respective schemes are met.

[24] Allotey Pascale (2003), "Is Health a Fundamental Right for Migrants", Guest Editorial Column in the journal *Development*, Vol 46, No 3, September.

[25] The National Commission on Rural Labour (NCRL) estimates the number of internal labour migrants in rural areas in India alone at around 10 million (including roughly 4.5 million inter-state migrants and 6 million intra-state migrants in 1999-2001). The 2001 Census, has recorded about 53.3 million rural to rural migration within the country.

[26] Delay in health-seeking also due to associated costs, inability to miss work, problems of transportation. Many are unfamiliar with the local health-care systems and have linguistic or cultural difficulties communicating their problems.

Among the migrants who are vulnerable, the Internally Displaced People (IDPs) deserve mention. In India, the Internally Displaced People are estimated to be around 6 lakhs (IDMC, 2006). Internal displacement arises out of ethnic conflicts, religious conflicts, political reasons, development projects, natural disaster etc. The Internally Displaced People are vulnerable to health risks and access to treatment. The emotional stress of displacement and the toll that this takes does have a great impact on physical as well as mental health. Large number of mental health problems are reported among Internally Displaced People. Stress disorder leads to cardio-vascular stress, psycho-trauma, endocrine stress, musculo-skeletal stress, stress-belly (ulcers etc) and cranial stress (tension headaches and migraines). Hypertension, reactive depression and nervous breakdown are common even among the youth who are Internally Displaced People. There are reports of lack of basic facilities like food, medical supplies and sanitation in the State government organized relief camps for the internally displaced people in case of a political conflict (Human Rights Watch, April 2006).

Women and child migrants are the most vulnerable. In the case of internal migration in India, women and children mostly migrate as *associated* migrants with the main decision to migrate being taken by the male of the household. As associated migrants, they suffer greater vulnerability due to reduced economic choices and lack of social support in the new area of destination. In the case of semi-skilled, low-skilled or unskilled women migrants, this can translate into their entry into the low paying, unorganized sector with high exposure to exploitation and abuse. International migration of women for employment has also increased.

In India, there are a large number of international women migrants. Female migration to India constitutes 48 per cent of the total in-migration from other countries. Migration among women has been high from Bangladesh and Nepal as compared to other neighbouring countries. Low/skilled or semi-skilled migration has an impact on their choice of occupation and the conditions of work. Many of the low/semi-skilled female migrants work in the unorganized sector,[27]

[27] Many of the migrant women work as domestic help, in beauty parlours as helpers, sweepers, prostitutes etc.

Integrating Health and Migration: Achieving a Balance

Receiving Population
- Improved disease protection
- Better resource utilization
- Infrastructure support
- Improved health and productivity

Migrant Population
- Timely and safe movement
- Targeted health intervention
- Reduced morbidity and mortality
- Better health care access-reduced stigma

Migrant workers often fall outside of state-sponsored health programmes

in hazardous conditions, live in shanty arrangements and are denied access to health and healthcare.

Trafficking also contributes to the cross-border movement of a large proportion of women and children into other countries. There are established routes of trafficking in India, used to facilitate the movement of women and children from across the borders in order to sustain the underground economy. Women and children in an irregular situation are doubly vulnerable owing to their lack of proper legal status and high risk of sexual exploitation and suffer from poor antenatal care coverage, prevalence of anemia, prevalence of reproductive tract infections experience high incidences of violence. Children of poor migrant parents suffer from malnutrition and low immunization due to their parents' perpetual low-income uncertain jobs that necessitate frequent shifts based on concentration and are more susceptible to HIV/AIDS infection.

5. VULNERABILITY DUE TO STIGMA AND DISCRIMINATION (People living with HIV/AIDS, Sexual Minorities)

There are certain attitudes and perceptions towards certain kinds of illnesses and sexual orientation which results in discrimination against individuals/groups. This section deals with the stigma and discrimination faced by the People living with HIV/AIDS and Sexual Minorities. These groups face various kinds of discrimination and have reduced access to healthcare. Stigma is the greatest barrier of health and healthcare in their context. Negative responses and attitude of the society towards these groups are strongly linked to people's perception of the causes of HIV / AIDS and sexual orientation.

The rights of **People living with HIV/AIDS** are violated when they are denied access to health, education, and services. They suffer when their close or extended families and friends fail to provide them the support that they need. India's National AIDS Control Organization (NACO) estimated in 2005 that there were 5.206 million HIV infections in India, of which 38.4 per cent occurred in women and 57 per cent

Stigma refers to attitudes that certain groups are inferior in one or many ways based on their membership in a group.

The term "discrimination" is used whenever people are treated adversely, either by treating them differently where they should be treated the same or by treating them same where they should be treated differently. *Discrimination* is breach of human rights obligation. Discrimination leads to violence, torture, and exclusion from the society. It impacts upon the health. Treating people equally does not necessarily mean that people should be treated the same.

occurred in rural areas.[28] Many experts argue that the current figures are gross underestimations and that a significant number of AIDS cases go unreported or untracked. Prevalence estimates are based primarily on sentinel surveillance conducted at public sites. The national information system for collecting HIV testing information from the private sector is very weak.

A sizeable proportion of population are now living with HIV / AIDS. Expanding access to essential drugs including ARV (Antiretroviral) treatment for people living with HIV / AIDS is the pressing challenge most nations are facing.

Vulnerability to HIV is also increased by the lack of power of individuals and communities to minimize or modulate their risk of exposure to HIV infection and once infected, to receive adequate care and support. Some individuals are more vulnerable to the infection than others. Low status of woman may force a monogamous woman to engage in unprotected sex with her spouse even if he is engaging in sex with others. Similarly adolescent girls and boys may be vulnerable to HIV by being denied access to preventive information, education, and services. Sex workers may have greater vulnerability to HIV if they cannot access services to prevent, diagnose, and treat sexually transmitted infections, particularly if they are afraid to come forward because of the stigma associated with their occupation.

There are strong perceptions of the causes of AIDS, routes of transmission, and their level of knowledge about the illness. These are compounded by the marginalization and stigmatization on the basis of such attributes as gender, migrant status or behaviors that may be perceived as risk factors for HIV infection. For example, women whose husbands have died of AIDS are rejected by their own and their husband's families and they are denied property inheritance of their husbands.

The available provisions of care are inadequate. Since April 1, 2004, anti-retroviral treatment is provided free of cost in India, at government hospitals in the six high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnakata, Manipur, and Nagaland. However, of the estimated 5.1 million people living with HIV/AIDS in 2005, 600,000 people needed antiretroviral therapy, but only 7,000 adults were receiving such treatment through the government programme. Besides anti-retroviral drugs there is shortage of several other drugs

[28] NACO HIV/AIDS epidemiological Surveillance & Estimation report for the year 2005, April 2006 http://www.nacoonline.org/fnlapil06rprt.pdf

Stigma is different than discrimination. It is more about attitude than practice. *Discrimination* is more overt than stigma. But stigma and discrimination are linked to each other as stigma permits or promote discrimination.

in the public facilities which are needed by persons living with HIV/AIDS. People living with HIV/AIDS face discrimination even from the health providers who deny them quality of care. Negative attitudes from health professionals generate anxiety and fear among people living with HIV/AIDS, and as a result many do not reveal or seek treatment for their HIV status.[29]

Another group that faces stigma and discrimination are the **sexual minorities**. Those identified as gay, lesbian, transgender, bisexual, kothi and hijra, experience various forms of discrimination within the society and the health system. Due to the dominance of heteronomous sexual relations as the only form of normal acceptable relations within the society, individuals who are identified as having same-sex sexual preferences are ridiculed and ostracized by their own family and are left with very limited support structures and networks of community that provide them conditions of care and support. Their needs and concerns are excluded from the various health policies and programmes. Only the National AIDS Prevention and Control Policy recognize sexual minority and homosex in the context of identifying 'high risk behaviour'. But pervasive discrimination from the health providers delays or deters their health seeking. Hence they remain excluded from the process of government surveillance carried among the high risk population in the context of HIV/AIDS. The surveillance amongst 'MSM' or men who have sex with men, is usually carried out by NGOs and through 'support groups', i.e. amongst males who are accessible to NGOs and who are willing to identify with categories, such as kothi, around which support groups are structured (Khanna 2006). They also undergo considerable amount of psychological stress.

[29] USAID, 2005

Section 3

WHAT CONSTITUTES VIOLATION OF RIGHT TO HEALTH FOR VULNERABLE GROUPS?

The violation of the right to health of vulnerable groups may result from *direct* government action, from *failure* of the government to fulfill its minimum core obligations and from the patterns of systematic *discrimination*. The specific examples of violations of right to health of vulnerable groups would be:

- Deliberate withholding or misrepresentation of information on the health status of disadvantaged groups that may have been essential for the prevention and treatment of illness or disability.
- Imposing discriminatory practices affecting the group's health status and needs.
- Adopting laws and policies that interfere with the rights of the groups, for example, women's reproductive rights.
- Failure to protect women against violence; violence against women is often systematic and serious enough to require women to seek hospital treatment for injuries and involve other health complication related to violence. When governments fail to take preemptive steps to prevent and treat victims of violence it is tantamount to violation of right.
- Failure of government to provide adequate public health measures against infectious diseases that affect the disadvantaged groups.
- Failure to cover the eligible population with child immunization packages.
- Failure to provide adequate obstetric and family planning services
- Failure to provide adequate primary healthcare, basic healthcare service to disadvantaged group.

The right to the highest attainable standard of health (referred to as "the right to health) was first reflected in the WHO Constitution (1946)[30] and then reiterated in the 1978 Declaration of Alma Ata and in the World Health Assembly in 1998. It has been firmly endorsed in a wide range of international and regional human rights instruments

[30] Basic Documents, forty-third edition, Geneva World Health Organisation, 2001. The constitution was adopted by the International Health conference in 1946.

- Inappropriate health resource allocation including disproportionate investment of public resources in ways that benefit the health of only a narrow section of the population, i.e., when government spends in expensive diagnostic and curative health services and equipment that limited number of privileged people can afford and on the other hand primary and preventive health services which large section of people use, suffer due to lack of adequate funds. Such a pattern of financing is a form of indirect discrimination affecting the health and healthcare of vulnerable groups.
- Government policies and practices creating imbalances in providing health services, i.e., poor infrastructure in rural areas or predominantly tribal areas.
- Systematic discrimination in access to medicines and essential drugs for particular groups, i.e., HIV/AIDS drugs, reproductive health services for particular groups like women living in poverty, in rural areas, belonging to marginalized communities.

Section 4

ADVOCACY ON HEALTH AND HUMAN RIGHTS OF VULNERABLE GROUPS IN INDIA

- Identify disadvantaged/marginalized groups; their health status and needs in different situations
- Review the health information and services that are available to protect the health of the poor, vulnerable, or otherwise disadvantaged groups, including their quality, accessibility, affordability and acceptability.
- Collect disaggregated information on the health disparities among the marginalized groups. Identify the unmet need, particularly those resulting from adverse discrimination
- Assess the relevance of public health messages and determine whether they are accessible and meaningful.
- Assess whether the vulnerable group's dignity is preserved by the health services made available to them; whether they have the necessary health information and services that they require; whether they are allowed freedom for the choice of treatment; whether their full, free and informed consent was obtained during specific interventions; and whether confidentiality has been a part of the treatment where it was necessary.
- Identify barriers to the implementation of relevant laws, obligations and commitments; this could mean lack of political will; weak infrastructure or mechanisms for effective administration of policies and programmes; harmful traditional practices; cultural norms or policies imposed by and as a result of adverse reforms of the health sector to funding health services

[31] Many are spelt out in specific human rights instruments, such as the international labour organization convention concerning indigenous and tribal peoples in Independent Countries (No. 169, 1989) and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990)

Substantive Elements of Right to Health[31]

- Safeguarding human dignity.
- Paying attention to those population groups considered most vulnerable in society – children (girls and boys), adolescents, women and men; indigenous and tribal populations; national, ethnic, religious and linguistic minorities; internally displaced persons; refugees; immigrants; the elderly persons with disabilities; prisoners; economically disadvantaged or otherwise marginalized and/or Vulnerable groups.
- Ensuring health systems are made accessible to all, especially the most vulnerable or marginalized sections of the population.
- Using a gender perspective, recognizing that both biological and socio-cultural factors play a significant role in influencing the health of men and women, and that policies and programmes must consciously set out to address these differences.
- Ensuring equality and freedom from discrimination in the design and implementation of health programmes.
- Disaggregating health data to detect underlying discrimination.
- Ensuring participation of beneficiaries in the decision-making process of health development policies or programmes targeted for them.

- Promoting and protecting the right to education and the right to seek, receive and impart information and ideas concerning health issues. The right to information should not impair the right to privacy, which means that personal health right should be treated with confidentially. This is particularly important while dealing with HIV/AIDS.
- Esuring the optimal balance between good public health outcomes and the promotion and protection of human rights.
- Identifying benchmarks and indicators to ensure monitoring of the progressive realization of rights in the field of health.
- Increasing transparency in, and accountability for, health as a key consideration at all stages of programme development.
- Incorporating safeguards against potential violations upon vulnerable groups.
- The health system must have in-built processes and mechanisms to protect and promote health rights for all.

- Promote capacity-building among health professionals to ensure conformity with the right to health in service delivery.
- Examine the curricula of medical and other health professional training schools and advocate for the inclusion of health and human rights of vulnerable groups in Medical Education.
- Increase public awareness on the right to health of the vulnerable groups and engage in community education and mobilization.
- Assess government compliance with specific obligations; whether government is meeting minimum essential level of health rights; whether there is systematic discrimination associated with the treatment of poor, vulnerable and otherwise disadvantaged groups.
- Undertake advocacy to facilitate change by identifying violations to right to health; familiarize yourself with the nature of the state obligations arising from the right to health and the common ways in which government violates them; document any identified violations and use it as a basis for monitoring and advocacy.
- Work on national enforcement procedures to ensure state accountability.
- Prepare parallel reports.

Section 5

ADVOCACY FOR RIGHT TO HEALTH INTERNATIONALLY

Advocacy for right to health of vulnerable groups involves identifying the barriers to health and healthcare of the vulnerable and disadvantaged groups and lobbying for their rights with the government nationally and internationally. The rights of the vulnerable groups are recognized in numerous international instruments. The **International Covenant on Economic, Social and Cultural Rights** which provides the most comprehensive article on the right to health in the international human rights law recognizes the health needs of the vulnerable groups and explains by illustrations a number of steps to be taken by the State parties to achieve the full realization of the right to health of general population and vulnerable groups in particular. The signatories of the Treaty of International Covenant on Economic, Social and Cultural Rights representing nearly 155 governments of the world made an international commitment to protect and respect, **Right to Health** of the population of the respective nations as Parties while another 66 governments are Signatory Parties of the Covenant. The Treaty came into force on the 3rd January 1976.

By ratifying international human rights treaties that affirm the right to health, a state agrees to be accountable to the international community, as well as to the people living within its jurisdiction, for the fulfillment of its obligations. State parties to an international human rights treaty are required to adopt **legislative measures** and to employ all *appropriate means* to ensure that the population can enjoy

The General Comment sets out four criteria by which to evaluate the right to health[32]

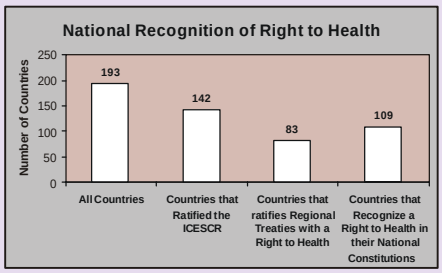
A) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity[33]

B*) Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
Non-discrimination[34]
Physical accessibility;[35]
Economic accessibility (affordability);
Information accessibility.

C) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

D) *Quality*. Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

[32] General Comment 14.
[33] This should include the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO action programme on Essential Drugs.
[34] Health facilities, goods and services must be accessible to all, in law and in fact, without discrimination on any of the prohibited grounds.
[35] Health facilities, goods and services must be within safe physical reach for all the section of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous population, women, children adolescents and older persons

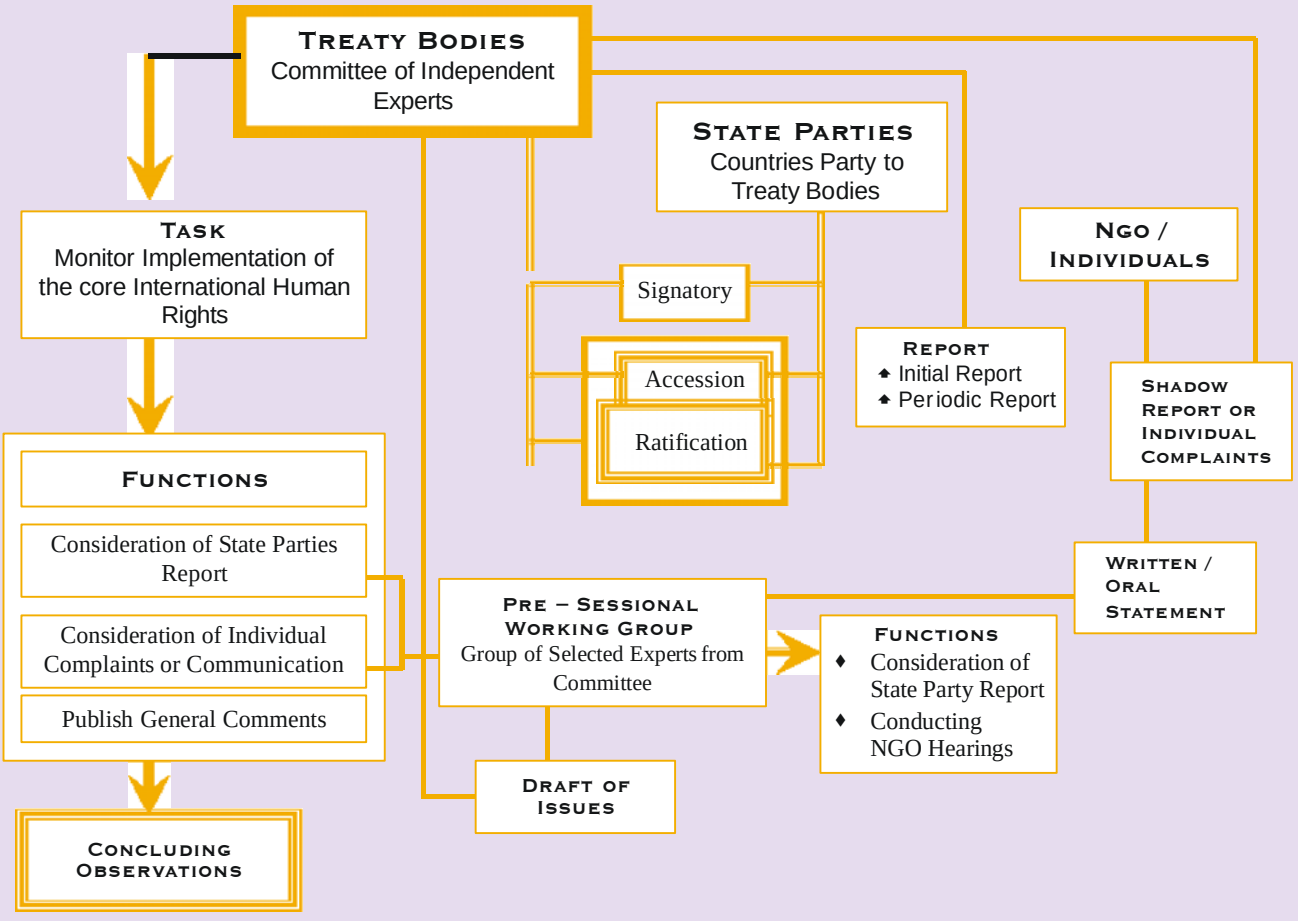


Source: Eleanor D. Kinney, The International Human Right to Health: What Does This Mean For Our Nation And World? Indiana Law Review, Vol. 34, Pg 1465, 2001

the rights conferred by the treaty. This means that international treaty provisions must be incorporated into the domestic legislation. Individuals and communities can access effective judicial or other appropriate remedies in the face of violations of their rights. A central advocacy principle for NGOs using a human rights approach to health hence should be that governments are accountable for their obligations under international law, regional law, and within the framework of national constitutions and legislation.

Monitoring and state compliance with universal norms of human rights related to health is an essential component of the Treaty of Economic Social and Cultural Rights. There are three forms of monitoring rights: **investigative reports** prepared by the special rapporteurs or working groups; **individual complaint** procedures by which nationals and other residents of a state can complain to international bodies for alleged violations of their human rights; and **reports prepared by states** which have ratified international human rights conventions and which therefore are parties to the convention. Such reports are submitted periodically to the international expert bodies set in conformity with the convention. The periodic reports are examined in the presence of representatives from the state concerned. Reporting obligations are built into the convention as a mechanism for monitoring the human right. NGOs involved in monitoring the right to health must ensure that the governments send periodic reports to the Committee on Economic Social and Cultural Rights. They can also send parallel reports to the committee.

Chart 1: How Human Rights Treaty Ensures Protection of Human Rights



Section 6

SCOPE AND LIMITATIONS OF THE INDIAN STATE VIS-A VIS RIGHT TO HEALTH

Existing Constitutional Provisions in India that can be used to evolve right to health and healthcare

Articles 41, 42 and 47 of the Directive Principles enshrined in Part IV of the Constitution provide the basis to evolve right to health and healthcare:

41. Right to work, to education and to public assistance in certain cases: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

42. Provision for just and humane conditions of work and maternity relief: The State shall make provision for securing just and humane conditions of work and for maternity relief.

47. Duty of the State to raise the level of nutrition and the standard of living and to improve public health: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

The **Constitution of India** and the laws do not accord health and healthcare as rights to the population in general. While civil and political rights are enshrined as fundamental rights that are justiciable, social and economic rights like health, education, livelihoods etc. exist as Directive Principles for the State and are hence not justiciable. There are however instances in which cases have been filed in the various High Courts of states and Supreme Court of India on the right to life, Article 21 of the Indian Constitution, or on the various directive principles to demand access to healthcare, especially in emergency situations.

International protection of human rights is only effective when they are made viable by national protection. National-level legislation, policies and enforcement mechanisms are the key factors in rights being operationalized for individuals and groups within a nation. National laws offer variable degrees of protection against human rights violation and enables national bodies to hear cases of denial and enforce the norms. At present there is a problem of justiciability of the Right to health in Indian Constitution since the same is not protected by national legislation. Though India has ratified the Treaty on the Economic Social and Cultural Right which covers Right to Health (Article 12), that cannot be effectively used to advocate for right to health in India. The Courts or petitioners can merely derive inspiration from the treaties on the cases on denial/violation on right to health but may not be able to use it effectively to deliver justice. The international treaties have only an **evocative significance** unless protected by national legislation. Absence of national legislation on right to health in India is the main reason why it cannot be realized.

Health and human rights advocacy in India needs to intensify the attempts towards transforming the critical principles of the Directive principles on health and work into independent rights through rigorous judicial activism, i.e., filing Public Interest Litigations, gathering testimonials for denial on right to health, etc. There needs to be a concerted move towards making a national legislation on right to health.

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INTERNATIONAL INSTRUMENTS RELATING TO SPECIFIC GROUPS

WOMEN

- Convention on the Elimination of All Forms of Discrimination against Women (1979) - http://www.ohchr.org/english/law/cedaw.htm
- Declaration on the Elimination of Violence against Women (1993) – http://www.unhchr.ch/html/menu3/b/21.htm
- General Recommendation 14 of the Committee on the Elimination of Discrimination against Women (CEDAW) on female circumcision (1990) – http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm
- General Recommendation 19 of CEDAW on violence against women (1992) - http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm
- General Recommendation 24 on women and health (1999) - http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm

CHILDREN

- Convention on the Rights of the Child (1989) – http://www.unhchr.ch/html/menu3/b/k2crc.htm
- ILO Convention No 138 (Minimum Age for Admission to Employment, 1973) – http://www.ilocarib.org.tt/childlabour/c138.htm
- ILO Convention No 182 (Worst Forms of Child Labour Convention, 1999) - http://www.ilocarib.org.tt/childlabour/c182.htm
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice (1985) - http://www.unhchr.ch/html/menu3/b/h_comp48.htm
- United Nations Rules for the Protection of the Juveniles Deprived of their Liberty (1990) - http://www.unhchr.ch/html/menu3/b/h_comp37.htm
- Declaration of the Rights of the Child (1959) - http://www.unhchr.ch/html/menu3/b/25.htm
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MIGRANT WORKERS & REFUGEES

- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990) - http://www.ohchr.org/english/law/cmw.htm
- Convention related to the status of refugees (1951) – http://www1.umn.edu/humanrts/instree/v1crs.htm

PEOPLE WITH DISABILITIES INCLUDING MENTAL DISABILITIES

- **Declaration of the Rights of the Disabled Persons (1975) – http://www.unhchr.ch/html/menu3/b/72.htm**
- **Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) – http://www.un.org/ecosocdev/geninfo/dpi1647e.htm**
- **Principles of Protection of Persons with Mental Illness and the Improvement of Mental Healthcare (1991) - http://www.unhchr.ch/html/menu3/b/68.htm**
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- **Human Rights Committee General Comment 21 (1992) - http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument**

ELDERLY

- **United Nations Principles for Older Persons (1991) – http://www.un.org/esa/socdev/iyop/iyoppop.htm**
- **CESCR General Comment 6 on the economic, social and cultural rights of older persons (1995) - http://www.unhchr.ch/tbs/doc.nsf/099b725fe87555ec8025670c004fc803/482a0aced8049067c12563ed005acf9e?Opendocument**

RACIAL AND ETHNIC GROUPS

- **International Covenant on the Elimination of All Forms of Racial Discrimination (1965); ILO Convention No 169 - http://www.ohchr.org/english/law/cerd.htm**
- **Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992)**

‘It is my aspiration that health will finally be seen, not as a blessing to be wished for; but as a human right to be fought for. It is important to note that while many countries have legislation that provide for various elements of the right to health, including constitutional provisions on non-discrimination, many of them have failed to introduce the procedures or mechanisms required for enforcing such laws. In addition, the tendency to regard economic, social and cultural rights, including the right to health, as second-class rights that are more akin to policy goals than justifiable (legally enforceable rights) rights has resulted in there being comparatively few legal precedents for their enforcement. This situation, however, is changing. There is an increasing number of examples of court cases, as well as other laws and decisions at the international, regional and national level that confirm the justifiability of the right to health.’

Kofi Annan,
Former UN Secretary General

Centre For Enquiry Into Health And Allied Themes
Research Centre Of Anusandhan Trust

CEHAT, in Hindi means "Health". CEHAT, the research centre of Anusandhan Trust, stands for research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. Its institutional structure acts as an interface between progressive people's movements and academia.

CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

We are a multi disciplinary team with training and experience in Medicine, Life Sciences, Economics, Social Sciences, Social Work, Journalism and Law. CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients' Rights, (3) Women's Health, (4) Investigation and Treatment of Psycho-Social Trauma. An increasing part of this work is being done collaboratively and in partnership with other organisations and institutions.

Previous Publications

		Year of Publication
1	Review of Health Care in India: Country Health report	2005
2	Health and Health Care in Maharashtra: Health Status Report of Maharashtra (in English and Hindi)	2005
3	Health Facilities in Jalna: A Study of Distribution, Capacities and Services Offered in a District in Maharashtra	2004
4	Health and Health Care Situation in Jalna, Yawatmal and Nandurbar	2004
5	Population Ageing And Health In India	2006
6	Gendered Vulnerabilities: Women's Health And Access To Healthcare In India	2006
7	Tracing Human Rights In Health	2006
8	Identities in Motion; Migration and Health In India	2006
9	Disability, Health and Human Rights	2006
10	The Right to Health and Sexuality	2006
11	Health & Healthcare in Assam	2007

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