JOURNAL OF HEALTH STUDIES

From the Editors' Desk

This second issue of the Journal of Health Studies brings to you a collection of original papers on diverse areas. Sociological research on diseases has not been a major component of health studies in India. Arima Mishra, Tulsi Patel and K.Srinath Reddy report on the social reconstruction of chronicity: case of heart disease in India. The article raises a number of questions: How is chronicity defined? How important is the labelling of a disease as acute or chronic and how does it affect the management, control and prevention of the disease.

Raju Prasad Chagai, a public interest lawyer working in Khatmandu explores the trajectory of public interest litigation in Nepal. It aims particularly at assessing the applicability of public interest litigation in enhancing enforceability of reproductive rights.

'Eliminating Childhood Malnutrition' is a research note reports on a systematic study based on formal and informal discussions with mothers and anganwadi workers on the benefits or otherwise of supplementary nutrition programmes. The authors A.R.Dongre, P.R.Deshmukh and B.S.Garg of the Mahatma Gandhi Institute of Medical Sciences, Sewagram point out that there is an urgent need to change the design of the programme if it is to be useful.

In a thought provoking essay Adriaan van Es of the International Federation of Health and Human Rights Organisations takes a candid look at the involvement of health workers in the struggle against human rights violations.

We record the sad passing away of Deepti Chirmuley, a paediatrician by training and a long-time health activist and educator well-known to the health movement. Shyam Ashtekar writes a note in memoriam.

All the articles are open to discussion. Please send discussion notes to jhsindia@gmail.com.

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Social Construction of Chronicity Case of Heart Disease in India

Arima Mishra*
Department of Sociology, Delhi School of Economics, University of Delhi

Tulsi Patel
Department of Sociology, Delhi School of Economics, University of Delhi

K. Srinath Reddy
President, Public Health Foundation of India,

Abstract: Heart diseases, medically understood, are chronic diseases that develop gradually with multiple risk factors, require long-term care of the ill and can be controlled and prevented. Drawing on evidence from focus group discussions held with communities in Delhi, India the authors find that chronicity is far from central to the understanding of heart diseases among community members. Community members understand heart disease in terms of 'sudden onset of symptoms', 'sudden death', 'serious killer', and 'dangerous disease'. Such perceptions negate the conventional definitions of chronicity as slow acting, persistent and morbidity oriented. The article raises and discusses a series of questions: How is chronicity defined? What is the point of emphasis in the definition, i.e. persistence, etiology, morbidity or disability? How important is the labeling of a disease as acute or chronic? How does it affect the management, control and prevention of the disease?
**Corresponding author's Email:*

Research on chronic illness continues to grow in medical sociology. The recent reviews of the major contributions to the field provide only a glimpse of the huge body of literature that capture the diversity of illness experience, offer a range of concepts and methods to understand chronic illness [Pierret 2003; Lawton 2003; Williams 2000; Throne, Paterson, Acron et al 2002]. The study of chronic disease is of no less interest to medical scientists including epidemiologists, albeit for different reasons. The latter are more interested in intervening in the disease process to be able to prevent and control it. Consequently, research is geared towards designing preventive strategies targeting at the whole population as well as those at high risk. Our interest in chronic illness and/or disease, in this paper, however is very specific. We raise a simple yet fundamental question regarding the notion of chronicity associated with heart diseases. Medically defined, heart diseases are chronic diseases that develop gradually with multiple risk factors. However, the lay understanding of heart disease is in terms of `sudden onset of symptoms', `sudden deaths', `serious

killer', `dangerous disease' as was found to prevail among community members in India. This negates the traditional definitions of chronicity as slow acting, persistent and morbidity oriented. How then is chronicity defined? What is the point of emphasis in the definition i.e. persistence, etiology, morbidity or disability? How important is the labeling of a particular disease as acute or chronic? The paper seeks to discuss some of these questions in the context of the evidence on the understanding of heart disease based on focus group discussions conducted with community members in Delhi, India.

The paper falls into four main parts. The first part reflects on the understanding of chronicity in medical discourse, the second revisits chronicity in the context of medical sociology's contributions to the study of chronic illness, the third examines chronicity in lay discourse with specific reference to a community's understanding of heart diseases in India. The fourth concludes the paper by problematising the definition of chronicity associated with heart diseases.

I
Understanding Chronic Conditions in Medical Discourse

It is acknowledged by medical scientists, that the definition of a chronic disease or condition is problematic. While persistence, residual disability, non-reversible pathological alterations, long-term supervision of the ill are associated with chronic diseases, persistence for all practical purposes serves as a point of departure between acute and chronic disease. However, persistence is not clearly defined. Park argues that 'there is no international definition of what duration should be considered long-term, although many consider chronic conditions are generally those that have had a duration of at least 3 months' (2001:270). He puts the definitional issue to rest by saying 'A practical definition should be established which will suit the particular conditions of the community' (ibid). Defining a chronic disease or condition is in fact a non-issue for medical scientists compared to issues of managing, controlling and preventing these diseases.

It is not chronic diseases per se but chronic non-communicable diseases that have received attention of the global public health community since the mid-nineteenth century. The widely quoted epidemiological transition theory [Omran 1971; Olshansky and Ault 1986] suggests that with modernisation and advanced levels of development characterising improved standard of living, better nutrition, improved sanitation and environmental hygiene, advances in the field of medicine (prevention of many childhood related diseases through immunisation, for example) societies experience a changing disease burden from acute, communicable diseases (for example, cholera, small pox, measles) to chronic, non-communicable diseases (cancer, cardiovascular diseases, asthma, arthritis). The epidemiological transition implies corresponding changes in the demographic composition of societies with an increasing number of people surviving to adulthood and beyond. This has become possible due to reduction in mortality particularly of infants and children due to

acute childhood related diseases. Thus the chronic non-communicable diseases are the diseases of the adults and the old. The epidemiological transition might have implied a uni-directional process when it was originally conceived in the seventies. However, as the experience in many countries shows, the process is more complex and dynamic [Wahdan 2003]. Most of the developing countries are experiencing both communicable and non-communicable diseases which is aptly termed as the 'double burden of disease' while some of the new forms of communicable diseases (HIV/AIDS, for example) are surfacing even in developed countries.

Apart from the shift of burden of diseases, the significance of the epidemiological transition lies in its contribution to theorizing chronic non-communicable diseases, i.e. explaining the incidence of these chronic diseases. Labarthe thus argues in the context of increased rates in deaths due to heart diseases (from a little more than 100 deaths to about 400 deaths per 100,000 population) in mid-nineteenth century in Unites States,

> Such vast shifts in causes of death stimulate strong epidemiological interest, because they must reflect profound changes in the factors that influence health and disease. Factors that are identified or confirmed through their association with such trends may constitute clues to causation or point to potential interventions (1998:6).

Thus the epidemiological transition witnessed an upsurge of epidemiological surveys that looked for 'associations' between social, behavioral, biological factors and the incidence of the diseases. Such associations get refined later in the 'risk factor approach' [Aronowitz 1998] Several epidemiological surveys, for instance, have established the risk associated with high blood pressure, obesity, high cholesterol, physical inactivity and smoking with chronic non-communicable diseases like cardiovascular diseases, diabetes, cancer, etc. [Keys 1970; Reddy 1993; Kruger, Venter and Vorster 2001; Rodgers, Greeway, Davies et al 2004; Kerner, Yang, Bianchi et al 2003; Limburg, Vierkant, Cerhan et al 2003]. Thus in the western medical discourse, etiology through risk factors, their control and prevention is central to understanding chronic diseases. Intervention in the disease process is significant to understand chronic diseases in medical discourse.

The risk factor approach is an important development in the study of chronic diseases for several reasons. Firstly, it signals a shift from the mono-causal, reductionist approach in biomedicine to a probable multi risk factor (causes which are more than one in number and also are less certain) approach in explaining the etiology of diseases. Thus it is not any bacteria or virus (an external agent) causing a disease but several endogenous factors such as biological, social, economic and environmental contribute to the incidence of these diseases. [2]

Secondly, the risk factor approach implied that chronic non-communicable diseases are preventable through controlling and preventing the risk factors. There is evidence, for example, to show that mortality and morbidity due to these diseases

have been reduced through controlling the associated risk factors in developed countries [Puska, Tuomilehto, Berrios and Vartianien 1995; Berrios and Puska 2001]. This has led to a shift in emphasis from merely treating diseases to preventing these. [3] The emphasis on prevention as part of management and control of the disease has made clinical practice more challenging than ever because treatment would not merely be medicinal through prescribing drugs but include non-medical measures that aim at lifestyle modifications [Abbraham 2004; Pescatellols, Fraklin, Fagard et al 2004]. Hence, health education on prescribed diet, physical activity, abstaining or reducing tobacco use, stress management need to be integrated into the management of chronic non-communicable diseases.

Thirdly, the risk factor approach puts the onus of responsibility for the disease to a great extent (both for risking the disease and controlling/preventing it) on the individuals. Thus an individual risks heart disease when he adopts an unhealthy life style implying when he chooses to smoke, be physically inactive, consumes fatty diet etc. whether he is aware or not of the dangers associated with such behavior. Thus, Brundtland, the director –General of the World Health Organization (WHO) in the 2002 Annual Report of the WHO (aptly Titled 'Reducing Risks: Promoting Healthy Life') says

> …the world is living dangerously--- either because it has little choice, or because it is making the wrong choice and describes the report "as a wake up call to the global health community.(emphasis added).

However, there has recently been considerable concern in medical discourse regarding the importance of social determinants of such risky behaviors. The concern is further expressed in the need to influence these behaviors through policy interventions for effective prevention and control of chronic non-communicable diseases. The central Tobacco Control Act (2003) targeting at sale, advertisements of tobacco products and passive smoking is one such example of policy intervention.

Fourthly, the focus on individuals/communities and prevention in relation to chronic diseases has resulted in a concern for understanding research questions at two levels, viz, individual and community and in two ways, i.e. not merely 'what' but the 'why' of risk factors. For example, why do people consume tobacco? Why do patients with suspected heart attack symptoms delay in seeking professional care? Why is aspirin not administered (self or by physicians) in primary emergency care? Why do people with diagnosed high blood pressure do not go for regular follow-ups? The research questions might not necessarily be explanatory alone but exploratory as well to understand community's perceptions about the disease, its risk factors and prevention. Such concern for research questions, which are beyond numbers, has resulted in an acknowledgement (among medical scientists) of the contributions of qualitative research through the works of social scientists. Thus recently there have been studies that advocate for triangulation of research

tools and methods (quantitative method typical of epidemiological surveys and qualitative characteristic of social science more particularly sociology/ anthropology). The study of chronic diseases thus provides a platform for greater academic exchanges between these two streams, a fact increasingly acknowledged both by anthropologists and medical scientists including public health specialists. This has resulted in a growing interest of studies exploring possibilities of combining research methods (qualitative and quantitative) and perspectives from these different streams in the larger interest of public health. [Baum 1995; Carey 1998; Roberts et al., 2002; Goering and Streiner 1996; Nakaash et al 2002; Nichter et al 2002].

II
Meaning of Chronicity in Medical Sociology/Anthropology

Chronic illness is being widely researched in medical sociology. We do not attempt to review the literature on chronic illness, a task that is neither feasible nor desirable in this paper. However, we glance through the major issues that have been addressed in the study of chronic illness, if only to understand the notion of chronicity. The study of chronic illness has a specific significance in medical sociology, which in our view, does not flow from the study of chronic illness in contrast to other forms of illness (acute forms of illness, for example) but its contribution to redefining the sociological meaning of health and illness in general. The emergence of much of the study on chronic illness can be traced to developments both in the field of western medicine and theoretical developments within sociology. On the former, the epidemiological transition ushered in a paradigm shift in western medicine in terms of theorizing diseases and changes in health care demands, i.e. emphasis on lifestyle modifications than only hospital based treatment. This amounts to advances in treatment designed for implementation of treatment outside the hospital walls, for example, measurement of blood pressure, urine and blood sugar, use of aspirin in first-aid for heart attack patients. These developments have established the need for addressing not merely new forms of diseases but new ways of looking at diseases, to begin with, extending the locus of study of illness from hospitals/ clinics to the community and creating space for studying linkages between micro-processes of health seeking practices at the individual/ community level and the macro social structures [Pescosolido 1996; Pescosolido and Levy 2002].

Such changes in the field of medicine have influenced but not necessarily shaped the agenda and scope of sociology of health and illness. Hence, it is not surprising that epidemiological transition does not find explicit mention in most of the qualitative research on chronic illness in medical sociology. Instead, it launches a broader attack on the medicalised notion of disease in western medicine. In this context, the theoretical developments in sociology, perspectives like symbolic interactionism, phenomenology and the social constructionist debate seem significant that have influenced the arena of much of the critical sociology of health

and illness.[4] Thus, most of the qualitative research on chronic illness is engaged explicitly or implicitly with an external critique of the biomedicine's view of disease (thus establishing a difference between disease and illness) and an internal critique of Parsons's concept of 'sick role'[Parsons 1951; Davison et al 1991]. Qualitative research on chronic illness addresses the dynamics of body, self and society by focusing on the meanings, interpretation and the experience of illness. Thus, lay conceptions of health and illness, which are culturally and socially embedded, are a subject of critical enquiry in medical sociology/anthropology. The focus is not on the patient or the sufferer alone but the sufferers in relation to others (family members, friends, relatives, healers/curers and the wider network). Illness in this context is not an individual but as Kleinman (1988) says, an `inter-subjective' experience5. The emphasis is on the shared meanings and experience of illness. It is an experience of how people make sense of the symptoms, respond to, perceive and live with symptoms, suffering and disability.

Following this thrust in the study of sociology of health and illness, a wide range of issues have been studied in the field of chronic illness. In a recent review, Pierret (2003) roughly groups these issues into a) patients' subjectivity or meaning attached to the experience of illness b) strategies for coping with illness experience in everyday life and c) effects of the social structure on illness experience. These are issues, which are interlinked, for instance, ways of coping would depend on how patients make sense of their illness, that in turn might be shaped or constrained by macro structural factors like access to healthcare, particular representation of the disease in the media, state of medical knowledge and its dissemination, etc. Burry (1982) and Charmaz (1983) have had a major influence in contributing to a conceptual understanding of chronic illness: chronic illness as 'biographical disruption' (chronic illness disrupting the perceived normal trajectory, taken for granted assumptions, behaviours and resulting in a rethinking of a person's biography and self) and chronic illness as 'loss of self' (illness as damaging the previous normal self and how patients try to reconstruct their lives and develop preferred identities at several stages of the illness).

The issue of coping with chronic illness is woven into the understanding of illness experience. As Strauss (1981) articulates, the main problem with chronic illness is not of illness but of living with illness. It is not disability but coping with disability that becomes the focus for qualitative research. Strauss (ibid) discusses the problem of managing medical crises, symptoms, daily routine of activities, adjusting to changes in the disease trajectory and normalizing interaction and life in chronic illness. Thus normalization of life despite chronic illness has been widely addressed in the study of chronic illness experience. Normalization of course has varied meanings. It might mean normalizing treatment regimen and incorporating into the ill persons' identity [Burry 1991], intelligibility in terms of understanding the disease (symptoms and causes) through interactions and communications with fellow patients and professional staff [Cowie 1976]. It might also mean greater

publicity about managing such diseases through professional and non-professional sources (for example, advertisements for alternative medicine for diabetes, gym, healthy diet, yoga, spiritual discourse of healing which claim to prevent many of the so-called life style diseases).

Relevant to the issue of making sense of chronic illness, the 'style' or the language used to communicate the meanings and experience of chronic illness seems important to the research on chronic illness. In this context, illness narratives as a concept and method have fascinated medical sociologists/anthropologists [Williams 1984; Kleinman 1980, 1988; Bury 2001; Good 1994; Robinson 1990; Scrambler and Hopkins 1990]. Advancing the conception of illness narratives, Williams shows how narrative reconstruction is used to 'reconstitute and repair ruptures between body, self and world by linking and interpreting different aspects of biography in order to realign present, past and self and society' (1984:197). While employing different methods of enquiry and focusing on different aspects of chronic illness, much of this research on chronic illness has assumed chronicity associated with a chronic condition. Chronic illness is assumed to be long-term and permanent.

In an attempt to define a chronic disease Maddox and Glass (1989) emphasise the following features: a) persistence b) low specificity in terms of etiology, course and intervention c) course is self sustaining unlike self limiting in the case of acute diseases d) endogenous etiology and e) ambiguous identity. The patient may be highly or completely unaware of his/her illness. They talk about a continuum of specificity. Acute illness (diseases of viral origin) is highly specific while mental illness is highly non-specific. Most of the chronic diseases are of intermediate specificity. However qualitative research on chronic illness has not focused upon these few connotations and has pointed out several other important connotations. For instance, disability is not spelt out in Maddox and Glass's definition of chronicity while most of the studies on chronic illness stress on coping with disability. Is disability then an essential feature of a chronic disease? The definitional part is implicit or assumed in sociological/anthropological research on chronic illness.

Chronicity in Lay Discourse: Community's Understanding of Heart Disease

We discuss here community's understanding of heart diseases that reflect in their recounting of episodes of heart diseases that are experienced, shared, witnessed or even heard. We argue here that chronicity is far from central to the community's understanding of heart disease. By focusing on the community, we have moved to larger setting (and have not confined ourselves to patients' attribution of meanings and experience of the illness alone), which encompasses patients and non-patients or 'healthy bodies'. This is significant as Lawton (2003) articulates medical sociology will have to take up the challenge of addressing healthy bodies 'if the discipline has to keep pace with the emerging 'risk society' within which 'healthy' bodies rather than the 'sick' or diseased are increasingly the sites for

medical attention and intervention' (2003:33). The lay discourse on heart disease follows Davison et al 's (1991) concept of lay epidemiology that is formed through 'routine observation of cases of illness and death in personal networks and the public arena'. However the lay discourse discussed here does not merely tap into construction of health risks but also place, time, symptoms exhibited, diagnosis, treatment, general causes vs. personal risks etc.

We conducted a study to explore community members' understanding of heart diseases, knowledge and recognition of symptoms, management of the disease (both emergency and chronic care), healthcare seeking practices, views on the existing medical infrastructure, perceived risk factors and their views on possible prevention of the disease. This study is part of a larger project (study period 2000-2002) that aimed at assessing capacity for the control and prevention of cardiovascular diseases in developing countries conducted by a research team comprising of medical scientists and sociologists. The strength of the study hence is interdisciplinary which has opened up challenges (in terms of issued raise) for both sets of disciplines.

We conducted Focus Group Discussions (FGDs) with low, middle and upper socio-economic status groups in Delhi, India between June–August 2001. The communities were spread around in four different zones of Delhi i.e. East, West, North and south. They were selected on the basis of housing structure, occupation, education, visible gadgets and self as well as others' perceptions (perceptions of socio-economic status). Area profiles concerning the socio-economic status of the residents and medical infrastructure of the localities were prepared by consulting the residents as well as own observations of the research team. In each zone, three FGDs were conducted, one with each socio-economic group, low, middle and upper. Thus twelve FGDS were conducted in urban Delhi with a total of 85 respondents (45 males and 40 females). The age group ranged from 30-60. Data were analyzed concurrently with data collection. This helped us to identify issues emerging in one FGD to bring back for discussion in subsequent ones, thus each FGD enriched the process of data collection. The following section discusses the key results.

Heart disease as heart attack

Heart disease was synonymously used with heart attack even while community members discussed a number of heart related complications like congestive heart failure, angina, damage of valves, left ventricular failure, hypertension and hole in the heart. All forms of heart diseases had a uniform connotation of a heart attack that is sudden, serious and fatal. Consequently, reference to heart attacks in the lay discourse does not necessarily imply acute myocardial infarction, the technical term for heart attack. It makes little or no difference to community members if a particular experience is professionally diagnosed as angina or heart failure. Both these would be characterised as heart attacks. The emphasis is on understanding

all forms of heart complications as being acute, fatal events.

Community members in the low and middle socio-economic status groups dropped their voice to a whisper when they referred to patients with heart disease. Such whispering did not stem from any stigma, shame or even cultural taboos (as in the case of menstruation or sex issues) but from a sense of fear and helplessness in comprehending (what, why and how it happens) and managing the disease. The fear in low socio-economic status localities was so strong that there was an initial reluctance to discuss incidence of heart diseases. Initially, they denied any incidence of heart disease in their community. They deliberately led the discussion to epileptic attacks, other forms of convulsions among children. But again in the course of discussion, they did admit that they have heard cases of heart attacks and that it was becoming a very common phenomenon. Later they cited cases of deaths due to heart attacks in their own families. The middle and upper SES groups equally expressed helplessness, if not fear, towards heart diseases. They considered heart to be a vital organ and any complication could be life threatening. Hence the serious concern, more so, because the disease occurs suddenly with unspecific symptoms, unspecific causes and requires emergency care.

'Sudden Onset of Symptoms', `Sudden Deaths in Heart Disease'

Community members across socio-economic groups highlighted the sudden onset of symptoms and potential sudden deaths as the central features of heart disease. The vignettes given below are only a few from the large numbers recalled during the FGDs.

Mr. Das (48) felt some uneasiness in the morning. He consulted a doctor who did not find anything wrong but advised him to be hospitalized and be under observation for sometime. He ignored the advice and was getting ready for the office. He fell unconscious and died instantly. The doctor was called later who declared him dead due to heart attack (Upper SES Group).

My neighbor's son Mr. Singh (28) went for picnic and was playing tennis. He developed chest pain and collapsed to death immediately (Upper SES Group).

My colleague, Mr. Lal who was in his early fifties all of a sudden developed severe chest pain. He was taken to a nearby government dispensary. The dispensary did not have any medicine, you know, sorbitrate. He died there due to lack of emergency treatment (Lower SES group).

Sudden onset of symptoms and sudden deaths are so closely associated with heart attack that often experiences of sudden deaths have been narrated (suspecting these deaths to be due to heart attack) without professional consultation or diagnosis. This is particularly the case of the lower socio-economic groups and the villagers. For example,

Mr. Sharma (50) while in the office got into an argument with a colleague who pushed him hard. Mr Sharma fell down and died there. Later the doctor came and declared him dead due to heart attack (Low SES Group).

From the point of view of a cardiologist, this could also qualify for a case of brain injury because the victim did not manifest any common symptoms of heart disease, an autopsy can ideally locate the cause of death.

However, what we wish to emphasize here is the interpretation of the experience by those who witnessed it. The interpretation is shaped by an association of sudden death with heart disease and also an outburst of anger with heart attack. The causal association of anger with ill health (if not any specific disease) is a common feature in many cultures including that of Chiapa Highlands in Mexico (Manning and Fabrega 1973).

In another incident, a mother attributed the death of her son who supposedly had a sudden attack, due to brain hemorrhage.

My son who was forty five year old, one day came back from the fields where he was working complaining of stomach pain. I gave him some churan (indigenous digestive powder) thinking this to be due to gastric pain. He had taken porridge in the morning. Later he complained of pain in the chest and left arm. I thought this could be due to weakness and gave him a glass of buttered milk. The pain did not subside. So I went to the other room to get his medicines for High B.P, which he used to take in case of emergency. When I returned, I found him dead. (Low SES locality)

Later, on being asked, if the death was due to heart attack, the victim's mother said that her son came in her dream and revealed the cause of his death to be due to a hemorrhage of vein in the brain. The narration reflects an understanding of the association (if not in a causal sense) of high blood pressure with heart disease. What is crucial here is the suddenness of death irrespective of it having occurred owing to a heart attack or a brain hemorrhage. Interestingly, experience of most of the heart patients (those who have survived and those who have not) that were recalled in the FGDs involved diagnosed high blood pressure.

However, it is not very clear whether such association of high blood pressure with heart disease and particularly stroke (hemorrhagic stroke) is informed by the doctor's explanatory model or merely inductively derived from many instances where people with heart disease have had high blood pressure as well. Such sudden onset of symptoms and sudden deaths associated with heart disease negate the essential feature of chronic disease as slow acting. Interestingly, there is a clear recognition even in medical science that coronary and cerebrovascular events (stroke for example) often present suddenly for the first time and that these could be fatal events. However to the community members, the notion of sudden onset of symptoms and potentially fatal nature of heart disease goes beyond the first episode.

Sudden deaths in three, if notional, episodes

Another feature of heart disease that many of the community members highlighted, pointed towards a potential course of heart disease involving 'three' episodes of

heart attack. They say that if a patient survives the first attack, he is likely to get two more attacks in which the third attack would necessarily lead to death. With each attack, the chances of survival are reduced. The understanding of three episodes or heart attack appearing 'three times' is not arbitrary but based on witnessing or even hearing about patients not surviving beyond the third attack. Even when they view that heart disease might involve more than one attack, the course of the disease is neither specific nor predictable. Thus in no way do such episodes would point towards a chronic course of the disease as the medical scientists would try to make them believe. As per the medical trajectory, the course of the disease is relatively specific and predictable. The process of fat deposition in the arteries, which is the main cause of a heart attack is a gradual process and is initiated and accentuated by modifiable risk factors like obesity, fat rich diet, inadequate physical activity, smoking etc Thus when a person survives one episode of heart attack, he/she can ideally control the course of the disease by controlling these risk factors. In spite of the modifiability, community members emphasized the sudden onset of symptoms before each attack. The episodes are looked upon as independent events. They held that once a person gets one heart attack, he is mentally prepared for another attack and lives in fear of the same. However, the attacks are entirely unpredictable and the person may get it anywhere and anytime. While uncertainty has been highlighted as an essential feature of chronic illness experience [Strauss 1981; Royer 2000], in the present study, community members expressed uncertainty despite their consideration of heart disease as chronic. Uncertainty here refers to the time and place of the acute episode of heart attack that is considered potentially fatal. Such understanding of three independent, potentially fatal episodes of heart attack (without reference to a course of the disease) also negates the self-sustaining character of chronic illness.

Such experience of heart attacks offer a contrast to Cowie's London study (1976), which establishes that heart attack gets normalised after the first episode. It becomes less threatening and more intelligible. Such normalisation takes place through patients' experience in the hospital i.e. communication with the doctors, nursing staff and fellow patients. Cowie seems to have taken a very selective and convenient sample i.e. married men or women below 60 years who have *reasonable access* by car to the Coronary Care Unit (emphasis added). His discussion also shows that all the patients in the sample had easy access to General Practitioners (GP).

However, our findings suggest that accessibility to treatment and access to health care practitioners are important indicators shaping community's perception towards heart diseases. Most of the lower socio-economic groups of people in Delhi did not have easy access to formal care. Further, such differences were also manifested in the doctor-patient interaction, particularly in disseminating relevant medical information. Many of the community members from low socio-economic status groups said that doctors did not tell them clearly 'why and how this has

happened and how best to take care of the disease' except hurriedly prescribing medicines on a slip of paper, while many community members from the middle and upper socio-economic status groups were informed about the details of the treatment procedure, prescribed diet etc. Even in pre-hospital stage, all the middle and upper socio-economic status groups had consulted their 'family doctors' and shared the initial symptoms. Further, the middle and upper socio-economic status groups exercised a range of choices when accessing clinical institutions where attitude of the hospital staff including doctors is one of the factors. The socio-economic differences however cannot be stretched too far because we need more research evidence to examine other factors like graduate training in medical schools, exposure to additional practical training like continuing medical education and work load (it is not surprising to see that in some instances, primary care physicians in Delhi see as many as 300 patients in a daily slot of six hours in the out patient departments) act as constraints on information sharing in doctor-patient interactions.

There are certainly a number of instances where family members' accounts (dealing with more than one heart attack) offer some sense of intelligibility through establishing causality. For instance, some in the middle and upper socio-economic status groups did say that because of the particular episode of heart disease in the family, they have tried to collect information on the causes and care of the disease from professionals and from other sources. However, the notion of suddenness is more dominating than such intelligibility towards heart disease as sudden deaths have occurred in all SES groups.

Heart disease as `dangerous' and `serious'

Heart diseases, from the point of view of medical scientists, can be managed and controlled through regular screening, seeking early treatment (when symptoms develop), following a medical regimen and controlling risk factors. However, as the aforesaid discussion suggests, community members considered heart disease a sudden, life threatening disease with little or no scope for management. The constraints to mange and control the disease were discussed in a number of contexts, more specifically, sudden and unspecific symptoms, unspecific causes, limited availability and access to healthcare facilities and information.

Unspecific symptoms: Recognition of symptoms is an essential prerequisite to seek health care (self/ professional). Apart from the fact that symptoms of heart disease manifest suddenly, community members expressed concern about the problem of recognition of symptoms. Most of them, across SES groups and region felt that symptoms of heart disease were not specific. It is interesting to see that while most of the community members did enumerate the symptoms of heart disease as chest pain, pain in left arm, breathlessness, excessive perspiration, anxiety on questioning, they repeatedly said that recognition of these symptoms to be able to

seek health care is problematic. They offered several instances of patients where such symptoms of heart disease have been attributed to gastric trouble, asthma, acidity etc. and managed accordingly in the initial phase (inhaler for asthma, antacid tablets for gastric trouble etc).

Community members felt even doctors (primary healthcare providers) have occasionally misdiagnosed the symptoms of heart disease. Such recognition of symptoms of heart disease and its misattribution to other health problems makes it difficult to seek emergency care, thus resulting in delayed diagnosis often leading to deaths. Acknowledging the problem with the recognition of symptoms, a number of qualitative studies focus on the reasons for patients' delay in presentation of symptoms of heart attack from the point of view of interventions [Heriot, Becker and Coltart 1993; Leslie, Urie and Morrison 2000; Dracup, Moser, Eisenberg, Meischke, Alonzo and Braslow 1995; Ruston, Clayton and Calnan 1998].

Unspecific and uncertain causes: Intelligibility towards heart diseases was limited because most of the people across socio-economic status groups did not have much clue to the causes or associated risk factors of heart diseases. When probed about causes, they looked completely blank and thought very hard about it. They looked for associations through reflecting on earlier instances of heart disease patients. Thus high blood pressure was seen significantly associated with heart disease. Such association unlike in an epidemiological sense did not imply risk. Instead the associations were derived retrospectively from earlier cases of heart attack. We also came across patients who challenged the very notion of risk factor saying they did not have any of the common known risk factors and yet have suffered from heart disease.

While diet and stress were considered as 'causes' of heart diseases, there was lot of confusion on how diet leads to a disease of such magnitude. Further, diet did not have any uniform connotation; it ranged from typical kind of food (oily, fried food, adulterated food, cold drinks, noodles etc) to dietary behavior (undisciplined diet not having regular meals, late night partying etc.). Stress was relatively more emphasized as a cause. Stress also meant a whole range of cognitive phenomena: continuous mental pressure, sudden hearing of shocking news of deaths or any other news of such magnitude, outburst of anger. Stress did not always mean negative emotions alone but also included positive emotions like 'laughing heartily' or 'sudden hearing of some unexpected good news'. These might also cause heart attacks. While some of these events are unpredictable, stress is so intrinsic to day-to -day life that controlling or managing stress remains problematic. Moreover diet and stress are commonly associated with ill health and hence its specific contribution to heart disease remains unspecific.

In the same way, smoking and lack of physical activity (the latter was considered more a problem with the upper and middle SES groups) were distantly associated with heart diseases while smoking was considered important in causing lung

cancer. We wish to emphasize here that even when community members spoke about association, it did not imply either objective or subjective risk perception. The notion of a 'coronary candidacy', a person who is likely to get heart disease, or to say that having single or multiple risk factors increase the risk of getting heart disease was unconvincing to community members [Davison et al, 1991]. The concept of multiple risk factors in the medical trajectory implies to the community members unspecific causes. Management and control of heart diseases understood in a medical sense, through regular medication and life style modifications hardly existed among community members. Even when they talked about prescribed diet, prescribed physical exercise, they are far from convinced that following such prescriptions could actually prevent heart attacks.

Limited access to healthcare facilities: Community members expressed concern over the inadequate infrastructure for emergency care in most of the nursing homes, which are otherwise physically accessible. They felt that heart diseases needed high quality treatment including competent specialists, advanced technology; effective medicines and not all hospitals have all these facilities. Most of the facilities were available in private tertiary centers where access is limited. Many patients interviewed narrated their experience of shuttling from one hospital to another to receive treatment. Availability, accessibility and affordability (to treatment) are important factors that influenced the perception of the disease. On a number of occasions, some of the middle socio-economic groups also called it a `rich man's disease'. This is said not in terms of vulnerability but affordability to treatment. The existing infrastructure thus acts as a constraint to manage the disease, where in management implied emergency care.

Thus, contrary to the medical perception of the disease as manageable, community members considered heart disease a dangerous and serious disease. The low socioeconomic groups considered heart disease as dangerous, something that evoked fear. Like many of the acute diseases, heart disease was considered fatal. The middle and most of the upper socioeconomic groups, considered the disease a serious one but not quite dangerous. Some of them did use the term dangerous not to imply fear but to highlight the seriousness associated with suddenness of the disease that stemmed from unspecific symptoms, unspecific causes and problems of access to healthcare facilities.

Cure in heart disease

The notion of care through regular medication and lifestyle modifications associated with chronic illness was conspicuously absent in the community's understanding of the management of heart disease. They looked for 'causes' of heart disease (as every disease has a cause and so should heart diseases have), which should ideally be cured. The notion of cure, more applicable to an acute condition, is applied to heart disease and thus the medical trajectory or the allopathic construction of the

disease particularly in managing the disease through long-term care is resisted. Management, to the community members, implied cure through medicines or any other healing strategies. It did not include chronic care at all. One patient recounts her experience,

I got an attack last three years back. I was 35 year old then. I was sleeping at night and when I woke up in the morning I suddenly realized that my face had been deformed and I could not open my eyes. I was taken to the doctor. He told me that I had got a paralytic attack and such paralytic attacks are like heart attacks that might come in 'three installments' (implying that he is likely to get two more such attacks in future). The doctor prescribed medicine for six months. He also gave me injections. I took the medicines for three days. I did not feel relieved. I then consulted an Ayurvedic doctor who stayed near our village. He treated me and asked me to see him after a week. As I was completely cured by his treatment, did not feel the need for a follow up. However subsequently, I started having extreme feelings of cold and hot. When I was in the sun, I felt terribly hot and when I was inside, I felt very cold. I then went back to the Ayurvedic doctor who proscribed certain diet like rice, fried food, dalda ghee etc. I followed his diet religiously and went back again for consultation. He suggested that I could take it easy on prescribed diet. I feel fine now and did not have to go to the doctor again. (Patient who was 41 years old)

Having no botheration to manage her condition gives her little reason to see heart disease as a manageable disease. Instead, in her experience, what was akin to heart disease according to an allopathic doctor is fully cured with no restrictions of life style. Had it been a heart attack, she would have died by now. For any disease, there has to be a cure. Thus, cause, cure and medicines (treatment essentially means treating a disease through medicines) remain central to the understanding of heart disease, its management and expectations from treatment. When treatment through medicines fails (either it does not give quick and complete recovery or treatment is prolonged), people looked for alternative curative strategies. Prescribed diet, physical exercise, abstaining from smoking etc are acceptable as part of the treatment only to the extent that it is specific both in terms of its content and period of time (what kind diet and how long?) but not in terms of a permanent altered life style. Thus the Ayurvedic doctor who seemed to have cured the patient and had allowed the patient to withdraw from the restrictions on diet after the cure, matched with patients' expectations from the management of heart disease.

Episodic vs disability trajectory in heart disease

Disability (physical and mental) is considered an essential feature of chronic illness even while there might be little agreement on measuring and conceptualizing disability both among medical scientists and sociologists. The notion of disability was implicit in the discussion on the impact of the disease on the patients and the family. Some did mention that once a person gets a heart attack (for that matter any other complication in heart), he is named a heart patient i.e. *dil ka marij*.

The patient cannot do strenuous physical and mental activities. Surprisingly, this is not substantiated in the narratives provided of those patients who have survived. The participants emphasise the delicacy of the mental state than that of the physical state of the heart patients. They emphasize that patients with heart disease should be avoided from being communicated any extreme news good or bad. Such association of extreme news with heart disease is quite strong. One patient narrates,

I got a heart attack one year back. One day, I started having pain in the chest that spread to my head and left arm. I shared this with my daughter-in law. She called a doctor. He did an x-ray and told us that if the pain increases, I should go to a bigger hospital. If it subsides, I should take the medicine, which he prescribed. The pain however increased. I was rushed to the hospital. I was admitted for two days. My B.P was diagnosed to be high. The doctor asked me to undergo an operation. I refused and have still not undergone the operation. My children are small and if I undergo the operation I will not be able to work hard for at least six months. I feel more or less fine except occasionally when I get to hear shockingly bad news; I start getting pain in my chest. When I take the medicine (prescribed by the doctor) the pain subsides. I do not find it necessary to take these medicines on a regular basis.

Here, the notion of disability (not being able to work hard) was accepted as part of heart disease, yet at the same time the element of chronicity and thus the management of it were resisted by not undergoing the operation. The understanding of the disease as episodic (triggered by extreme news etc.) that can be managed by medicines was dominant. Sudden deaths and episodic character of heart diseases were so dominant in the lay discourse that notion of disability was subdued.

III
Conclusion

Irrespective of socio-economic status, community members in India share an understanding of heart disease as sudden and potentially life threatening disease. The sudden, fatal and serious characters of heart disease are dominant in the lay discourse on heart disease and experience of heart disease patients are recalled, retold and reported in this light. Sudden onset and unspecific symptoms, potential sudden deaths, need for timely and expensive emergency care, uncertain causes of heart disease have resulted in what we may call 'heart disease fear syndrome' with a sense of helplessness towards the disease among community members. This is more so because heart unlike other organs is considered vital to life and survival.

It is important to mention here that unlike in developed countries, there is no 'official' (Government, non–government, professional/academic bodies) discourse on management and prevention of heart diseases except vague messages in the media in the form of 'cardiovascular exercise', 'diet coke', 'low cholesterol cooking oil' 'healthy diet' etc. The Government's efforts still focus on the 'unfinished agenda' of preventing communicable diseases like polio, malaria. Thus the medical/

professional discourse on heart disease as a manageable and preventable disease remains confined to the limited research agenda of preventive cardiologists and public health specialists.

The accepted notion of chronicity in chronic diseases in the discourse in medicine and the natural corollary of managing and preventing it is challenged at the community level. Even the classical sociological notions of chronic care, living and coping with the disease, persistence, chronic illness assuming a life of its own do not exist in the lay discourse on heart disease. It seems factors like the state of medical knowledge (the bio-medical, epidemiological and public health research on symptoms, detection, early warning signs, risk factors of heart diseases), clinical practice (knowledge, skills and attitude of healthcare providers in clinical interactions in relation to heart diseases), existing healthcare infrastructure, the absence of an official discourse are critical in the social construction of chronicity in heart disease India.

Qualitative research on heart diseases in the Indian context is rare and hence this study fills in this critical gap, providing enough food for thought both to medical sociologists and medical scientists working on heart diseases in India. While the findings of the study challenged the notion of chronicity associated with heart diseases, more in-depth research is however needed, which could focus on patients' experience of this disease, decision making process in seeking health care in cases of heart disease, notion of 'unhealthy life style' preventive health in day to day life etc.

Notes

[1] Medical here refers to the western and allopathic system of medicine.

[2] This also implies that the classic trinity in epidemiology i.e. hosts agent and environment undergoes fundamental changes in its content. Agent does not necessarily imply the external agent i.e. bacteria but the behavioral and life style factors. Host again is not necessarily external but includes individuals who contribute to the disease. The environment includes both physical and social.

[3] See Beaglehole, Bonita & Kjellstrom 1993

[4] See Gerhardt 1990, Nettleton 1995, Idler 1979 for a discussion of some of these perspectives and the study of illness in sociology

[5] Alfred Schultz originally developed this concept of inter-subjective to refer to shared meanings and experience (in interactions) between self and others.

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Judicial Response to Reproductive Rights
Experience of Public Interest Litigation in Nepal

Raju Prasad Chagai*
Public Interest Lawyer, Forum for Protection of Public Interest (Pro Public),
P.O.Box 14307, Gautambuddha Marg, Anamnagar Kathmandu

Abstract: *The paper is mostly aimed at examining the effectiveness of Public Interest Litigation (PIL) in enhancing the enforceability of reproductive and sexual rights in Nepal. It highlights major achievements of judicial intervention in this regard through a critical analysis of selected Supreme Court decisions in the light of state obligations under the Constitution and international conventions ratified by the government.*

**Email: rpchapagai@enet.com.np*

The basic freedom of the world is woman's freedom. A free race cannot be born of slave mothers. A woman enchained cannot choose but give a measure of that bondage to her sons and daughters. No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother…" – Margaret Sanger

I
Introduction

Throughout much of the history of Nepal, defective cultural beliefs allowed women only limited roles in society. Many people believed that women's natural roles were as mothers and wives. Women were considered to be better suited for childbearing and household work rather than for involvement in the public life. Till 1990, Nepalese society formally denied women some significant rights and freedoms accorded to men. Since the promulgation of democratic Constitution in 1990, women's efforts to control their own reproductive systems have been an important part of the women's rights movement. Subsequently Nepal also ratified Convention on the Elimination of all Forms of Discrimination against Women 1979 along with other important human rights instruments that has further vitalised the reproductive issues

Though the Constitution does not explicitly incorporate reproductive rights but it provides wide scope for the materialization of these rights in living reality. Article 11 not only guarantees formal equality but also aims at securing substantive equality that requires the state to devise various measures to promote reproductive health of the women. Directive principles provided under Article 25 and 26 further impose positive obligation upon state to give priority to women's health. Moreover, Article 9 of the Treaty Act 1990 gives the status of domestic laws to the ratified human rights convention;[1] therefore, reproductive rights guaranteed under the conventions are also equally enforceable. Scope of remedy in the case of violation

is also effectively provided especially through the Article 88 as it empowers the Supreme Court with jurisdiction for judicial review and Public Interest Litigation.

Against this backdrop, the paper is mostly aimed at assessing applicability of Public Interest Litigation (PIL) in enhancing enforceability of reproductive rights. It highlights major achievements of judicial intervention in this regard through critical analysis of selected Supreme Court decisions in light of state obligation under the Constitution and ratified conventions. For examples, the Supreme Court for the first time in Mira Dhungana V. His Majesty's Government et al asked government to eliminate discriminatory laws against women that ultimately resulted in reform of abortion laws also through which women are now provided freedom of choice whether or not to have abortion within first twelve weeks of pregnancy. In Annapurna Rana V. Kathmandu District Court[3] the Supreme Court recognized women' right to control over their own body through nullifying Virginity Test Order of Kathmandu District Court. Most significantly in Mira Dhungana V. His Majesty's Government et al[4] the Supreme Court labeled marital rape as heinous sexual crime and endorsed the sexual autonomy of women even within marital bond. Judgments concerning maternity leave, breastfeeding promotion, forced abortion, sexual harassment, state protection of polygamy are also counted important in this regard.

The paper finally observes that Public Interest Litigation has become instrumental in promoting government accountability towards reproductive rights, eliminating discriminatory legal provisions and accelerating law reformation process.

II
Reproductive Rights in Texts

Constitutional Imperatives

The Constitution of the Kingdom of Nepal, 1990 is a fundamental law of the land. Any laws inconsistent with the Constitutional provisions are deemed void and null[5] . This notion of 'Constitutional supremacy' has some implications upon reproductive rights as it sanctifies also the Constitutional norms that are applicable or aimed to protect reproductive rights in either way.

Though the Constitution doesn't provide any explicit provisions for 'reproductive rights' but it has wide scope for the materialization of this type of rights. Many Constitutional provisions can be invoked for this purpose. To begin with the preamble, it comprises paramount objectives of the Constitution as to secure social, economic and political justice through protection of basic human rights.[6] It can be meant in a way that reproductive rights are also integral parts of the basic human rights and without protection and promotion of which paramount goal of social justice cannot be secured. That is why, to pave the way for 'reproductive justice' through protection, promotion and fulfillment of reproductive rights that ultimately result in securing goal of social justice is one of the Constitutional imperatives.

Most significantly, the Article 11 not only guarantees 'formal equality' but

also pave the way to secure 'substantive equality'.[7] Constitution declares that all citizens are equally entitled to non-discrimination, equal protection and equal application of laws regardless of sex. Obviously, sex is one of the prohibitory grounds of discrimination so it cannot be used to create reproductive injustices. So that, there is no room for any form of discrimination and injustices against women as this article relies on zero-tolerance against discriminations approach. Therefore it can be said that state is charged with the Constitutional obligation to eliminate all type of negative discriminations against women that inhibit them from enjoying reproductive rights and freedoms. Rather, Constitutional mandate for accelerating substantive equality under proviso of Article 11 requires state to devise special measures for the protection and advancement of women. Fulfillment of this positive obligation of state is mostly expected to promote gender equality taking into account the reproductive function of the women. In Rina Bazaracharya Vs Cabinet Secretariat of Council of Ministers et al[8] Supreme Court has further clarified the intent and purpose of the special protection clause that it doesn't permit any state action or measure that results in disadvantage to women; it only permits measures that are in favor of women and result in acceleration of de facto equality.

In order to materialise goal of substantive equality as envisaged under Art 11 the Constitution also prescribe positive state obligations under chapter of directive principles. State is charged with the responsibility to create supportive environment for protecting life, liberty and property of the people[9] and further enjoin the government to eliminate all types of social and economic inequalities.[10] The Constitution also directs government: to pursue a policy of making the female population participate, to a greater extent, in the task of national development by making special provisions for their education, health and employment;[11] to make necessary arrangements to safeguard the rights and interests of children and shall ensure that they are not exploited, and shall make gradual arrangements for free education;[12] to pursue such policies in matters of education, health and social security of orphans, helpless women, the aged, the disabled and incapacitated persons, as well as ensure their protection and welfare.[13] Though abovementioned directive principles are Constitutionally declared unenforceable but the Supreme Court through the way of interpretation has enhanced the enforceability. The Court has established the judicial precedent that 'judicial intervention can be made if Public Authorities don't comply with directive principles'; [14] therefore, state cannot refrain from fulfilling it's obligation to promote reproductive health as directed under the directive principles.

Many others Constitutionally guaranteed fundamental rights could also be invoked for the protection and promotion of reproductive rights. Among them right against deprivation of personal liberty guaranteed under Art 12(1) is significant one.[15] Supreme Court has further expanded its horizon by adopting the interpretation that right to life is inherent in Constitutionally guaranteed right to

personal liberty. [16] This type of interpretation has also significant implication upon reproductive rights. Forced abortion, forced pregnancy, forced and un-consensual marriage, forced contraception and sterilization, forced sexual intercourse within marital bond which negate reproductive choice and self-determination and ultimately result in violation women's right to dignified life can obviously counted as infringement of Art 12(1). This provision also entitles women to enjoy freedom from customary values and practices that are detrimental to reproductive health of the women. Besides, Art 22 guarantees fundamental right to privacy[17] that could be invoked to protect the right of all clients of sexual and reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers. In addition, it is also significant to protect women's right to bodily integrity and right to freedom from physical intrusion. In one landmark case[18] the Supreme Court held that women's right to control over their own body is a part of fundamental right to privacy. Guarantee of fundamental rights to freedom of speech and information are extra advantages in protecting reproductive rights which can be invoked to protect the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.

Despite the aforesaid provisions, the Constitution is not beyond the criticism. It contains gender-based discrimination in term citizenship rights. Art 8 of the Constitution deprives woman from right to transfer their citizenship to her children and husband that is unquestionably responsible to render women subordinated to men in society. On the one hand, it is big hurdle for women to enjoy freedoms and rights concerning marriage and family life, on the other hand it is playing role to keep patriarchal dominance going. It also affects negatively upon the enjoyment of all other social and economic rights. Also that ultimately narrows down women's capabilities to exercise reproductive choice and self-determination. Very unfortunately, Supreme Court judgment in Chandra Kanta Gynwali V. HMG Cabinet Secretariat et al.[19] along with some of the other judgments[20] also legitimised Constitutionally protected gender-based discrimination in citizenship rights.

Treaty Obligations

Nepal has a unique legal provision regarding the national application of international instruments. Treaty Act 1992 provides that the provision under the international instrument to which Nepal is a state party, are equally applicable to prevailing Nepalese laws within the territory of Nepal. Even it has also provided that if any provision of municipal law is inconsistent with the provision of such treaty the provision of treaty will get primacy.[21] Nepal has pioneered in ratifying human rights convention in the region. It has already become party of most of the major international human rights treaties.[22] Most of these conventions recognise various rights that are relevant to protecting reproductive rights. The two core treaties

of the International Bill of Human Rights – International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) –recognise numerous rights that are relevant in the context of addressing reproductive issues. The ICCPR, for example, recognizes, the right to life,[23] the right to liberty and security of person.[24] It also recognizes the right to be free from arbitrary or unlawful interference with "privacy, family, home or correspondence". [25] It also recognises the principles of nondiscrimination, equal protection and equality before the law and further prohibit discrimination on the basis of sex". [26]

The ICESCR also has several relevant provisions. Especially, marriages may only be with "the free consent" of both spouses, [27] 132 and everyone has the right to an adequate standard of living for himself and his family, including adequate food, clothing and housing.[28] The ICESCR also recognizes that everyone has the right "to enjoy the benefits of scientific progress and its applications"[29] Most significantly, the ICESCR grants the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[30]

In addition, the other two core international human rights treaties Elimination of All Forms of Discrimination against Women (CEDAW) and the United Nations Convention on the Rights of the Child (CRC) enumerate very significant provisions concerning reproductive rights along with enunciation of "principle of shared reproductive responsibility".[31] In particular, as a state party of CEDAW Nepal is charged with the obligation to eliminate all forms of discrimination and biasness in laws and practices against women through adoption of legislative, executive or administrative measures as required.[32] Art 11 specially provided with obligations towards health of the women. It obliges states parties to ensure that women have access to healthcare on an equal basis with men. Also states are entrusted with obligation to remove all legal and social barriers that obstruct access to healthcare for all women, including whose access is impeded by factors such as disability, illiteracy, or where they live. It is important to note that women have the right to highest standard of physical and reproductive health. It has further recognized a woman's right to decide freely on matter related to her sexuality including reproductive health.[33] Talking about marital rights and freedoms, CEDAW addresses discrimination against women in the private spheres of marriage and family relations. States are under the obligations to take appropriate measures particularly to discourage polygamy and ensure that women are not forced into marriage and remarriages, and that child marriage and betrothals have no legal effect. It is also required by CEDAW that women must be accorded equal rights with respect to their children, through legal tools of guardianship, ward-ship, trusteeship and adoption and men must share equal responsibility, including care and financial support, in relation to children. CRC also contains important provisions in relation to reproductive rights of women. Art 24 is notable in this regard that not only recognises the child right to the enjoyment of highest attainable

standard of the health and to facilities for the treatment of rehabilitation of health but also impose certain obligations upon state to take appropriate measures for the protection and promotion of the health of mother. These obligations include: to ensure appropriate pre- and post -natal health care for mother, to ensure that all segments of society, in particular parents and children are informed, have access to education and are supported in the use of, basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents, to develop preventive health care, guidance for parents, and family planning education and services, to abolish traditional practices prejudicial to the health of children.[34]

III
Reproductive Rights in Action

State Protected Discrimination

Nepal has failed to perform its duty to guarantee non-discrimination as provided under the Constitution and the ratified international conventions. Many legal provisions are problematic in terms of a meaningful realisation of reproductive rights. Under the Chapter on Homicide of the Country Code women are still mostly prohibited from exercising their choice on abortion. Very limited freedom of choice is provided to women as 11th Amendment of the Country Code allows women to abort pregnancy in the first trimester (12 weeks).[35] Penal provisions concerning abortion are also found to be discriminatory. Voluntary abortion is severely punished rather than forced abortion.[36] Recently the Supreme Court asked the government to avoid an unjust penal provision taking into account the Constitutional and treaty obligation for gender equality.[37]

Though 11th Amendment of the Country Code increased the penalty in the case of child marriage, this is scanty, as child marriage is still not declared void.[38] According to law child marriage is violable upon the age of 18 only in case where no child is born to the couple.[39] However, statistics reveals the fact that law has become failure to combat the child marriage. Even 30 percent of women who are married between the ages of 15 and 19 have three to four children and about 35 per cent of such women one to two children.[40]

As for citizenship rights, a woman does not fall under the descent of the family in Nepal. Therefore, she alone has no right to give any identity to her children as a mother of the child. Citizenship can be acquired either through the father or through the husband only.[41] A woman of foreign nationality who is married to a Nepali citizen and who has initiated proceedings for renunciation of her foreign citizenship may acquire Nepal's citizenship. However, a foreign man who has married a Nepali woman is not entitled to acquire Nepali citizenship by virtue of such marriage.[42] She even has no right to give the citizenship to her children. Hence, the State obligation to grant women rights equal to that of men with respect to the nationality of her children are denied by the law. Many children who are

born of a Nepali mother and a non-Nepali father in Nepal are facing complications arising out of discriminatory laws. Children of unmarried women are also facing severe problem.

Women are still compelled to face marriage-based discrimination in respect of property rights. The daughter has to return her share of parental property upon marriage[43]. Simultaneously, women are also restricted to dispose their own property. Unmarried daughter are required to take consent of father and mother and widows are required to take the same from their son and daughter.[44] These discriminatory laws have been brought to the Supreme Court as public interest litigation.[45] Supreme Court has placed the cases in priority list for final disposal.

Section 9 of the chapter on marriage in the Country Code allows a man bigamy even if his first wife is living, if she becomes incurably insane; no child is born or are alive within ten years of marriage or if the children do not survive; turns blind; becomes crippled; is separated after taking share of her husband's property. However, the same rights do not apply to a wife under similar circumstances because women are subject to punishment on adultery.[46] Although polygamy is illegal except abovementioned condition, it is not declared void as Section 10 of the Chapter on Marriage recognizes the second marriage of a man, after a punishment of one to three year imprisonment and payment of a fine or NR5000 to 25,000.

Women are provided inadequate maternity leave; even women in the informal sector are not provided maternity leave and breastfeeding facility; there is also a disparity in providing maternity leave (60 days in government services, 52 days for labour sector except tea estates, 45 days for tea estate).[47] No provision of leave is provided in case of miscarriage, abortion and also in case of more than two deliveries.

Legal norms concerning adoption are also not gender neutral. Women are not entitled to adoption at the presence of husband but same norm doesn't apply in their counterpart.[48] The right to birth registration is recognized under the name of the husband, and, in his absence, under that of the head of the family.[49] Also women are not provided equal right to name their new born baby.[50]

The present definition of rape is very restrictive that seems to exclude marital rape. In a case brought to the supreme Court challenging the validity of the definition of the rape in the Country Code 1963[51] the Court recognised marital rape as a offence but ignored to overturn the provision; rather Court issued directive to the government for making necessary legal arrangement to protect women from marital rape.[52] However the law has not been amended to date so marital rape is still exempted from punishment.

Weak Implementation

Problem is not only due to the prevalence of discriminatory laws but also due to the lack of effective implementation of positive laws. For examples: women do not enjoy the freedom of choice in terms of abortion even to the extent of allowing

right to abortion by laws due to the absence of safe abortion facility throughout the country. The law prohibits female feticide[53] but women are forced to commit selective abortion due to lack of monitoring and inspection of medical clinics having the technology to detect sex of the unborn baby. As for maternity protection, laws provide some special measures[54] aimed to strike balance between reproductive and productive function that include maternity leaves; child care and breastfeeding facility at the workplace, but implementation status is very weak. Employers are found reluctant to hire women employees due to statutory obligations towards maternity protection.[55] Special legislation concerning breastfeeding promotion does exist[56] but unfair marketing practices of artificial baby food are dominating breastfeeding practice in reality. Women as the consumers of goods and services relating to family planning, contraception and abortion facilities are entitled to several consumer rights under Consumer Protection Act [57]. But consumer rights are only limited in text due to lack of effective implementation. The same is case of law relating to iodized salt that is specially aimed to diminish iron deficiency problem.[58]

There is a legislative vacuum in many areas that is directly or indirectly resulting in violation of reproductive rights. The enactment of new laws is urgently felt in many other areas including marital rape, sexual harassment at work place and public place, family planning, prostitution and maternity protection. Also some customary practices detrimental to the reproductive health of the women including *chaupadi tradition*[59] have not been covered by legislation. The Supreme Court, through several judicial decisions,[60] has already alerted the government to the urgency of new enactment in many areas the government has not responded positively,

The lack of appropriate legislation to protect women and their rights is seen in these statistics. Approximately 70 per cent of the women of childbearing age are anemic and an estimated 40 per cent have given birth to at least one child between the ages of 15 and 19. Because of poor maternal health and nutrition, 27 per cent of newborns have low birth weights. These high rates also result from a health care system that reaches less than 15 per cent of the population. In addition, the maternal mortality rate (MMR) of Nepali women (539 per 100,000 live births) ranks among the highest in the world. One out of every 185 pregnant women dies because of pregnancy and childbirth-related complications. Currently, only 53.4 per cent of women receive any antenatal care, and only 18.8 per cent receive post-natal services. Almost all deliveries take place at home; a skilled birth attendant assists only 13 per cent of deliveries.[61] Induced abortion is one of the main reasons for high maternal mortality in Nepal. WHO has estimated that 50 per cent of maternal deaths are caused due to induced abortion.[62] The average age of marriage for girls is between 16 and 20 years. The mean age for marriage for girls is 19.5 and 21.9 for boys. Population Census in gender perspective shows that 55.5 per centof girls get married between the ages of 15 to 19 years.[63]

IV
Experience of Public Interest Litigation

The Constitution not only provides wide scope of reproductive right but also paves the way for effective judicial remedy. The right to Constitutional remedy guaranteed as a fundamental right[64] can be exercised to ensure women's accessibility of justice in field of reproductive rights. The Supreme Court is charged with an obligation and is also empowered to ensure complete justice through enforcing fundamental freedoms and rights at individual as well as collective level under Art 88 of the Constitution.[65]

On the one hand the Supreme Court is empowered to review laws inconsistent with the Constitutional provisions, on the other the Court can also issue any type of order for the enforcement of fundamental rights and for the settlement of the disputes of public interest. This jurisdiction of the Supreme Court can be exercised to nullify the discriminatory provisions and also to get state obligation under the Constitution and other human right instruments concerning reproductive rights enforced. Any public spirited individual and organization has standing to represent the reproductive issues to the Court. Public Interest Litigation jurisdiction of Supreme Court can be used for fulfilling following purposes:

- To get discriminatory legal provisions eliminated through judicial review those are contradictory with reproductive rights.
- To hold government accountable through issuing appropriate order towards translating the international obligations into domestic laws.
- To accelerate the implementation process of domestic laws those are aimed to promote reproductive rights.
- To get governmental authorities sensitized in contemporary issues concerning reproductive rights.

Review of Select Judgments

Virginity Test Order held violative of Right to Privacy: Petitioner had filed a case in Kathmandu District Court against her brother and mother asking for maintenance and marriage expenses because they had made partition of their property in her absence. Replying before the Court, respondents had proclaimed that she got married and procreated child. They produced the record of the Hospital in order to prove their statement. District Court, during the trail of the case ordered the plaintiff to give presence personally for her vaginal and uterus test by at least three gynecologists of the governmental hospital. Challenging the 'virginity test order', she petitioned at Appellate Court; Court didn't allow her appeal. As a final resort she brought the issue before the Supreme Court under the Art 88(2).

In response to the case Annapurna Rana V. Kathmandu District Court,[66] the Court delivered its landmark decision in favor of the petitioner. The Court invalidated the 'Virginity Test Order' relying on the ground that the order violated Constitutionally guaranteed right to privacy. It was held that gynecologic examination of the private

reproductive organ of the petitioner constitutes an interference with the right to respect for privacy under the Art 22 of the Constitution of the Kingdom of Nepal 1090. Significance of the decision also lies in holding state institutions including Court accountable towards the observance of fundamental human rights of individual. According to the judgment, even judicial authority cannot enable itself to supersede the fundamental rights of an individual by administrating virginity test in the name of collecting evidences. Recognising the petitioner' sexual freedom and her right to control own reproductive organ, the Court interpreted:

> As right to privacy over own body and private organ is guaranteed as inviolable right under the Art 22, if the test of the private reproductive organ is administrated even as per the Court order without taking consent, it also results in violation of the right to privacy. The result is same for the petitioner in both conditions: in case of encroachment by other and test performed as per the Court order; that is why, the order of the District Court is unConstitutional as it undermine the right to privacy of petitioner.

The decision introduced a new parameter on calling sexuality, cohabitation and marriage as the Court went on to say that having promiscuous sexual relationship, cohabitation and bearing of child too does not amount to marriage and all these facts do not affect or alter the legal status of a woman. The Court further interpreted that mere sexual relationship does not create any change on the legal status of a woman girl. Before marriage, they may practice cohabitation for years. It emphasised that this ipso facto does not establish matrimonial relationship between them. The crucial interpretation of the Court is that sexual relationship before marriage does not tantamount to marriage. Also this decision boldly challenged the patriarchal social norms and values that ignore women's sexual autonomy.

Character-based Penal Provision against Prostitute Overturned: Responding the Sapana Pradhan Malla for FWLD V. Ministry of Law an Justic et al,[67] the Supreme Court overturned the No 7 of the Chapter on Rape under Country Code 1963[68] that constituted discriminated against prostitute by prescribing very nominal punishment in the case of rape on prostitute. In the case, the Court upheld women' equal right to freedom from sexual violence irrespective of their character and practice of the profession. The Court went on to say that it is unConstitutional to exempt rapist from criminal liability only on the ground that the victim is of loose character. The Court further observed that such provision encourage criminal to commit heinous crime like rape against prostitute. And it places prostitute in inferior position then other citizen. The Court also made very important remarks about the rape:

> Rape is an act that totally deprives victim women from enjoying right to individual liberty and self-determination. It affects victim psychologically, socially and spiritually. It is not only crime against the victim woman but also against society at large. It is an offence of brutal nature; therefore every legal system has strictly forbidden and prescribed the punishment.

Judgments Aimed at Property Rights Result in Relaxation of Abortion Laws Too: In Dr. Chanda Bazaracharya V. HMG et al[69] and Mira Dhungana et al V. HMG et al[70] several discriminatory provisions of the Country Code 1963 especially relating to ancestral property were brought to the Supreme Court under Art 88(1) of the Constitution. After the promulgation of new Constitution it was the first such case that raised the question of gender discrimination on property rights. The Court went through weeklong hearing and finally concluded that the denial of equal entitlement of ancestral property to daughter contravened the right to equality under Art 11 of the Constitution. Nevertheless, the Court did not overturn the unconstitutional provisions; rather, the Court ordered the government to bring bill in the Parliament within a year in order to reform discriminatory legal provisions. As a result, the 11th Amendment of the Country Code came in force. That Amendment not only brought a change in property rights but also changes in abortion laws.[71] Most importantly, women became entitled to enjoy complete freedom of choice whether or not to abort fetus within first trimester (12 weeks). Additionally, it made abortion permissible with the consent of women up to 18 weeks in case the pregnancy results from rape or incest. It also legitimized abortion at any time during the pregnancy with the recommendation of an authorized medical practitioner if the life of the woman is at risk or if the fetus is deformed.

Order Issued to Formulate National Standard of Maternity Leave: Nepal lacked separate legislation dealing with maternity protection. But Several Regulations provided for maternity leaves differently. Despite the similar cause and objective of providing the leave, no uniformity was maintained in providing leave for all working women as women employees were provided 60-days in all government services, 52-days in all enterprises governed under the Labour Act and 45-day in tea estates and Royal Nepal Air Line Corporation. The period of maternity leave was also insufficient to harmonise the women workers right to motherhood and their right to work protected under the Constitution and international conventions.

In this backdrop, invoking the right to equal protection of laws of all working women similarly situated in term of pregnancy and delivery, discriminatory leave provisions were challenged in Prakash Mani Sharma et al for Forum for Protection of Public Interest (Pro Public) V. HMG Cabinet Secretariat et al.[72] Also the Supreme Court was called upon to issue mandamus for adoption of uniform national standard of maternity leave. Petitioners also prayed to ask government for providing at least 98 days maternity leave as per the ILO standard as the health of mother and child doesn't permit to work before that.

Responding to the case, the Supreme Court issued a directive order to the Government for formulating a national standard of maternity leave to be applicable to all working women and make essential arrangements for the maternity protection. The Court also asked the government to take into account the ILO Convention on Maternity Protection 2000, Special Protection Clause of present Constitution, Breast Milk Substitute (Control of Sale and Distribution Act) 1992, Labour Act

1991 and Child Act 1992 in formulating such standards. In this case, the Court held that it is a matter of state obligation to make proper arrangements concerning nutrition and health care of the women during their pregnancy and post-delivery period. Upholding the importance of the leave in terms of maternal and child health the Court went on to say that:

> Maternity benefits including maternity leave are provided in order to enable women at work to have complete rest before and after pregnancy and facilitate them to provide proper care for their newly born baby. Weak health status of the women those who are pregnant and mother of newly born baby may result in miscarriage, premature birth and it may also cause risk to the health of fetus and newly born baby. Taking into account the role of women to care and breastfeed baby and the baby' right to be breastfed as well, working women can't be denied the rest period or maternity leave at that condition.

Ridiculously, relying upon the orthodox notion that 'leave is only a matter of facility but not a matter of leave' the Court denied recognising maternity leave as a matter of right. It seems that the Court neglected to take into account the implication of maternity leave upon the enjoyment of right to work and healthy.

Women's Right to Freedom from Sexual Harassment Upheld: In response to Sharmila Parajuli for Pro Public V. HMG et al,[73] the Supreme Court issued a directive order to the Government to enact a comprehensive legislation in order to ensure women's right to freedom from sexual harassment in work places and public places as well. In issuing such a directive, judges, though implicitly, relied upon the state obligation under Art 2 of the CEDAW that requires adoption of appropriate measures including legislation to eliminate all form of discrimination.

The case was brought before the Supreme Court taking into account the scenario of the violation of women's right to employment and freedom of mobility. Issuance of judicial guidelines to be applicable was also demanded by petitioners to fill up the gap of law. However, the Court didn't agree upon that demand to issue certain guidelines as Indian Supreme Court formulated in Bisakha's Case.[74] Anyway, the Court recognised the sexual harassment as a sexual violence against women that results in violation of the right to dignified life. Also the Court empathetically agreed upon the reality that:

> Sexual harassment inhibits women from enjoying Constitutionally protected right to equality and freedoms. Unless and until sexual harassment is fully prevented, it is undisputed fact that realization of the Constitutionally protected rights to equality and freedoms of women cannot be materialized in living reality.

Marital Rape Held Punishable: In Mira Dhungana for FWLD V. Ministry of Law an Justice et al the Court issued a radical judgment that stands for women's right

to self-determination in deciding whether or not to have sexual intercourse with the husband. The Public Interest Litigation was filed at the Supreme Court stating that No. 1 of the Chapter on Rape[76] failed to criminalise rape of a wife committed by her husband using force, threat, fear and duress thereby provided penal exemption to the offenders. Petitioner also contended that such exemption was contrary to right to equal protection of law irrespective of marital status protected under the CEDAW Convention.

Upholding the right to a dignified life for women the Court held that marital rape unconstitutional and denied the husband's ownership over the sexuality of women. Stressing on the implication of 'free and full consent' as a recognised ground of marriage upon conjugal life, the Court ruled that there must be mutual consent between husband and wife for the sexual intercourse after marriage. Recognising the independent personhood of women after marriage the Court observed:

> Right to self-respect, right to self-determination and right to co-existence are indivisible right provided only for human being; so that, women can also enjoy these rights before and after marriage equally. To get married does not mean that to be transformed into slave; that is why, it is obvious that marital relation does not result in deprivation of women' human right because every human is entitled to enjoy inalienable human right till she/he exist as human. So that, to allow husband to have forcible sexual intercourse with his wife is the same to deny women's coexistence, right to self-determination and right to dignified life.

The Court further noted that to compel woman for letting other to use her organ or body resulted in violation of her right to live with dignity and her right to self-determination; that is why, right to privacy has been guaranteed under the Constitution.

Finally the Court issued a directive order to introduce a Bill for providing immediate relief by allowing the wife to live separate from or to divorce the rapist husband; prescribing the degree of offence in rape committed in the circumstance of child marriage, and for making complete legal provisions for justifiable and appropriate solution in an integrated manner with regard to marital rape taking into account the special circumstances of marital relationship and position of husband.

Judicial Intervention for Dignified Life of Badi Community:[77] Women from the *Badi* community were forced to involve in prostitution due to social and economic problems. They were further compelled to continue the way of prostitution because of the lack of alternative employment opportunities on the one hand and prevalence of cast based untouchability and social atrocities, on the other. Those poor, illiterate and ignorant victims of the trap were target group in the flash trade. They were being trafficked and sexually harassed by the people from the so-called high caste. Discriminatory laws concerning citizenship and birth also heavily affected this community. Many children from this community, especially those born in the

course of prostitution and sexual exploitation were faced problems of citizenship, birth registration and education. This problem had further accelerated many other socio-economic problems. Despite the guarantee of gender equality under the Constitution, the plight of badi women remained intact due to the insensitivity of the Government. Taking into account this plight of *Badi* community the Pro Public brought a Public Interest Litigation to the Supreme Court. Demands made by the petitioners in this case included the enforcement of rights concerning citizenship and birth registration, arrangement of alternative employment opportunities, vocational training, free education and health care facilities.

In this case, initially the Supreme Court asked for written statement from respondent government authorities and placed the case in a priority list for disposal. Subsequently, in response to one of the demands of the petitioners the Court constituted an expert committee comprising representatives from the victim community, National Dalit Commission and Public Interest Petitioners. The Committee coordinated by the Joint Secretary of Ministry of Women, Children and Social Welfare was also provided terms of reference by the Court. The committee was charged with the responsibility of conducting study overall problems facing by *Badi* community, efforts of HMG towards addressing problems and recommend measures that are essential to be adopted in future for ensuring dignified life of *Badi* Community. As per the order of Supreme Court Committee submitted the report to the Court that has recently been hared by special bench of the Court. Final verdict on the basis of that report is yet to be delivered. In fact this litigation has created ray of hope to this community. It seems that women from this community have expectations that the Supreme Court will soon make meaningful intervention to hold the government authorities accountable and one day their problems will by taken way.

Order Issued for Effective Implementation of Breastfeeding Promotion Laws: The case Raju Prasad Chapagai et al for Pro Public V. HMG Ministry of Health et al[78] was filed in the Supreme Court demanding the fulfillment of the government's obligation to promote breastfeeding. Responding the case the Court issued mandamus to hold Ministry of Health accountable for the effective implementation of the provision under Breast Milk substitute (control of sale and distribution) Act, 1992 that aimed to promote breastfeeding practices. Significantly the Court ordered the government either to appoint adequate number of inspectors as per the Art 13 of the Act.

In this case, the Court expressed serious concern about the health of the children. Giving effect to the directive principle under Art 26(8) that requires the state to take care of maternal and child health, the Court held that the government is not allowed to be reluctant towards enforcing legal and Constitutional provisions that are aimed to promote child health. Also it was observed in the case that the Court should not refrain from intervening in such a sensitive issue merely because of

leveling it as a matter of public policy.

Noting the importance of breastfeeding, the Court said that children are indisputably entitled to exclusive breastfeeding for six month. No thing is found as nutritious as breast-milk. The state is under legal and moral obligation to comply with the national and international standard that are aimed to promote health of the children and mother. Linking right to breastfeeding with the right to dignified life inherent under "right against deprivation of personal liberty" protected by Art 12(1) of the Constitution, the Court also observed that the government has prime responsibility to keep children healthy by preventing them from being victim of malnutrition. The Court further noted that children who are deprived from proper breastfeeding and nutritious food cannot be imagined to have sound mental and physical health that situation tantamount to violation of Art 12(1).

Child Care and Breastfeeding Break Facilities at Workplace (sub-judice): Under Labour Act 1992 all enterprises employing 50 women were obliged to provide child care and breastfeeding facilities at work place; this provision was made in order to make sure that reproductive function doesn't hamper the productive function. In spite of the legal obligation, most of the enterprises were not providing these facilities; therefore, women workers were being deprived of enjoying this facility. Pro Public filed a public interest petition at the Supreme Court on 1st January 2004 that aimed to get it effectively implemented. After initial hearing, the Court issued show cause notice and listed case in priority with a view to speedy settlement. The Court in Prakash Mani Sharma for ProPublic V. HMG et al[79] drew attention of the government towards implementation of the legal provision.

Government Held Accountable to Reform Discriminatory Penal Provision on Abortion: In Sapana Pradhan Malla for FWLD V. Ministry of Law and Justice et al[80] the Court entered into the rationality and reasonability of penal provisions concerning forced abortion. In this case Constitutionality of No 28 (A) and No 32 of Chapter on Homicide was challenged. Challenged provisions provided that perpetrator who forces pregnant woman to have an abortion and consequently that results in miscarriage is subject to nominal punishment ranging from 3 to 6 month imprisonment; whereas, under No 28 a woman who commits abortion voluntarily except in permissible grounds prescribed by law is subject to severe punishment ranging from 3 to 5 years imprisonment.

The Court held that the law that provides different punishment for similar type of offence couldn't in any way be considered rational and reasonable. The Court went on to say that though punishment is a matter of state policy, the Court shouldn't refrain from fulfilling it's Constitutional obligation towards eliminating discriminatory laws. The Court found said provisions discriminatory and insufficient to protect women's right to freedom from violence. Hence, directive order was issued to the government for amendment of said No 28(A) and 32 so as to make

them compatible with the provision under No 28 of the Chapter on Homicide.

Discriminatory Incest Law Against Widow's Freedom of Marriage Legitimised: Ishwori Prasad Paudel who was employed in the Indian Army died while he was in service. His widow Tara Paudel and his younger brother got married with their free and full consent. A son was also begotten from them. Dwarika Upadhyay who was other than a beneficiary coparcener had filed a lawsuit of incest in District Court invoking the No 4 of the Chapter on Incest of the Country Code that aims to prevent incestuous relationship between younger brother and elder brother's wife.[81]

Challenging the validity of No 4 of chapter on Incest, Tara Devi filed the case[82] in Supreme Court under Art 88(1) of the Constitution. She also prayed to quash the lawsuit filed in District Court against her. Petitioner contended in the petition that prohibition imposed upon marital relationship between "widow of an elder brother" and "younger brother of deceased husband of widow" tantamount to gender discrimination because disputed law has not prohibited the marriage of widower with the younger sister of his deceased wife. Rejecting the plea of the petitioner, a special bench of the Supreme Court held the No 4 of the chapter on Incest Constitutional. Despite the guarantee of gender equality in term of freedom of marriage under the Constitution and CEDAW, the Court legitimized the defective norms and values of Hindu Religion at the cost of individual liberty of Tara Paudel. The Court specially went through mechanical interpretation in order to legitimize disputed provision as follows:

> Under the Nepalese Legal System the rights and liabilities of the husband get transferred to his widow after his demise simply because the wife is a member of the family and she is entitled as a coparcener to the share of the partition, the relationship between husband and wife shall remain effective so long as the wife maintains piety to her husband. And so long as she continue to hold the previous relation as the wife of the elder brother regarding the younger brother of the dead husband it doesn't seem to be lawful to say that the widow of an elder brother does not continue to hold the previous relation as the wife of the elder brother regarding the younger brother of her dead husband.

Responding the contention of the petitioner that the impugned No 4 is discriminatory between male and female as it does not prevent a marriage between a widower and the younger sister of his wife the Court observed:

> …Such a sister of deceased wife does not become either a member of the widower's family having any type of claim to any beneficiary right or to be a collateral. That is to say a widower and a widow cannot be treated as equals in this regard. Both of them do not seem to have equal status in view of the legal provisions influenced by social, religious and traditional beliefs and practices.

The Court further noted that objective of said provision is to control adultery in the society and generally, it shall not be at all proper for the Court to interfere with the wisdom and reasoning of the legislature regarding such matter.

Order Aimed to Eliminate Chhaupadi Tradition Issued: Responding Dil Bahadur Bishwokarma et al V. HMG Office of Prime Minister and Council of Ministers et al[83] the Supreme Court issued mandamus to the government to take pro-active intervention including the creation of awareness to eliminate *chhaupadi* tradition from society. Simultaneously, the Court also issued directive order to the government for bringing comprehensive laws to cope with the customary practices like *chhaupadi* detrimental to health of the women. The Court took serious concern over governmental reluctance towards elimination of such inhuman tradition. The case was brought to the Supreme Court by dozen of lawyers representing different social organisations challenging the long standing customary practice that has proved detrimental to the reproductive health of the women. In fact, Chhaupadi is a superstitious tradition performed specially in time of menstruation and delivery. It mostly exists in the far western regions of Nepal where the socio economic and educational situation of people is pathetic. Under this tradition women are placed in a dark room for several days without hygienic foods especially during first menstruation and post delivery period also. Mobility is severely curtailed. Women are treated as untouchable. They are also considered impure, polluted, and not allowed out for religious and other social functions.

Directive Issued for Amendment of Polygamy Law: In Chandra Kanta Gnywali et al V. HMG, Office of the Prime Minister and Council of Ministries et al[84] , the petitioners contended that No 9 of the chapter on Marriage contravened the fundamental right to equality under Art 11 of the Constitution and demanded that the Supreme Court declare it ultra virus of the Constitution. Disputed No 9 provided that a man was allowed for bigamy even if his first wife was living, if she became incurably insane; no child was born or was alive within ten years of marriage or if the children did not survive; turned blind; became crippled, or was separated after taking a share of her husband's property. However, the same rights were not applicable to a wife under similar circumstances because women were subject to punishment on adultery.

In response to the petitioners' plea, a special bench of the Supreme Court observed that the legal provision that allows man to get remarried and disallows woman making her subject to the punishment if she gets remarried on the same grounds can be counted as discriminatory against them. Though the Court was mainly called upon to eliminate discriminatory legal provisions allowing polygamous marriage based on disability and infertility, the Supreme Court seemed much more concerned about provision on adultery that prevents women from getting remarried. The Court seemed unwilling to strike a gender balance by allowing women for

remarriage as Court noted that to allow only man for remarriage tantamount to gender discrimination. Most crucial point here is that if women are also allowed to remarriage by making law it further extends the disability-based discrimination.

Notwithstanding the judicial interpretation, the Supreme Court finally did not dictate particular amendment but left it to the parliament as the Court just issued directive to the government for making proper amendment of No 9 as per the Constitution and CEDAW Convention. The Court also asked government to go through public consultation on the issue before amendment takes place.

Women's Equal Right to Found Family Upheld: The Supreme Court of Nepal delivered another landmark decision in Meera Gurung V. Department of Immigration[85] that recognised equal status of men and women in term of right to found family. Petitioner Meera Gurung, a Nepalese national, married an Iranian national, Dr Reja Mehumudhi, while they were pursuing their medical education in the Philippines. In 1991, they came to Nepal. They decided to stay in Nepal and continue their medical practice. However, the Immigration Department refused to grant Dr Mehumudi a spousal visa for a period beyond four months in a year, on the basis of clause 8 (4) of the Immigration regulations. Under clause 8 (3) of the Immigration Regulations 1976, a foreign woman married to a Nepalese man could obtain a residential visa for the duration of the marriage, and for three months following it's termination; whereas, the foreign husband of a Nepalese woman was not entitled to the same privilege. But, under clause 8 (4) the alien husband was only permitted a four-month visa in one year. Nepalese women and their foreign husbands were therefore not entitled to the privileges given to Nepalese men and their foreign wives under clause 8 (3).

Meera brought the case in Supreme Court challenging the Constitutional validity of clause 8(4) of Immigration Regulation. The division bench delivered divided opinion so the case was referred to special bench comprising three judges. Finally the Special bench of the Supreme Court found the disputed provision discriminatory and declared ultra virus of the Constitution. The judgment specially recognised the independent identity of women and upheld the rights of women to marriage and to found a family without any limitation. It also guaranteed women's right against forcible change of citizenship due to marital relationship with foreign husband. In declaring ultra virus the Court made very significant observation:

Nepalese man is privileged through the favorable treatment of their wives in matters regarding visas. A foreign spouse is entitled to preferential treatment in the issue of a visa simply through her marriage to a Nepalese man. However, the same privilege is not granted to the foreign husbands of Nepalese women, who are not able to obtain a residential visa. Hence, the said clauses of the Immigration Regulations being discriminatory and as such inconsistent with Article 11 of the Constitution of the Kingdom of Nepal are declared null and void. The petitioner's husband is therefore entitled to obtain a residential visa to

stay with his wife in Nepal.

Other notable achievements:

1. Exercise of Public Interest Litigation has become fruitful in term of eliminating discriminatory laws. For example, No 7 of the Chapter on Rape and Clause 4 of the Immigration Regulation 1976 have been eliminated which were impairing the enjoyment of reproductive rights. Additionally, the abortion law has been liberalised as a result of PIL.
2. Another most important achievement obtained through PIL is the judicial recognition to 'the marital rape as a form of heinous crime', 'sexual harassment as a gender based violence', 'virginity test order as a violation of right to privacy', 'right to equal protection of law irrespective of character'. This type of judicial recognition has immense jurisprudential significance in enhancing reproductive rights.
3. Judicial activism through PIL has also resulted in acceleration of law reform process. Government has been asked by the Court to take immediate initiative for amendment of unjust and discriminatory laws, which are preventing women from enjoying reproductive rights. For example, No 9 of the Chapter on Marriage that allowing polygamy, and No 28(A) and No 32 of the Chapter on Homicide encouraging forced abortion fall under this category.
4. The process of implementation of law has been accelerated due to judicial intervention. Specially, the Court held the government accountable for the implementation of legal provisions aimed at promoting breastfeeding and the provision of child care facilities at the work place.
5. PIL has also become instrumental to hold government accountable towards the translation of reproductive rights protected under the Constitution and the ratified conventions. Judicial decisions that dictate government to bring laws dealing with 'marital rape', 'sexual harassment', and '*chhaupadi* tradition' and maternity protection are counted important in this regard.
6. PIL has also played educative role. It brought many reproductive rights related issues like marital rape, polygamy, maternity protection and women's sexuality into public consultation and debate. Judges, law enforcers, law makers, bureaucrats and general public have got sensitised and educated.
7. Contributions have also been made in terms of domestication of treaty provisions. The Court delivered most of the judgment specially taking into account the provisions under ratified conventions that are aimed protecting and promoting reproductive rights.
8. Last, but not least, is the weakening patriarchy due to the huge blow given by PIL. In fact, during this period PIL has played a tremendous role in getting Nepalese women to be rid of patriarchal norms and values that are responsible for keeping men's control over women's sexuality.

Despite the above achievements some weaknesses can also be observed. In Maternity Protection Case, though the Court recognised the urgent need for adequate maternity leave at the workplace for the sake of maternal and child health, the Court did blunder by refusing the maternity leave as a right. Likewise, in the Sexual Harassment Case the Court declared harassment a serious violation of women's human rights but stopped short of formulating judicial guidelines that are needed to enable women to enjoy their rights even during the absence of legislation. In the Polygamy Case though the Court found the legal provision discriminatory on the basis of gender but refused to declare such laws ultra virus of the Constitution. Also the Court failed to recognise disability-based discrimination as the Court was more concerned about creating gender neutrality by allowing women to get remarried rather than by eliminating polygamy.

V
Concluding Observations

Nepalese women are entitled to various reproductive rights which are explicitly or implicitly protected under the Constitution and international instruments. Reproductive rights decorated in such way in texts are still dream for most of the Nepalese women. In practice violation of reproductive rights is rampant. Many women are facing serious problems especially due to discriminatory laws, weak implementation and absence of laws in many reproductive areas. Reproductive justice is still beyond the reach of women who are born in ignorance and die in ignorance. In such a situation the judiciary must play a positive role for the meaningful realization of these rights. Public Interest Litigation is one of the tools through which the judiciary can play that role. To some extent the judiciary has played its role through PIL to enforce these types of rights. On the whole, the judicial responses made in this regard through PIL have been positive. Judicial responses in eliminating discriminatory laws, in accelerating implementation of positive laws and in holding government accountable for the enactment of new laws are highly appreciable. Though PIL in Nepal is in its infancy it has become instrumental in making the state accountable towards such reproductive rights as are protected under the Constitution and the ratified conventions.

Notes

[1] Article 9

[2] NKP, 2052(1995) Vol. 6, P.462

[3] NKP 2055(1998) Vol. 8, P. 476

[4] Publication of Decisions relating to Human Rights, Special Issue, Supreme Court, 2058(2002), P 129

[5] Article 1

[6] Preamble reads " Whereas, in keeping with the desire of the Nepalese people expressed through the recent people's movement to bring about Constitutional changes, we are further inspired by the objective of securing to the Nepalese people social, political and economic justice long into the future…"

[7] Article 11 reads: (1) All citizens shall be equal before the law. No person shall be denied the equal protection of the laws. (2) No discrimination shall be made against any citizen in the application of general laws on grounds of religion (dharma), race (varna), sex (linga), caste (jât), tribe (jâti) or ideological conviction (vaicârik) or any of these. (3) The State shall not discriminate among citizens on grounds of religion, race, sex, caste, tribe, or ideological conviction or any of these. Provided that special provisions may be made by law for the protection and advancement of the interests of women, children, the aged or those who are physically or mentally incapacitated or those who belong to a class which is economically, socially or educationally backward.

[8] NKP, 2057(1999) p..376.

[9] Constitution of the Kingdom of Nepal, Art 25(1).

[10] Id Article 25(2).

[11] Id Article 26(7).

[12] Id Article 26(8).

[13] Id Article 26(9).

[14] Prakash Mani Sharma for Pro Public Vs HMG, NKP, 2054(1997) P.312; Yogi Narahari Nath et al Vs Prime Minister Girija Prasad Koirala et al NKP 2053, P 33.

[15] Art 12(1) reads: No person shall be deprived of his personal liberty save in accordance with law, and no law shall be made which provides for capital punishment.

[16] Surya Dhungel V. Godhavari Marbal Industries Pvt. Ltd. et al, NKP, Golden Jubilee Special Issue 2052, P 168.

[17] Article 22 reads: Except as provided by law, the privacy of the person, house, property, document, correspondence or information of anyone is inviolable.

[18] Supra Note 5.

[19] WPN 3668, Decided on Dec 10, 2001, Published in Compilation of Gender Sensitive Judicial Decisions, Pro Public, 2060(2003) p.31.

[20] Chhabi Peters V. Home Ministry and others, NKP 1992 SC 443; Benjamin Peters et al V. Home Ministry et al, NKP 1992, SC 432

[21] Section 9

[22] Nepal is a party of ICCPR, ICESCR, CEARD, CEDAW, CRC, CAT etc.

[23] ICCPR, Article 6(1).

[24] ICCPR, Article 9(1).

[25] ICCPR, Article 17(1).

[26] ICCPR, Article 26.

[27] ICESCR, Article 10(1).

[28] ICESCR, Article 11(1).

[29] ICESCR, Article 15(1)(b).

[30] ICESCR, article 12.

[31] CEDAW, Preamble

[32] CEDAW, Article 2, 5.

[33] CEDAW, Article 12.

[34] CEDAW, Article 16 obliges States parties to take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations.

[35] No 28 of the Chapter on Homicide, Country Code of Nepal 1963.

[36] Read No 28 and 28(A) along with the No 32 of the Chapter on Homicide, Country code of Nepal 1963

[37] Infra Note 77.

[38] No 2 of the Chapter on Marriage, Country Code of Nepal 1963

[39] No 2(9) of the Chapter on Marriage, Country Code of Nepal 1963

[40] Population Census Result from Gender Perspective (Population Census 2001) Vol. 3, National Planning Commission Secretariat, Central Bureau of Statistics, Kathmandu, Nepal

[41] Constitution of the Kingdom of Nepal 1990, Article 9.

[42] Id Article 9(5).

[43] No 16 of Chapter on Partition, Country Code of Nepal 1963.

[44] No 2 of the Chapter on Exclusive Property of Women, Country Code of Nepal 1963.

[45] Currently Prakash Mani Sharma et al for Pro Public V. HMG Cabinet Secretariat et al and Lili Thapa et al V. HMG Cabinet Secretariat et al. are under consideration of Supreme Court.

[46] No 2 of Chapter on Adultery, Country Code of Nepal 1963.

[47] Civil Service Regulation, 1993, Rules 59(2); Labor Rules 1993, Rule 34; Labor Rules relating to Tea Estates 1993, Rule 35.

[48] No 2 of Chapter on Adoption, Country Code of Nepal 1963.

[49] Section 4, Birth, Death and Personal Incident Registration Act 2033.

[50] Section 4, Child Act 1992.

[51] No 1 of the Chapter on Rape reads " It is deemed rape: a) if a man has a sexual intercourse with a woman, who is unmarried, widow, and other's wife and is under16 years of age with or without her consent ; b) if a man has a sexual intercourse with a woman, who is unmarried, widow, and other's wife her consent by means of either physical force, or intimidation, or undue influence or any of them."

[52] See Infra Note 72.

[53] No 28(A) of Chapter on Homicide, Country Code of Nepal 1963.

[54] For example: Labor Act 1991, Section42 requires Enterprises having at least 50 female workers must provide child care facility and arrange special break for breastfeeding.

[55] See, Special Measures for Women and Their Impact, FWLD, April 2003, P 83.

[56] Breast Milk substitute (control of sale and distribution) Act, 1992

[57] Article 6 declares consumer rights that have implication upon reproductive rights also.

[58] Iodized Salt Act 1999.

[59] It prevails particularly in far eastern Region of Nepal. Under this women are compelled to observe defective cultural norms at the time of mestruastion and delivery. They are restricted to go outside. They are treated as untouchable and considered unfit for religious and social functions.

[60] See Infra Note 69, 70, 80, etc.

[61] UNDP, Nepal Human Development Report 2004, p. 53-54

[62] Ministry of Women, Children and Social Welfare (MWCSW), CEDAW Status Review, A Study to make the State accountable towards effective implementation of the CEDAW Convention, November 2001, p..55

[63] CEDAW Monitoring Committee, Nepal, Shadow Report on the the Second and Third Periodic Report of Government of Nepal on CEDAW Convention, November 2003, p.48.

[64] Constitution of the Kingdom of Nepal 1990, Art 23.

[65] Art 88 reads: (1) Any Nepali citizen may file a petition in the Supreme Court to have any law or any part thereof declared void on the ground of inconsistency with this Constitution because it imposes an unreasonable restriction on the enjoyment of the fundamental rights conferred by this Constitution or on any other ground, and extraordinary power shall rest with the Supreme Court to declare that law as void either ab initio or from the date of its decision if it appears that the law in question is inconsistent with the Constitution.

(2) The Supreme Court shall, for the enforcement of the fundamental rights conferred by this Constitution, for the enforcement of any other legal right for which no other remedy has been provided or for which the remedy even though provided appears to be inadequate or ineffective, or for the settlement of any Constitutional or legal question involved in any dispute of public interest or concern, have the extraordinary power to issue necessary and appropriate orders to enforce such rights or to settle the dispute. For these purposes the Supreme Court may, with a view to imparting full justice and providing the appropriate remedy, issue appropriate orders and writs including habeas corpus, mandamus, certiorari, Prohibition and quo warranto

[66] NKP 2055(1998) Vol. 8, p. 476.

[67] Publication of Decisions relating to Human Rights, Special Issue, Supreme Court, 2058(2002), P144

[68] It reads " Whoever commits rape to a prostitute in any manner with physical force without her free will and consent shall be punishable with fine up to five hundred rupees or with imprisonment up to one years".

[69] NKP 2053(1996) SC, Vol. 7, P537.

[70] NKP 2052(1995) SC, Vol. 6, p. 662.

[71] No 28 of the Chapter on homicide, Country Code of Nepal, 1963.

[72] WPN 88, Decided on September 11 2003.

[73] WPN 3434 (decided on 2060/11/29)

[74] Vishaka V. State of Rajasthan, AIR 1997 SC3011; AIR 1997 SC 3014.

[75] WPN 55, Decided on May 2, 2002.

[76] See, supra Note 55

[77] Tek Tamrakar et al for Pro Public Vs Office of Prime Minister and Council of Ministers at al filed on 22nd April 2003 (sub-judice)

[78] WPN 2612, Decided on November 5, 2004.

[79] WPN 34, Decided on May 2, 2005.

[80] WPN 52, decided on February 24, 2005.

[81] No 4 reads "…If someone committed incest with the wife of his elder brother he will be sentenced to 3 to 6 years of imprisonment if the women happened to be the wife of an elder brother born of the same mother…"

[82] Dr. Ram Krishna Timilsena (Editor), Some Landmark Decisions of the Supreme Court of Nepal, Supreme Court,2003, P.261

[83] WPN 48, decided on April 5, 2005.

[84] WPN 37, decided on March 24, 2005.

[85] NKP, 2052(1993) p. 68.

Eliminating Childhood Malnutrition
Discussions with Mothers and Anganwadi Workers

A.R. Dongre, P.R. Deshmukh*, B.S. Garg
Dr Sushila Nayar School of Public Health, Mahatma Gandhi Institute of Medical Sciences, Sewagram – 442 102 India.

Abstract: *This study explores anganwadi workers' (AWW) perceptions of the operational constraints in reducing child malnutrition and the mothers' perceptions regarding the supplementary nutrition given to beneficiaries. The present triangulated formative research was undertaken in the villages surrounding the Primary Health Centre at Anji in rural Wardha district. The AWWs indicated four major groups of operational constraints in reducing malnutrition. The first comprised reasons related to co-operation like poor cooperation from villagers and parents, irregular and poor health check up activity. The second comprised reasons related to the mothers like failure to follow medical and dietary advice as they remained busy in their seasonal agricultural work. The rest were related to poverty and poor sanitation. The major issue mothers was related to poor quality of supplementary food.*

*Email: prdeshmukh@gmail.com ,

The Integrated Child Development Service (ICDS) scheme is presently the only major national programme in the country which focuses on the nutrition needs of under six children, adolescent girls, pregnant and lactating women through Anganwadi Workers (AWW). She has to ensure key child services like supplementary nutrition, micro-nutrient supplementation, immunization, periodic health check-ups and referral. Being a signatory of the Millennium Declaration of the UN Millennium Summit, India has to halve childhood malnutrition by year 2015 [UNDP, 2008]. Even after 30 years of implementation of ICDS, about 39.7 per cent of below three years children in Maharashtra were found undernourished and about 50 per cent children used Anganwadi services in the last 12 months [NFHS India, 2008]. The need for reappraisal of ICDS has already been recommended [Tandon and Kapil, 1993]. Therefore the aim of the present study was to formatively explore the Anganwadi workers' (AWW) perceptions regarding operational constraints in reducing child malnutrition and the mothers' perceptions regarding supplementary nutrition given to the beneficiaries under ICDS.

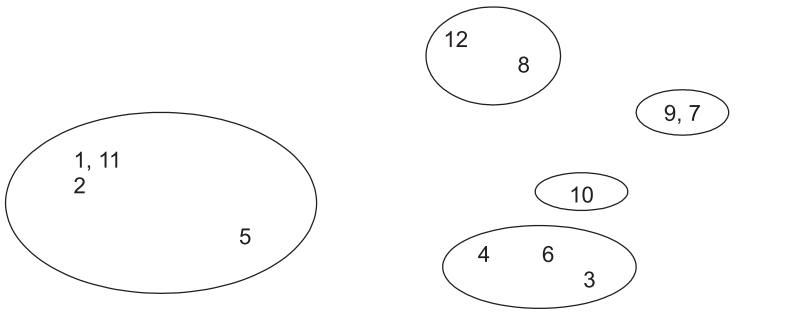
Study area and methods

The present study was undertaken in 23 villages surrounding the Primary Health Centre at Anji of rural Wardha, which is also a field practice area of Dr Sushila Nayar School of Public Health, Mahatma Gandhi Institute of Medical Sciences, Sewagram, having population of 31,482. It is a rural, agriculture-based population

with 80.5 per cent literacy (87.7 per cent among male and 72.8 per cent female), where the predominant religion was Hindu (86 per cent) followed by Buddhist (12 per cent) and other religious groups comprised 2 per cent of the population. About 11.4 per cent of the population was, below poverty line as per the norms of the Government of Maharashtra. Recently, in all the 23 villages, supplementary nutrition is being provided through women's self help groups (SHGs).

A triangulation of qualitative methods like free list, pile sort exercise [Dawson, Manderson and Tallo, 1993] and Focus Group Discussions (FGDs) [Hudelson, 1994] ,which are useful to explore the perceptions and attitudes of local people [Morgan, 1997] was undertaken to increase the validity of results. To begin with, all the Anganwadi Workers (n=25) were asked to individually enlist the operational constraints in reducing childhood malnutrition. Later, 12 operational constraints (Figure 1) with relatively high Smith's S value were pile sorted. In pile sort exercise, ten purposively selected Anganwadi Workers, who were willing to participate and talk freely, were individually asked to form the groups of these 12 constraints which they felt went together. These exercises were carried out in their monthly meeting where all the 25 anganwadi workers from 23 villages were present. A two dimensional scaling and hierarchical cluster analysis was completed with pile sort data to get collective picture of their perceptions. The analysis of free list and pile sort data was undertaken using Anthropac 4.98.1/X software *[ANTHROPAC,1998]*.

Figure 1: Causes of persistence of malnutrition as a public health problem as perceived by AWW: Two dimensional scaling and hierarchical cluster analysis



To understand the mothers' perceptions regarding supplementary nutrition, we conducted eight FGDs with the mothers of pre-school children from different purposively selected socio-economic strata of the study area. A trained social worker after obtaining informed consent conducted FGDs in local language with

the group of mothers (6-8 respondents) using semi-structured guidelines. The numbers of FGDs were decided by saturation point i.e where it stopped yielding any new information. The facilitators encouraged the participants to freely exchange their experiences related to supplementary nutrition at Anganwadis. A note taker carefully recorded the discussion in local language. Qualitative content analysis was used to analyze the data. All these exercises were carried out by a trained social worker with a degree of Masters in Social Work and who has five years of experience in using these methods. The sampling technique adopted for the present study was purposive with maximum variance.

According to AWWs, the various operational constraints in reducing child malnutrition (with descending Smith's S value) were: 1) poor cooperation from villagers; 2) poor understanding of parents; 3) mothers do not follow medical advice; 4) mothers are busy with farm work; 5) Irregular and poor health check up service; 6) mothers do not follow dietary advices; 7) poor personal hygiene of families; 8) poverty; 9) poor environmental sanitation; 10) poor child care practices; 11) poor support from authorities, and 12) various social problems.

Operational Issues and Quality of Food

In pile sort exercise, four major groups of causes of persistence of malnutrition were formed. The first major group comprised of reasons related to the co-operation like poor co-operation from villagers and parents, irregular and poor health check up activity. AWWs felt sandwiched between programme targets to reduce malnutrition and high expectations of village people from the government schemes. Sometimes, AWWs have to spend money from their pockets to prepare nutritious diet for severely malnourished child. The second group of constraints was related to the mothers. These related to failure to follow medical and dietary advice as they remained busy with their seasonal agricultural work. The rest of the two groups were related to poverty and poor environmental and personal hygiene. During discussions participating AWWs, revealed that apart from record keeping and supplementary nutrition for beneficiaries, which take up most of their work time, they have to spend time for other National Health Programmes like sanitation campaign and family welfare programme. (Figure 1)

The major issue that emerged from the mothers during FGDs was related to the poor quality of supplementary food. Mothers said that the khichari, a preparation of rice and dal (pulses), a common supplementary food, contained very little oil and dal component. So children refused to eat it every day. Although, there was variety in the supplementary food available, such as use of sprouted grains and green peas, it was less frequently prepared. Few women appreciated the newer initiative of involvement of village based women's self help groups in supplementary food distribution. The quality of supplementary nutrition improved in terms of use of oil and vegetables. It ensured involvement of villagers and supervision of gram panchayat (local self government) in service provision. However, the variety of

supplementary food items has decreased.

Anganwadi workers said the village based operational constraints for multifaceted problem of malnutrition ranged from poor cooperation at various levels to various social and financial problems related to beneficiaries. The mothers identified loopholes in supplementary nutrition program of ICDS.

One of the main objectives of Integrated Child Development Services Programme (ICDS) is to improve maternal and child nutrition. The effective delivery of ICDS services at village level depends on the efficiency of AWWs. In the present study, the AWWs pointed out several village level operational constraints in reducing child malnutrition. Most of the workload was due to record keeping which led to the neglect of their other primary functions such as nutritional education and informal education. Ghosh (2008) have already pointed out the similar fact and emphasized that AWWs prime responsibility should be health and nutrition education. Ghosh et al (2002) have also stressed that in-depth nutrition education regarding feeding with home available foods can help to improve nutrition. Integrated Management of Neonatal and Childhood Illnesses (IMNCI) have emphasized dietary counselling of the mothers on frequency of feeding and adding oil/ghee in diet [MoHWF,2006]. AWW should devote more time for nutrition education on faulty feeding practices of mothers. The arrival of another village level female worker called Accredited Social Health Activist (ASHA) under recently launched National Rural Health Mission (NRHM) may be trained in effective communication to bridge gaps in present maternal and child health services and to support the Anganwadi Worker in imparting Nutritional Education of mothers [Ghosh, Kilaru and Ganapathy, 2002].

Without adequately addressing the existing field level operational constraints in ICDS, the involvement of AWWs in other national health programs at the cost of their essential primary functions and the quality of supplementary food, the problem of malnutrition is less likely to get reduced. As a step towards ensuring community participation, the involvement of village based women's self help group and village gram panchayat(local self government) in supplementary food distribution is encouraging, but their sensitisation regarding qualitative and nutritive aspects of supplementary nutrition is crucial. The grampanchayat can now ensure this through Village Health, Nutrition and Sanitation Committee (VHNSC) formed in each village under National Rural Health Mission. Kent (2006) has suggested the right based approach specifying entitlement of beneficiaries for supplementary feeding and entitled families should be informed of what services they are entitled to. Notably, the success of community based Tamil Nadu Integrated Nutrition Project (TINP) was in their focused approach on nutrition intervention including growth monitoring and selective nutritional supplementation [Rohde, Chatterjee and Morley, 1993].

To efficiently tap the potential of AWWs for reducing multidimensional problem of malnutrition, ICDS needs to design and implement flexible, area-specific and

focused activities for AWWs. The capacity of ICDS staff should be improved to address field level operational constraints in reducing child malnutrition. In order to maintain quality, the selective supplementary nutrition may be undertaken. AWW should spend more time on nutrition education related to faulty feeding practices of the mothers. The scope of the present formative study was limited to explore perceptions of AWW and the mothers based on qualitative data, which is useful for generation of hypothesis for future research.

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Gender-specific Human Rights Responsibilities of Health Professionals

Adriaan van Es
Coordinator, International Federation of Health and Human Rights Organisations (IFHHRO)

Abstract: *The systematic violence against women and suppression of their human rights is a very clear area where the human rights advocacy of doctors and nurses is welcome, indispensable but unfortunately often absent. How can the involvement of health workers be bent towards active and effective participation in the struggle against these violations of women's rights?*

"Domestic violence against women includes (i.a.): women-battering, marital rape, incest, forced prostitution, violence against domestic workers, sex-selective abortions, female infanticide, forced & early marriage, son preference, FGM, honour crimes, enforced malnutrition, unequal access to health care, dowry violence, forces pregnancy, abortion, sterilization, trafficking. " --Special Rapporteur on Violence Against women (UNCHR)

This quote from the Special Rapporteur on violence against women provides clear examples where women are victims of violence in a systematic way, and in situations where health professionals, in their capacity of trusted nurse, doctor, caregiver, are also witness of the devastating effects of such violence. The question here is: What will these doctors and nurses do with their testimonies, besides their clinical duties they will perform?

The central objective of the International Federation of Health and Human Rights Organisations (IFHHRO) and its member organisations is to mobilise and facilitate health professionals to monitor human rights violations, such as the above mentioned, and to make their skills available in the investigation of human rights violations. The systematic violence against women and suppression of their human rights is a clear area where the human rights advocacy of doctors and nurses is welcome, indispensable but unfortunately often absent.

In their daily work many health workers are confronted with human rights violations, problems and dilemmas. IFHHRO's definition of health workers includes health professionals such as doctors and nurses, but also all others who work in the health sectors-from administrators to ambulance drivers-and those involved in health policy making and researchers in the field of health and human rights.

At the core of IFHHRO's human rights activities lies enhancing the implementation of the right to health, among other things by empowering health workers in this task. The UN Committee on Economic, Social and Cultural Rights consulted IFHHRO in the articulation of General Comment 14: the Right to the Highest Attainable Standard of Health.

IFFHRO's second important aim is to enhance the protection of other health-related human rights, including the right to life and the prohibition of torture. It investigates violations of these rights and reports on possible violations and malpractices.

Right to health as priority for health workers

The well-being of and care for their patients is the prime concern and responsibility of health workers. They apply their expertise to the best of their knowledge for the benefit of the sick, research for new approaches and technologies, and contribute to policy making in clinical and public health. They do this within the boundaries of regulations and budgets. These are increasingly subject to mechanisms of globalisation and privatisation.

Health workers are confronted with violations of the right to health on a daily basis. They witness discrimination – on the basis of gender, race, ethnicity or political faction - in access to health care. Increasingly they are concerned - and aware - of these violations. In their daily work however, they are hardly facilitated to systematically monitor (or contribute to monitoring) and reporting violations of the right to health. Too often health institutions pay no attention, let alone priority, to the implementation of the right to health. Many health workers perceive health not as a right, but as a commodity, charity or service. The level of lobbying for a rights-based approach in health policy by national medical associations varies widely, but is more absent than visible. They are hardly involved in holding their governments and agencies accountable for the non-implementation of the right to health. Little priority is given to human rights in the curricula in medical and nursing schools. Involvement of health workers in right to health litigation is scarce. IFHHRO strongly believes it is in the position to change this. It is the only federation of organisations that exclusively mobilizes health workers for the protection and promotion of human rights.

Health workers witness violations of health related human right

Frequently doctors, nurses and other health workers are confronted with human rights violations; they are often the first, and at times the only ones, who witness the painful and lifelong consequences and damage to individuals and groups.

The Right to Health

The Right to Health is short for "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", a phrase coined by the UN Committee on Economic, Social and Cultural Rights (CESCR) to ensure all people equal access to health care and health-related services (e.g., clean drinking water), within the limits of a State's capacity. In May 2000, CESCR published General Comment No. 14, which provided a detailed description of the obligations of States to secure the Right to Health, as well as criteria for monitoring this right.

General Comment No. 14 strengthens the basic principle that the accessibility, availability and affordability of health care of good quality are an inalienable right for all. In the 21st Century, the Right to Health is a right, not just a service and not a charity, commodity or a privilege. Absence of available, accessible and affordable health care and underlying preconditions of health is thus not an absence of service, but a violation of a basic human right.

Recognizing that there is a Right to Health implies that governments have obligations, both with regard to medical services and to other aspects of life that determine health, such as clean drinking water and adequate sanitation, or protection against environmental and occupational hazards. It also implies that individuals and groups can hold their governments accountable for not taking progressive measures to comply with these obligations. Since 2002, there is a Special Rapporteur on the Right to Health, who oversees the progress made by governments in realizing the Right to Health.

On a daily basis doctors and nurses face the discrimination, pain and stigma of women and men with HIV/Aids. However, they are hardly facilitated to apply existing guidelines, and they mostly don't know where to report failures of application of guidelines and violations of human rights. Health workers seeing the discrimination of vulnerable groups in access to health care have the same problems. Poverty related diseases, marginalisation, non-participation, loss of autonomy and dignity are all human rights violations that health workers have to face, often with a sense of powerlessness and frustration not knowing what to do about it.

Other examples are, sex- selective abortion and girl infanticide (i.e. through

negligence), leading to millions of missing women, avoidable deaths during maternity and delivery, violence against women. It all happens under the eyes of doctors, nurses and midwives. How can the involvement of health workers be bent towards active and effective participation in the struggle against these violations of women's rights?

Medical forensic experts – in cooperation with jurists – have greatly contributed to the investigation and documentation of torture and extra judicial killings. The Istanbul Protocol for the investigation and documentation of victims of torture and the Minnesota Protocol for the investigation and documentation of political murders, genocide and mass graves, were articulated with the indispensable input from the medical professions, and are now major cornerstones in the legal procedures against perpetrators.

Nevertheless there is still a lack of knowledge among health workers: ignorance about the existence, low priority and lack of capacity cause insufficient use of international conventions, protocols and national laws. In addition doctors who want to make the existing protocols work, may face unwilling and repressive political authorities.

Dual Loyalty

The prime concern of health workers is the well being of their patients. Many doctors and nurses, however, face the problem of dual loyalty. While expected to be loyal to the persons in their care, they are also expected to be loyal to their superiors, employers of institutions that have or serve interests contrary to the interests of patients.

Not only history (e.g., the second world war, apartheid South Africa – ref. the TRC hearings) but also today's reality (war on terror, military doctors in Guantánamo Bay) illustrates how weak, and how much under pressure, is the position of health workers, especially in locations such as prisons, forensic settings, military, refugee services.

Here too, the question is what facilities do these health workers have to expose violations of human rights, how much protection do they get when they speak out, how much awareness do they have and what is the level of training in human rights issues? What can they do when the political situation is repressive or unstable? How do they deal with patient confidentiality when reporting human rights violations?

A growing number of NGOs and social movements are involved in monitoring the implementation of the right to health. As an organisation that exclusively mobilizes health workers for the protection of human rights, IFHHRO has a crucial added value in the implementation of the right to health by prioritising human rights and the right to health among health workers and their organizations.

Health professionals are focussed on their duties towards patients in their daily work. At large they may be unaware of the larger context in which they perform

their professional duties. Many health professionals are unaware of the larger context that illustrate the huge gender difference in access to health care, clean drinking water and sanitation, the specific health aspects of the discrimination against women in health issues such as sex-selective abortion, girl infanticide, huge risk of maternal mortality and many other aspects.

Monitoring and advocacy by health professionals

IFHHRO has conducted two surveys to get a better picture of the degree to which health professionals play a role in the formal monitoring mechanisms, such as parallel reporting to supervising committees of international covenants.

> The International Criminal Tribunal on the former Yugoslavia has clearly condemned rape as a war crime. In all armed conflicts and wars, rape is being used by armed groups as a weapon and a tool of destabilisation. Women are always the victims on a large scale, and will often stay silent out of fear for marginalisation and victimisation. IFHHRO member Physicians for Human Rights conducted surveys in Darfur by applying medical (clinical and epidemiological) skills and established clear evidence of genocide, in which rape played an important role. From the report Rape as a Weapon of War in Darfur: "Rape and sexual violence continue at an alarming rate in the ongoing genocide in Darfur. Sudanese security forces, including police deployed to protect Internally Displaced Persons (IDPs), and allied Janjaweed militias have been implicated in acts of rape and sexual violence. Women IDPs and refugees report also being forced to exchange sexual favours for desperately needed goods and services. The Office of the Prosecutor of the International Criminal Court has identified "high numbers of… mass rapes and other forms of extremely serious gender violence" (http://physiciansforhumanrights.org/sudan/rape)

The conclusion was that health professionals are greatly underrepresented in groups and organisations involved in parallel reporting. The second survey showed that where monitoring takes place, such as by IFHHRO members and related organisations, this is mostly not done in a systematic continuous way.

There are however several good practices and hopeful signs of improvement. The IFHHRO survey found that the Dilaasa project of CEHAT one of the most appealing examples of good practice.

Agenda for Change

How can the involvement of health professionals be promoted? How can health professionals move more to the forefront in civil society?

The policy of IFHHRO contains several strategies for change. Together with its member organisations and observers, IFHHRO has extensive expertise in all aspects of health-related human rights and the right to health. Rooted in the health professions it is in the position to effectively mobilize this expertise for the promotion of human rights and the implementation of the right to health, and to sensitise health workers for human rights issues.

All activities aim at strengthening and empowering the international community of human rights concerned health workers, and making available the expertise of IFHHRO and its members. The activities are divided in capacity building, awareness raising, monitoring, advocacy and support for health workers.

There are many high quality impact assessment instruments. One of these is HeRWAI, an impact assessment instrument developed by the Humanistic Committee on Human Rights (http://www.hom.nl/publicaties/HeRWAI%20def05%20totaal.pdf) that focuses specifically on women's rights. Many impact assessment instruments prove to be a momentary exercise, and are likely to consume much time and energy of scarce (wo) manpower in NGOs.

IFHHRO is developing a uniform easy-to-use monitoring format for the regional focal points, members and others. The main aim of this format is to monitor the right to health and health related human rights by country and topic. By providing a structured format health workers and all other interested organisations will be able to share their knowledge and provide input to a worldwide system. The IFHHRO secretariat will moderate and facilitate the system to ensure the sustainability and uniformity of this unique system.

The format will be linked to a database, which will provide inputs for fact sheets, the bi-annual report and provide information about the involvement of health workers – individual and organised – in the implementation of the right to health. By making this database accessible to the public it can also facilitate research, become a main source of information on the right to health in different countries and serve as a tool for promoting the implementation of the right to health.

IFHHRO has established Regional Focal Points in Latin America (LIMA) and Asia (Mumbai, with CEHAT). The Regional Focal Points will be the focus and spearheads in the systematic monitoring the implementation of the right to health in the regions. The RFP's will involve other organisations to complete the formats of an increasing number of countries in the region. In addition the RFP facilitate activities that are aimed at mobilizing health workers and their organisations in these monitoring activities.

It is expected that each Regional Focal Point will complete the monitoring format of the country in which the RFP is established. India, Peru and the Netherlands

are the three countries selected for the test phase of the format. Once the format has been proven to be easy to use and to the point the RFP will contact other organisations in the region to guide them in the process of completing the format for their representative countries.

Cooperation with UN Special Rapporteur on Right to Health

Monitoring and promoting the participation of health professionals in the implementation of the right to health is a core element in the activities of IFHHRO. One of the components in this is cooperation with the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health---implementing and expanding on his recommendations and making his reports known.

The reports by the Special Rapporteur have contributed significantly to the understanding and interpreting of international law in relation to the right to health. IFHHRO wants to sensitise health professionals to the recommendations in his reports, such as the need for promoting research and treatment programs of neglected diseases, policies to counter the devastating effects of the skills drain from the South, and maternal mortality as a human rights issue.

Awareness raising

Training of health workers and related organisations in monitoring the right to health is one of the core tools for raising awareness. In 2006 IFHHRO designed a specific course outline on monitoring the right to health and this outline is used as basis for all trainings. The trainings aim at raising awareness, mobilisation toward advocacy and lobbying for inclusion of health as a human right in the regular curriculum of medical and nursing schools. One of the aims of the trainings is to involve the participants in the monitoring system so intensive contact with the participants after the training is needed.

Making Expertise Available

IFHHRO is designing a database with available expertise in IFHHRO and its member-organisations. This database will serve as a broker for organisations that are looking for expertise.

Areas of available expertise will include: teaching health and human rights, and right to health, prison health, counselling hunger strikers, refugees, asylum seekers and health, torture and its consequences, Istanbul Protocol, mass grave investigation, corporal punishment & medical profession, death penalty & medical profession, health impact assessment, violence, mental health

Thematic conferences

IFHHRO has organised thematic conferences, in connection with its annual meetings. The conferences are meeting places for debate and elaboration of specific issues on health a human rights and provide input for the fact sheets. One of the

thematic conferences was the successful CEHAT conference, 'Engendering the Right to Health' in 2005.

Fact sheets and tools

Health workers are in need of easily accessible, easy-to-read tool on how to deal with human rights problems they face in the course of their daily work. IFHHRO plans to develop fact sheets on specific subjects containing essential background information on human rights and the right

Maternal Mortality

Ask an average doctor or nurse what a case of maternal death is, and a likely answer is "bad luck, poverty, long travel distance, no medicine…". The Right to Health is its rights-based approach tells us that maternal mortality is a huge violation of a fundamental human right, an outcry that in hugely outnumbers torture, for which there is more attention, funds and NGOs. This attention is good, but maternal mortality should by now be perceived as an as serious violation of human rights.

Health professionals can play an important role in monitoring and advocacy. The Milennium Development Goal on maternal mortality is the single most 'medical' one, as it clearly implies involvement of doctors and nurses, the availability and affordability of emergency obstetric care, provision of medicines, the existence of an integrated health care system, adequate implementation of all sexual and reproductive rights, adequate priorities in health care budgeting and the fulfilment of international obligations of rich countries. It is the obligation of health and human rights organisations to accept his invitation to make health professionals perceive maternal mortality as an unacceptable violation to witness as a doctor or nurse.

[An earlier version of this paper was presented for the IFFHRO Conference organised by CEHAT in 2005.]

Deepti Chirmulay
Some Memories

Shyam Ashtekar

Months after her passing away, I have now finally deleted her name and number from mobile and the email id that I used to hit so frequently. On midnight March 8, International Women's Day, Deepti passed away after a long fight with cancer secondaries. She was just 48 and was looking ahead for some good work on urban health.

Pediatrician by training from JMC Pune, she never really got into pediatric practice. Instead she joined BAIF soon after her post graduation. She frequently told me later that she abhorred the idea of living off patients as a private consultant. Many of us felt those days that private medical practice was a sad profession and that it was better to be on public system, but Deepti also abhorred a sarkari job. At BAIF she joined a project on health development. As is the system in funded NGOs MCH-RCH was a favourite agenda and Deepti spent quite some time on this job. Around that time, she got a fellowship enabling her to study many country health systems and a three-month sabbatical in a UK school of health.

In her personal life she went through the pangs of separation for her first and only child in her marriage. But her sanity ensured that the son could live with love with both sides and grandparents till she died. For me, it is a lonely world, but I have made it sure that the child does not suffer on this account, she'd say. The dispute (between her and her husband) is among adults and the child must be free from this pain she felt. We just wondered how she could have such a stoic approach, something that was seen time and again in her life.

She came from an illustrious family of (Paranjape), well-connected with intellectuals and reformers since the freedom struggle. She was related to Shakuntala Paranjapae, the first woman who started to popularize the concept of family planning in India after the neglected reformer R D Karve who lived and died an isolated man due to his espousing of the cause of family planning. Deepti had a strong individualistic streak and an ability to hold her own.

After the 'developmental' stint with BAIF she joined GTZ, a German funding organization in Pune. Partly this was to ensure funds for her retirement as a single parent. On the first day of her work there, she sent me an email about about her

new world with new adversities and challenges. Here she did worked on health insurance, especially the schemes for rural families. In Buldhana GTZ was helping a district bank for a health insurance scheme. I think she had quite an understanding of the health insurance sector. It is a ironic that she could later undertake the costly struggle against her cancer only because of the insurance.

Our association with her was mainly within the Primary Health Care group in Maharashtra, which mainly focused on the problem and essentiality of CHW programmes. Many of us were directly or indirectly associated with CHW programmes in NGOs. The group deliberated on all aspects of CHW programmes---syllabus, training, books, methods, community ownership, medicine supplies, tasks, remuneration and above all the relationship of such programmes with the governments. We met several times over the two-three years of its existence. I was the coordinator and Deepti followed after two years. We made a representation to the Maharashtra Government about a new scheme on pilot basis.

Deepti was instrumental in making a one-page outline of the GLY and it is interesting to see how close that was to the ASHA NRHM except that ASHA is very weak on basic medicare—something that we strongly emphasised in GLY prescribing a community sponsorship for the same. It is another story that Maharashtra Government at that time hardly paid any heed to this even though the scheme for 1,000 villages was included in the 10th Five Year Plan of the state-yet to be implemented. The group had a deep dissent over the GLY's relation with government. Some of us, Deepti included, felt that government would never properly run such schemes, and implementing these schemes a safe distance from government was the key to their success. The others felt that such a scheme should belong to the public sector and the government had a solemn duty about it. The ASHA scheme was a state dominated scheme, and it remains to be seen how it fares in the decade to come.

USHA-the urban counterpart is following the ASHA from 2008-9. Deepti, through her last job with the Gates Foundation-led PATH India was working with a few states on the urban RCH programme. Deepti chose to work on the urban health (mainly RCH), a much-neglected sector in India. She worked out the details of USHA and the project is going on in some cities of Maharashtra.

Her breast cancer was diagnosed in 2003-4 and she got a mastectomy done in Pune. The pathology report confirmed a malignant form and we were all worried about secondaries. Life under chemotherapy is a hard one indeed and I remember visiting her at her parents' home in Pune, tonsured head and fragile frame. She tired very easily. It was a six-week job on chemo and we thought the disease was over probably.

In 2005, she was in our team studying the Mitanin programme in Chattisgarh. She could not do the fieldwork fully, but helped me put together the report. Our fears about CHW programmes worsened when we saw the Mitanin scheme. We were convinced that people would reject such a lame duck scheme. Unfortunately ASHA was following in the footsteps of Mitanin with some differences. Unlike Mitanin, ASHA was to be paid for her RCH tasks. But her observations in UP and elsewhere underlined the same fear-of ASHA losing wind. In phone calls, it was a frequent point of discussion—how the government bungles schemes time and again. The serious discussions had to give way to derision to save our sanity. India needs professional health workers who will be useful to people and community and will be happy to pay small sums if it saves them time and further losses.

Public health activists are generally left of centre if not leftists. Deepti was one on the other side like me. We valued private enterprise, freedoms, creativity and a minimal government. We were deeply convinced that bureaucracy and political systems abhorred performance, accountability and quality and people would bypass public system if they can.

Not that she was happy about the private sector or the ugly US health system. In her last days in a very sophisticated hospital in Pune, she was fuming at the services after so much money was being paid. She told me shw would write on this if she survived. In the last stages, her son and relatives sought a second opinion on her treatment. Dr Anant Phadke was very close to her and was part of the second opinion process. He found it painful that two oncologists should differ so much on the line of treatment.

She went through the 'alternative treatment' stoically but had surrendered to the growing brain deposits. She was finally taken home to spend what was left of her life there. I tried to meet her twice, but could talk to her only once, and she would answer in monosyllables. Life was on the ebb. I could never believe that a bright life was to be no more just any day. On the night of 8th March, the International Women's day, she was no more. My friend called from her home and I sent the SMS to our common friends. On a personal front all of us were amazed at her brave way of going about the life as a single parent.

We were together on a Himalayan trekking group. She carried some adrenaline ampoules just in case someone needed it for an emergency. I carried some other medical stuff. It so happened that our group was badly treated in the journey to the hills. Oh it is sad they are unkind to us doctors, lest some guy needs our help in the hills, so she quipped. The first to suffer was ironically she herself. Trudging on the long winding paths in the hills, she started experiencing a strange vision problem-seeing her own eyeballs reflect in the back of her goggles. I was rather confused and asked her to rest for a while and sat alongside her asking her to breathe deeply,

the only thing I could advise there. This was a case of poor blood supply to the optic nerves. We made to the camp as tail enders. The same night, at about 2 am, we were woken up by the group leader to help a woman afflicted with mountain sickness. She was severely short of breath and the whole camp could hear her scream for breath. We had a homeopath also with us. The three of us treated the woman and Deepti's shot of adrenaline carried her through the night. The next day everything was all right. After that the doctors got very good treatment!

On the return journey, we saw the first telephone booth and called our homes. Deepti was utterly tired after the trek and vouched never to do it again. Alas, in the next month her breast cancer was detected and operated on. She did not make it to the five-year survival stat after that. The Path India job required her to operate from Delhi. I visited her there once. She was tired of staying out of suitcases. The evening loneliness of Delhi was too much. She longed for her home and the son who was in the second year of Engineering. She quit her well paying job and wanted to do consultancy. Soon after that headaches came as a warning of secondaries. The brain scans were a blow to all. She had many secondaries in the vital organ. Then she could do nothing except for hospital trips. Then came the end. A bright and smiling photograph of Deepti adorns her son's table. I ever remember her the same way.

There is something left to do. We want to commemorate her in some creative way. One suggestion is to start a home health care agency for ailing patients, cancers especially. She believed in enterprise rather than charity. We are thinking of starting a city based network of home care agencies in the state, which will give trained hands for care and some good income for women and men who want to do this. This was what she wanted to do if she was all right again. Deepti will be remembered every time we engage ASHAs, the rural insurance, the USHA to come next, the distrust for the government machinery and the home care we want to start in her name.

Books

Strategic Issues and Challenges in Health Management

Edited by V.Ramani, Dileep Mavalankar and Dipti Govil
Sage Publications, New Delhi;
2008; 227 pp; Rs 495.

Reviewer

Anil Paranjape

Administrator & Programme Director (Urban Health), Institute of Health Management, Pachod. (Pune Office), Kharadi Road, Pune 411 014. Email: anil@ihmp.org

The book aims to address an area of immense interest to all of us working in the field of Health Management in these turbulent times: Strategic issues and challenges. The articles are classified into 10 thematic areas that have been identified well-each an area for research in itself-showing the degree of conceptual thinking that went into the formulation of this book.

The first section on health systems planning and development begins with a chapter by Jeffrey D Sachs. As the chair of the Commission on Macroeconomics and Health he is an excellent position to discuss the linkages between health and development and the challenges faced by India. He writes of the strange dichotomy of excellent policies but 'dreadful' implementation in India. He notes that India has an well crafted health system which is quite similar to the 'close-to-client systems' that are recommended by the CMH. He rues the lack of funding which results in the system being 'essentially dysfunctional'. His essential recommendations – establishing a system of village level workers and schools of public health, read like a case for the National Rural Health Mission (NRHM). Considering that the NRHM is now in its third year the article appears rather dated. In the second article in this section Andrew Green examines the evolution of health systems since Alma Ata (1978) and examines the contextual changes being wrought by globalisation, climate change, technology etc. Hind vision as always and in this case too is 20/20 but here foresight too is in good shape. However, one wishes he did more than just touch upon the issues that would emerge in the future. Resultantly the recommendations too appear rather brief.

The second section addresses health care financing. G N V Ramana addresses the issue of equity in health care financing with characteristic erudition. He highlights key issues, suggests appropriate strategies for addressing them and presents succinct examples to explain these. The third section follows from here and highlights the utilisation of public-private partnerships (PPP) to increase access and ensure equity in health care. Meenakshi Datta Ghosh examines the opportunities for PPP

without developing an adequate case with regard to the key issues and hence lacks clarity of thought. Muraleedharan and his colleagues examine PPP in the control of tuberculosis in a far more coherent fashion and present excellent arguments that are well developed and provide clear cut conclusions and recommendations. In the last article of this section Aruna Rabel describes the Sri Lankan experience of PPP. This is again an excellent article which describes the processes involved in the making of a mature and effective PPP in a country which is economically less developed than India but has achieved much more when viewed from a public health perspective.

The fourth section addresses governance in health and is about the most disappointing part of this book. To begin with neither author has defined governance and hence they address rather specific areas without providing even a thumbnail sketch of the larger issues in governance. S. R. Rao in his chapter spends an inordinate amount of space on the LaLonde model of health promotion. The writer also displays a surprising lack of 'political correctness', when he speaks of the mentally retarded, deaf, dumb (can this be considered a separate category from deaf?), blind etc. Further the possibility of anyone referring to the rate of population growth as 'distressing' makes one pause and wonder as to how dated the concepts presented here might be! And finally to compound the display of insensitivity the writer attributes the ban on private practice to the *"moral vulnerabilities of the medical staff"*. H. Sudarshan in his article sticks to his areas of expertise in the field of governance, corruption (he is vigilance director, Karnataka Lokayukta). This makes for interesting but, rather restricted reading. This section could have been among the most interesting but has not been developed adequately and it is felt that authors from outside the government would have provided an additional facet to this rather uni-dimensional section.

Capacity development is the topic of the fifth section which is by far the best this book has to offer. Joe Curian provides an erudite assessment of leadership in health systems. The chapter begins with an examination of the health care industry and then goes on to examine the qualities required in a leader. Finally this very well rounded chapter ends with an examination of challenges that await leaders in the future where a "tolerance for ambiguity" would be an asset to adapt to a fast changing world. Nancy Gerein in her chapter on capacity development examines the evolution of this field and its present state. The process of capacity building and strategies adopted are elucidated. Future challenges are also well presented and analysed. K.B. Pradhan's article on the Aravind eye care model makes for extremely interesting reading but is marred by missing values (number of surgeries conducted in 2005, p160) and grammatical errors. This however, does not take away from the information regarding this excellent example of low cost, high quality service provision and cooperation for capacity development between developing countries.

The sixth section addresses national health programs. Rajeev Sadanandan

presents a critical analysis of the Indian AIDS control program. He briefly touches upon various issues such as the role of international politics in funding for HIV programmes, stigma and the criminalisation of HIV and the lack of skilled HR in programme management. Dileep Mavalankar describes the progress made on the implementation of the National Rural Health Mission. However, the fact that the article is principally based on a presentation provided by a government functionary, and presumably does not provide any personal insight, makes for a huge disappointment.

The section on maternal and child health begins with a article by Ardi Kaptiningsih on achieving 'Millennium Development Goal (MDG-5) – Reducing Maternal Mortality'. An astounding editorial error (MMR is explained as Measles, Mumps and Rubella - p151) takes away from an otherwise extremely well-crafted and succinct article. Urvashi Chandra and Sangeeta Singh in the next article, present case studies of the *Mitanin and Sanjeevani* programmes in Chattisgarh and Haryana respectively. These are effectively utilised to examine the role of community participation in Maternal and Child Health.

The eighth section addresses Urban Health, an issue whose time has finally come. KV Ramani, Mavalankar and their colleagues from IIM-A present their study of the utilisation of the PPP strategy by the Ahmedabad Municipal Corporation which was earlier available only as a working paper from the institute website. This is an appropriate forum for this very interesting paper.

Communicable diseases are the topic of the ninth section, where Friedman examines quality of care issues in India. In a well-crafted paper he examines the issues and strategies available for the country to follow so as to develop a system of accreditation and uniform quality across sectors offering health care services.

The last section is devoted to non communicable diseases. Nandakumar in his chapter writes of the control of cancer as a model for control of chronic diseases. This interesting article examines the cancer registry programme where data is collected at diverse sites and collated by electronic means. Vaidheesh in the last article of this book writes on the challenges in the delivery of health care. The article commences by quoting the prime minister and president of India without clarifying as to their individual identities. This tendency for shabby editing is further confirmed by a plethora of grammatical errors (articles, specifically 'a' and 'the' are either omitted or unnecessarily / incorrectly used) and thus the paper makes for very poor reading. To compound this, the author appears prone to hyperbole referring to gastric cancer as a 'killer' disease, breast cancer as a 'menace'.

The book is a useful addition to the literature on Health Management. However, introductory comments at the beginning of every section from the editors would have woven the sections into common themes and held the concepts together. And finally the editorial errors in a book of this quality are unforgivable. (The concluding comments of the article by S. R. Rao are clubbed with and presented as a Polish proverb.) One hopes future editions wil address these concerns.

All said one expects this to be essential reading for students of Health Management as it is timely, appropriate and addresses issues that are still evolving. This is a definite addition to libraries and will add to the body of knowledge on management of health services in India.

[Abridged from *eSocialSciences,* 15/10/2008, Mumbai.]

Fertility Behaviour, Population and Society in a Rajasthan Village

By Tulsi Patel,
Second edition Oxford University Press, Delhi;
2006, 287 pp.

Reviewer
Lakshmi Priya
Assistant editor and social scientist, eSocialSciences, Mumbai.
Email: lakshmi@esocialsciences.com

When I first saw the book I thought it was yet another book that would be full of tables and various kinds of quantitative analyses. But I found it was not that at all, but was in fact an absorbing read. The book is an attempt to understand the fertility behaviour of a village community the village Mogra in Rajasthan by using the fieldwork method. In the introductory chapter is a picturesque description of Mogra village, the study village that gives the distribution of population by age and sex and other details. The relation of demography to anthropology and sociology comes through in all the chapters from 2 to 6 in the course of locating fertility in its social and cultural contexts. The author has used terms from the local language liberally giving the narrative a 'real' feel.

The study uses village and folk stories interestingly as a means of understanding the culture and sociology of fertility behaviour. The occasions and rituals during birth and death, the indigenous modes of fertility control, are all examples for this. The complex and changing roles and power of a daughter, daughter-in-law, mother and mother-in-law are drawn out painstakingly. The contradictory social norms and preferences are well narrated. For instance, there is son preference in the households but a daughterless mother is pitied. Women and girl children do household duties and they also have to work in the fields.

There are case studies showing how little girls are taught about married life even when they are very young. An ideal daughter-in-law has to be meek, docile and subservient (Chapter 3) the mother-in-law controls her and she works under her supervision. As the young ladies become older and are seniors in the family they are given the power of the household. But when it comes to child bearing and decisions about fertility control the women are forced to listen to their husbands and mothers-in-law. By actually going to the field, information on aspects like taking 'huavad' after delivery and how a woman and her baby are taken care of after delivery have been expolored.

The author has also taken up the debate of value and cost of children. The difference between how urban and rural couples think about their children is interesting. In fact it can be said it is not the rural couples, but the family and society that are mainly concerned about a child in the family. As we see in the third chapter an infant is looked after by numerous relatives than by its parents alone. It is not the economic costs but the social, cultural and institutional factors that come into play. Child rearing in Mogra involves minimal monetary expenses. The fertility behaviour is also influenced by social, cultural norms of the society. In the chapter 'Indigenous Modes of Fertility Control: People's Experiences' we can see that the longer the newly married bride stays in her own home, the longer the time to her first childbirth. Sleeping arrangements in a household also contribute to delaying childbirth. Breast feeding is another aspect by which fertility is controlled.

Unlike the first edition the second takes the case studies of all the caste communities which is a good because only comparative studies between different caste and communities can give the study depth.

The book provides an understanding of the fertility behaviour of the village community. Even more importantly, it serves as an ideal book for understanding how a study on village community is conducted and seems to be planned that way. For instance, Chapter 1 provides a description of the concepts used in the study and makes the reading of the book easy. A description of concepts like 'structuration' informs researchers and lay readers. Conducting fieldwork such as this is difficult. The 'Note on Fieldwork' is extremely useful giving as it does useful information on how to deal with a village communities and to interact with them.

In the 'Conclusion' the author has elaborated on the scope for future research. It would, for instance, be worthwhile to get more information from men in doing studies on fertility behaviour, as they also play a very important role in fertility control.

The book is a commendable piece of work as it is written in such a way that those who have a lay interest in the subject as well as academics and researchers will find it an interesting read.