



# Indian Medical Parliamentarians' Forum

## Newsletter

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Vinod Bhanu

Dear friends,

Greetings from IMPF!

On behalf of the IMPF, we are pleased to release this Interim Budget Session 2009 Issue of the IMPF Newsletter. This session marks the end of the UPA Government, and the beginning of heavy electioneering and campaigning for the General Election. We take this opportunity to remind the Government that there are several portions of unfinished work and commitments that were made as part of the NCMP, and we sincerely hope that these will be taken up as priority issues by the next government.

As the political party manifestos are now being finalised, the IMPF in collaboration with the Parliamentarians' Group on the Millennium Development Goals (PG-MDGs) has been carrying out a high level advocacy strategy to penetrate the party manifestos, with health and other connecting issues being key components. The advocacy will enable the raising of issues of tobacco warnings, child survival, undernutrition and access to medicine in the next parliament.

This edition of the IMPF newsletter highlights just some of the challenges that civil society and parliamentarians must work on collaboratively to improve health planning, policy formulation and implementation. In order to meet these challenges, it is crucial that all stakeholders are involved in all aspects of the decision making system at the district, state and national levels so that people are empowered and health rights can be claimed and realised. This is highlighted by the current review of primary health care and the need to decentralise and develop community led health systems.

Tobacco remains a key issue and graphic warnings on cigarette packets are imperative to saving lives in India and granting people their basic right to information. Over the past year, we have run a number of articles on the need for increased transparency in the drug regulation system. The articles on the cancer of the cervix vaccine and the on the proposed changes for the drug regulation system highlight this theme and how without proper accountability, the Ministry of Health and Family Welfare leaves itself open to criticism. Both the cervical cancer articles highlight the dangers of the disease and the challenges that need to be overcome for prevention and treatment to be rolled out. The article on sexual and reproductive health rights underlines the need for recovering the positive aspects of sexuality in order for individuals to lead a healthy life.

The forming of the new government will bring with it a whole host of new challenges and opportunities for the IMPF to work on. We will continue to build and strengthen our work and we have innovative pre and post election strategies planned for civil society, parliamentarians and the media.

Thanks are due to all the contributors of this newsletter, you have made this useful for parliamentarians across the political spectrum. Furthermore, we thank our friends and partners for their continued passion and drive to improve health care systems in India. We look forward to working with you all in the next session of the new parliament.

**Dr. R. Senthil**  
Convener-Secretary

**Dr. M. Jagannath**  
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## Pictorial Health Warnings in India: The unprecedented denial of an important public health policy measure

Tobacco use is responsible for more than 24 different diseases, including cardiovascular, respiratory diseases, and ten different forms of cancer and kills around six million people globally including around a million in India alone every year. The extent to which the tobacco users understand the magnitude of these health risks has a strong influence on their behavior (D Hammond et al). Most of the tobacco users have a vague idea that tobacco use is harmful. On the other hand the tobacco industry has continued to play down the health damage of tobacco.

warnings effectively inform these groups about the harms of tobacco. It is hard for them to ignore the message depicted so explicitly. Besides it interrupts the atomicity of tobacco use behaviour and creates “teachable moments” for thinking about quitting.

The government of India though introduced the legislation in 2003, and framed regulations to this effect in 2006. However, the pictorial health messages are yet to see the light of the day in India and simply points to the clout that the tobacco industry has in the government. More than two years from the original notification of



Fig. 1 - Currently notified health warnings on March 15, 2008



Fig. 2 - Pictorial health warnings notified on July 5, 2006 and September 29, 2007

WHO’s Framework Convention on Tobacco Control (FCTC), recognised the importance of health warnings in curbing the harmful effects of tobacco use. It calls for effective measures to ensure that there is no promotion or misinformation about tobacco products and health warning is displayed on each packet of tobacco product. India has already failed to fulfill its international obligation as the deadline for India to comply with Article 11 of the FCTC was 27 February 2008. The pictorial health warnings approved by the Government under guidance of the Group of Minister (GoM) (Fig. 1) though not adequate are better than the smaller, text-based warnings currently appearing on Indian tobacco packages (cigarettes only) and also an improvement on the pictorial warning (Fig. 2) depicting a skull and cross bones which caused revulsion.

A tobacco user who uses tobacco 20 times a day is potentially exposed 7300 times a year to the health warnings. Experts opine that there are probably no other public health interventions as effective as pack warnings that are delivered so often and in such an appropriate way.

India has a large population, about 35%, that is illiterate or who are immigrants and or migrants who speak neither English nor Hindi (42.3 million people migrate inter-state in India). Pictorial and graphic

these health warnings and a year after crossing the FCTC dead line and numerous unwarranted interferences, 21.3 lakhs Indians are likely to be pushed to the gallows by the newly announced implementation date i.e. 31 May 2009.

Request to Parliamentarians: The policy makers must recognize the rights of the Indians to information and good health and ensure:

The government performs its duty by early implementation of this important public health measure. The implementation date should not be further postponed.

Pictorial health warnings are displayed on all tobacco products by the due date with no differential treatment to any tobacco product.

No further attempt is made to dilute the pictorial health warnings.

Since these are rotational pictorial health warnings, Parliamentarians can insist on effective evidence based warnings, which are field tested, to be used in subsequent notifications by the Government.

- **Monika Arora & Amit Yadav**  
**Health Related Information and Dissemination Amongst Youth (HRIDAY)**  
**New Delhi**

## Cancer of the cervix: A women's health and equity issue

*"The pain in the right side of my abdomen was fierce, debilitating, I could not do my daily chores. I was worried as to who would look after my children."*

These words reflect the anguish of a woman suffering from cancer of the cervix

Despite being an eminently preventable disease, cancer of the cervix is one of the commonest cancers in women world-wide and is a leading cause of cancer death. Globally, nearly five lakh women are newly diagnosed with invasive cervical cancer annually. The majority have never been screened for the disease. India represents one fourth of the world's burden of cancer of the cervix; it is estimated that nearly 1,32,000 women are newly diagnosed and around 75,000 Indian mothers and grandmothers, the crucial family caregivers, die from the disease each year. These tragedies affect the woman, her family and the broader society. It is projected that by 2020 these figures will double if no action is taken. In addition, hospital cancer registries shows that about one third of the women who register for cancer diagnosis each year in India suffer from cancer of the cervix (ICMR, 2007). It is found in women as young as 20-24, but is more common in women aged between 40 and 54 years (ICMR, 2007).

Cancer of the cervix is caused by infection with certain high risk types of human papillomavirus (HPV). At least 15 HPV types can cause cancer and two of them, HPV-16 and HPV-18, are associated with 70% of cancer cases globally and in India. HPV infection mostly occurs within a few years after marriage (or after sexual initiation). If the woman is susceptible to persistent infection, it can lead to development of precancerous cervical lesions which, if not detected and treated, can progress to advanced cancer of the cervix over the next 15 to 30 years.

Poor women are most vulnerable because they rarely have access to effective screening to identify precancerous lesions. This situation is compounded by the fact that cervical cancer is a female disease, and often women and girls do not receive enough information

about or access to health care. By the time most women with cancer of the cervix suffer from symptoms and seek medical help it is too late; the disease already is advanced and incurable.

However, cancer of the cervix can be prevented by preventing initial HPV infection through vaccination and/or by screening for precancerous lesions and providing early treatment to prevent progression to cancer. Cancer specialists suggest that a comprehensive disease control initiative, a combination of improved screening and treatment with effective HPV vaccination, has the best potential to significantly reduce the burden of cancer of the cervix relatively soon.

Over the past two years, safe and effective vaccines against HPV have become available globally and have been recently introduced in the private sector in India. The vaccines should be given to girls before they are exposed to the virus (they cannot help women already infected with the relevant HPV types). The challenge now is to make these products available through the public sector so that a greater number of girls can have access at an affordable cost.

It also is crucial to improve screening in India, since even vaccinated women still need cervical cancer checkups. Past screening efforts based on Pap testing (cervical cytology) have failed in low resource settings because Pap requires skilled technicians and sophisticated laboratories. But new screening methods using simple visual identification and low-cost treatment options have been proven to work as well as Pap but at much lower cost. It is time to invest resources to scale up these research projects into sustainable programmes achieving high coverage.

Focussing on prevention of cancer of the cervix, a critical women's health issue, links women's health to larger issues of female empowerment and would represent an important legacy for Parliament to bestow on our country.

-Dr Martha Jacob  
PATH, New Delhi

## 30 years after Alma Ata Declaration, Universal Comprehensive Primary Health Care - 'Now more than ever'

In 2008, three major global health reports unanimously urged governments and policy makers of the world to return to the **Universal Comprehensive Primary Health Care (PHC)** to improve the health of the populations both in developed and developing

countries. These were i) the World Health Report 2008, the annual report by the technical people of World Health Organisation (WHO) ii) the report of the WHO Commission of Social Determinants of Health (CSDH) - by a group of scientists, health researchers and

academicians, politicians etc., and iii) the 'Global Health Watch 2 - The Alternative Health Report (GHW2)', a report generated by the grass roots civil society organisations.

2008 marked the 30<sup>th</sup> Anniversary of the 1978 landmark Declaration of "Health for All by the year 2000" to be achieved by means of comprehensive primary health care which was signed enthusiastically by nearly 150 countries, including India. No sooner was the declaration made, it came under attack from advocates who targeted vertical selective health care like the pulse polio programme and DOTS programme for tuberculosis. 30 years on what is status of the Public health policy for India?

### **30 years on..., the evidence of Comprehensive Primary Health Care**

In 1978, the concept introduced was very radical and was based on some of the initiatives worldwide that implemented the PHC model like the 'barefoot doctors' model of China, our own Indian initiative of Jamkhed in Maharashtra etc., But the 30 years of debate on comprehensive versus selective programmes is settled by the new evidence that the public health systems based on PHC have been more effective. Countries like Cuba, Oman, Brazil and our own state of Kerala are some of the successful examples whereas the United States has been the example of the costliest system with the most privatised and the least equitable health system (Rawaf S et. al 2008). Thailand which shifted to the PHC approach has reduced its child mortality by 8.5% per year between 1990 and 2006, but India is not among the top 30 developing countries which have reduced their child mortality rates. This comes despite Kerala and Tamil Nadu matching the performance of other countries (Rohde et.al 2008). There is evidence also of

disease based programmes, despite massive investments of billions of dollars, interfering with the already weak health systems and severely fragmenting the delivery of even the routine services (Banerji, D 2008).

*Looking back at the 30 years of half-hearted attempts at introducing PHC, WHO in its 2008 report suggests these basic reforms:*

a) Universal coverage - ensuring universal access to healthcare, b) Service delivery - more responsive to community needs, c) Public policy - integration of public health with the primary care, d) Leadership - to shift to decentralised systems nearer to the community.

The misplaced priorities of successive Indian governments have already made us lose valuable time. However, there is light at the end of this dark tunnel in the form of the National Rural Health Mission (NRHM), which was formulated by the present government to rejuvenate PHC under pressure from groups like Jan Swasthya Abhiyan etc. Some of the goals of NRHM are to increase the public spending from 0.9% of GDP to 2-3% of GDP by 2010, integration of all the vertical programs, inter-sectoral approach to health etc. It is very important that the momentum is sustained by the policy makers and further fine-tuned to respond better to the health needs of the community. With the next round of general elections due in April or May 2009, these global level reports are timely and it would be good to see the political class committing explicitly to the continuation of this process of comprehensive health.

**- Prasanna Saligram**  
University of Edinburgh & AID India and  
People's Health Movement

## **The forgotten HIV orphaned and vulnerable children**

India is emerging as the new epicenter of the AIDS orphan crisis having acquired the dubious distinction of the country estimated with the largest number of children orphaned by AIDS. Estimates suggest that India is home to roughly 2 million HIV/AIDS orphaned and vulnerable children and nearly 60,000 newborn babies are infected every year.

HIV/AIDS orphaned and vulnerable children left with little or no adult care and socio-legal protection are the worst victims of the stigmatization and discrimination that accompany the AIDS epidemic. A UNAIDS study found that 36% of the respondents felt that HIV positive people should kill themselves and the same percentage felt that they deserved their fate.

Children too young to even understand what's happening to them are at the receiving end of such discrimination, resulting in their exclusion from the community, schools and healthcare due to the common assumption that proximity lead to transmission of the virus, leaving them rejected and alone.

While many children orphaned or made vulnerable by HIV/AIDS live with surviving parents or members of their extended family, for a large number of children the streets become their home leaving them rootless and increasing their vulnerability to abuse exploitation, crime and the HIV infection. Furthermore, even children living with caregivers face challenges such as finding money for food, school fees, and clothing. The lack of

community based support for orphaned and vulnerable children that would integrate them in society has led to an excessive reliance on institutional mechanisms.

The spread of HIV/AIDS is fueled by and in turn perpetuates gender inequities. Young girls at risk of sexual abuse and exploitation are highly vulnerable to HIV. Furthermore, girl children orphaned and made vulnerable to HIV/AIDS often have to take responsibility of household tasks, child rearing and providing for themselves and the family by engaging in survival sex.

There is a lack of a national level policy framework on OVC related issues. Current policies do not address the disproportionate impact of the AIDS epidemic on children. There is a need for policy guidelines that facilitate large scale, long term integrated interventions.

Integrating HIV/AIDS in ongoing schemes for children is essential to ensure that the special needs of OVC's are met without targeting them specifically. Programmes that exclusively target OVC's would only further isolate them and increase stigmatization. Community based care for HIV/AIDS impacted children would ensure that the OVC's receive the needed care and support in a secure and protected family like environment. It is important that families and communities supporting OVC's are provided financial assistance in the form of stipends, food aid,

school fees etc. To prevent misuse of funds community groups would have to monitor the care and support provided.

Attaining basic education and employable skills is an important part of preventing the spread of AIDS and breaking the cycle of poverty and vulnerability. It is critical to provide livelihood options and support services for the caregivers of OVC's, especially in the Indian context where the caregivers are generally grandparents having no independent source of income, social security or retirement benefits. Developing and implementing an accessible confidential and child friendly legislative framework is central to protect inheritance rights of OVC 's and prevent exploitation and abuse.

It is important to design programmes that address the psycho social needs of OVC's. Witnessing the death of a parent/parents or caring for terminally ill parents bears its scars on the child's psyche. Not only do the children have to contend with the grief of losing their parents but also constantly question their own chance of survival. The loneliness and depression is only aggravated by the stigmatization, discrimination, isolation and exclusion that OVC's face due to the ignorance about HIV/AIDS.

- Hem Borker

Independent Researcher, New Delhi

## Overhauling India's Drug Regulatory System *Concerns about the Drugs and Cosmetics Amendment Bill 2007*

India's drug regulatory structure is provided for in the *Drugs and Cosmetics Act, 1940* ("DCA") and the *Drugs and Cosmetics Rules, 1945* which regulate the import, manufacture, distribution and sale of drugs and cosmetics. The regulatory structure is distributed between the Center and the States through statutory and non-statutory bodies. The present government has proposed significant changes to this law.

In August 2007, the *Drugs and Cosmetics (Amendment) Bill 2007* was introduced in the Rajya Sabha and referred to the Department-Related Parliamentary Standing Committee on Health and Family Welfare. The Standing Committee conducted extensive hearings on the Bill and submitted its report. The Bill is likely to be re-introduced in Parliament for consideration and passing in the current session.

The Bill is admittedly based on the 2003 report of the '*Expert Committee on a Comprehensive Examination of Drug Regulatory issues, including the problem of spurious drugs*', which detailed the weaknesses of the drug regulatory

system and proposed several initiatives to address these. This included strengthening the Central Drugs Standard Control Organisation ("CDSCO") giving it statutory status as an independent office in the Health Ministry and massive investment in infrastructure and personnel. The CDSCO is currently headed by the Drugs Controller General India ("DCGI") and discharges the Central Government's functions under the DCA.

The Bill proposes a complete overhaul of the drug regulatory system through the creation of the Central Drugs Authority of India ("CDAI"), the centralisation of licensing and specific provisions on clinical trials. The CDAI is expected to assume all key functions under the DCA with the DCGI as secretary. It will also replace the Drugs Technical Advisory Boards ("DTABs").

On 21 October 2008, the Standing Committee submitted its '*Thirtieth Report on the Drugs and Cosmetics (Amendment) Bill-2007*.' While the Committee accepted the need for the overhaul, the requirement for a central regulator and greater infrastructure, it noted that the

Expert Committee had recommended that the CDSCO perform this function and not a new statutory body as the Bill provided. The Committee was also concerned with the CDAI replacing the DTABs and noted that the proposal for self reliance in funding for the overhaul of the drug regulatory system through license and other fees was unrealistic.

It remains to be seen what changes the government has made to the Bill based on the Standing Committee recommendations. Regardless, several concerns remain about the transparency, accountability, independence and neutrality of the overhauled drug regulatory system. For instance, the Bill does not provide safeguards from industry influence by excluding from membership persons connected to the drug industry – financially or otherwise. In fact, it states that members of the CDAI can be appointed from persons with at least 15 years of “*professional experience in the pharmaceutical industry*”. As with the US Food and Drug Administration (“*USFDA*”), the model for the changes to India’s drug regulatory structure, this could lead to cases like Vioxx, (a drug marketed by Merck and heavily associated with significant cardiac side effects) where a third of the advisory panel that cleared the marketing of Vioxx had ties to drug companies.

Concerning funding, the government states that self reliance will be achieved through charging steep fees for various approvals. Similarly, a special legislation allows the USFDA to charge hefty fees from industry. This system, critics have said, has led to the creation of an institutional bias favouring the industry within the USFDA.

Increasing concerns about the ability of the USFDA to monitor the safety of food and drugs objectively have resulted recently in the US President calling for a full review of the USFDA. It is then a matter of great concern that India may be blindly following the USFDA model without examining its shortcomings and addressing them.

The ongoing changes to drug regulation in India have provided little scope for public accountability and transparency. It is essential that all information related to drugs and their regulation be provided in the public domain in a timely manner. Furthermore, patients, consumers and public interest groups and individuals should be closely involved in the functioning of the drug regulator.

- **Kajal Bhardwaj**  
Legal Researcher, Access to Medicines

## Cancer of the cervix: A controversial vaccine

Cancer of the cervix (cervix is the neck of uterus) is a common public health problem in India, as it kills approximately 200 women per day. It strikes usually in women between 30 to 45 years. And so every woman after the age of 30 years is advised a regular check up and Pap’s smear test, so that the cancer is detected in its earlier stage. Detection in the early stage of cancer provides a better chance to treat and survive.

The exact cause of this cancer, like most other cancers, has remained a mystery. But several causes have been elicited and usually more than one cause may be the causative agent, as is true for most diseases. One, is that it is caused by a virus, which is known as Human Papilloma Virus (HPV). Scientists have observed that HPV strains 16 and 18 are often involved with the cancer, but this does not rule out, involvement of other strains of viruses as the cause of cancer. This virus is transmitted by sexual activity and so the HPV vaccine is advocated to the age group of 13 to 14 years.

However, if it is to be administered to this young age group, how long will be the efficacies of this vaccine sustain so as to prevent cancer, which occurs at the age of 30 to 45 years? This vaccine does not guarantee that periodic checkups and Pap’s stain can be stopped, if vaccinated. If a 12-year-old girl is vaccinated, will she still be protected in college, when her risk of infection is higher? Or will a booster vaccine be necessary? So there

remains endless controversy surrounding this vaccine. Apart from the huge cost which will make it accessible only to the rich.

There are plenty of questions regarding the vaccine’s utility that still need to be answered before advocating it as a public health tool to fight cancer. Since most HPV infections are easily cleared by the immune system, how will vaccination affect natural immunity against HPV, and with what implications? How will the vaccine affect preadolescent girls, given that the only trials conducted in this group have been on the immune response? How will vaccination affect screening practices? If HPV-16 and HPV-18 are effectively suppressed, will there be selective pressure on the remaining strains of HPV? Given the above mentioned pitfalls how did the vaccine get pushed into the market as a weapon to conquer cervical cancer. The answer is the high promotion by the profit making vaccine manufacturers who are pushing for the rapid rollout of this new vaccine without sufficient medical evidence about how best to deploy them.

Legislative efforts to require girls to have the vaccine only add to the pressure. In the United States, hundreds of doctors have been recruited and trained to give talks about HPV vaccine – \$4,500 for a lecture – and some have made hundreds of thousands of dollars. Politicians have been lobbied and invited to receptions urging them

to legislate against a global killer. And former state officials have been recruited to lobby their former colleagues. "There was incredible pressure from industry and politics," said Dr. Jon Abramson, a professor of paediatrics at Wake Forest University who was chairman of the committee of the Centers for Disease Control and Prevention that recommended the vaccine for all girls once they reached 11 or 12.

Given all the realities one wonders as to how it would fit in the Indian context. It is unfortunate that ICMR has agreed to be part of the study, in the Indian context. It is time that these organizations spell out the conflict of interests. Governments should not make a business out of ill health.

- Dr Gopal Dabade,  
All India Drug Action network (AIDAN), DAF Karnataka

## Protection and Utilisation of Public Funded Intellectual Property Bill 2008: A Wrong Prescription for Public Sector R&D

Ministry of Science & Technology and Earth Sciences introduced a bill titled **Protection and Utilisation of Public Funded Intellectual Property Bill, 2008** in the last session of the parliament (December 2008). The bill is currently with the Standing Committee on Science and Technology (S&T), which is expected to submit its report within three months. Statement of objects and reasons lists the seven main objectives of the bill which include providing incentives for creativity and innovation, promotion of collaboration between government, private enterprise and non-government organisations and the commercialisation of intellectual property coming out of public funded research and development. The bill draws extensively from the US legislation Bayh-Dole Act 1980, which many studies suggest has miserably failed to achieve its stated objectives. There are therefore serious doubts about the success of the pending Bill if it is enacted in its present form. Consider the following:

The Bill proposes a compulsory intellectual property creation whenever there is an involvement of public fund, which is based on a wrong assumption that creation of intellectual property is the only answer to the problems faced by the research and development sector, especially the public sector R&D. For instance, to date there is no concrete evidence to support the role of intellectual property as an incentive for research and development. Governments and commercial enterprises are moving away from intellectual property paradigm and experimenting with various instruments like open source, prize funds and open innovation models to stimulate new research.

Secondly, the Bill does not reflect the Indian reality. There are serious concerns about the quality of R&D in India and its commercial value/potential. Intellectual properties, especially patents, are not a good yardstick to gauge the quality of R&D and research outcomes. Therefore the immediate concern of the law and policy makers should be to improve the quality of R&D rather than protecting R&D outcomes through an obsolete IPR model

Thirdly, the proposed Bill imposes penalties on the researchers and institutions for not complying with the legislation. In other words it means the Bill makes it compulsory for the recipients engaged in public fund R&D to protect the intellectual property that comes out of R&D. This Bill, however, doesn't take into account the many other ways of commercialisation of R&D, which don't involve the protection of intellectual property. In many cases, especially with reference to upstream research tools, commercialisation is automatic even if the invention is kept in the public domain. However, the bill rejects all these options and prescribes intellectual property as the only route for commercialisation. This would further create bureaucratic intervention in the public sector R&D and would hamper innovation and creativity.

Fourthly, the Bill covers not only patent but also all forms of intellectual property including trademark and copyright. Such a broad coverage especially the inclusion of copyright may prevent the researcher from publishing articles and free circulation of such articles. This would hamper the access of knowledge related to science and R&D.

In the light of the above discussion, some serious rethinking is required on the viability of the Bill, including its unintended consequences. The standing committee should examine the rationale behind the Bill and its implications for public policy before proceeding to examine the clause-by-clause analyses of the Bill. Standing committee may also use this opportunity to suggest ways and means to improve the quantity and quality of science and technology R&D in India.

*(This write up is based on the writings or discussion with Dinesh Abrol, K Sathynarayana, Rajeswari Raina, Archita Bhatta, Dr. Sathyjit Rath and Yogesh Pai. The author wishes to acknowledge them with usual caveat).*

- Gopakumar K.M.  
Third World Network (TWN)

## Sexual and Reproductive Health Rights: Mainstreaming Sexuality

Many believed that a new era was ushered in when in April 2006, contraceptive targets were removed as a barometer for measuring the success of the state's health policy and we witnessed a change from 'numbers' to 'needs'. This was then followed by the launch of Government of India's Reproductive and Child Health Programme (RCH) in October 1997, which preceded the Union Cabinet Approval of its National Population Policy, which took forward the programmatic vision enshrined in the RCH. Sections of the civil society presumed that this meant that the population ideology of the state had been reconceptualised. However, a closer scrutiny revealed that the change in focus didn't bring about a concomitant incorporation of people's experience of sexuality and they were still seen primarily as reproductive beings, which hindered the policy initiatives in helping individuals make safe and responsible choices about sexual and reproductive health.

Reproductive rights in India have had an uncomfortable relationship with sexuality and sexual needs, which in turn has had a long history of negative connotations of its own. Sexuality was often seen as part of the problem rather than a positive, contributing force to a person's health. So, even while mentions of sexuality and sexual needs have been made in different health policies, they have been incorporated in conjunction with ideas of population control or HIV/AIDS. The new direction that the discourse on sexual and reproductive health rights has taken worldwide indicates that it is time we recover the positive influences of sexuality on a person's health and well-being.

This new direction, which enshrined sexual rights as a part of the human rights discourse emerged in the 1990s after a protracted struggle of many international, national and local civil society organizations working for the recognition of sexuality as an important part of the human experience. This discourse seeks to see sexuality and sexual rights as an end in themselves, rather than a means to either population control,

HIV/AIDS, STDs etc. Sexual rights, therefore, have come to include not only a right to reproductive health but also a right to pleasure and fulfillment and this needs to be taken note of. An equal access to these sexual rights, and their realization, furthermore, as part of the human rights discourse, are part of human development and need to be seen as a matter of justice rather than the frivolous pursuit of a few. Routine violation of sexual rights of women and men, discrimination faced by individuals in access to health care facilities, lack of proper support services for safe sex and conception, lack of close sensitisation and advocacy on matter of sexual health all combine to make the current state of affairs deplorable.

A positive streamlining of sexuality and sexual needs in current health care agendas and policies will affect the latter in important ways. This process of positive streamlining will help combat HIV/AIDS, STDs in a way that doesn't compromise the rights of HIV positive patients and other people at large. This, however, can only be made possible if the lens through which the state looks at issues of sexuality and sexual needs can be traded in for one which is centered on the individual and is oriented towards meeting the specific needs of the people. Here, a mention about the gender sensitivity of the policies and health care services need to be made, for, more often than not women are the primary users of the health care facilities. In addition to a special focus on women, men need to be made more aware of their responsibilities in relation to sexual acts performed. Furthermore, sensitisation should be aimed at bringing about a change in how decisions regarding child-birth, contraception etc. are made. It is important that an informed choice is made, free of discrimination and coercion. Special attention to adolescents should also be paid to in such a manner that age-appropriate information about matters relating to sex is available to them, including proper counseling services.

- Shailey Hingorani  
Centre for Legislative Research and Advocacy (CLRA),  
New Delhi

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