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भवन्तु सुखिनः

Health Care as a Human Rights

National Human Rights Commission
Manav Adhikar Bhawan, C-Block
GPO Complex, INA, New Delhi-110023

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Recent Initiatives of the
National Human Rights Commission
On

Health Care as a Human Right

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NATIONAL HUMAN RIGHTS COMMISSION

INDIA

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National Human Rights Commission
on
Health Care as a Human Right

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FOREWORD

In 2002 the World Health Organization elucidated that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Article 21 of the Constitution relating to the right to life and liberty has been interpreted by the Supreme Court of India to include the right to health, so as to ensure a life of dignity. The right to health care has been recognized in numerous international human rights law instruments. Article 12.1 of the International Covenant on Economic, Social and Cultural Rights affirms that the State parties must recognize the right to everyone to the enjoyment of highest attainable standard of physical and mental health.

The National Human Rights Commission has taken upon itself the task of ensuring proper accessibility, quality and affordability of health care to the people of the country, especially those belonging to the vulnerable and economically weaker sections of society as well as those people living in remote rural areas. It has not only been taking up issues of availability of proper health services during its visits and Commission sittings in the States but has also been involved in organizing conferences/meetings on the subject in the National Capital. These conferences/meetings have served as a forum where all the stakeholders and experts in this area have participated and given their views, which have served as a basis for formulating useful recommendations. These recommendations have been sent to the concerned government authorities for necessary action. The NHRC has been especially concerned about the reproductive rights of women and has initiated discussion on the subject so that due priority is given

to the issues relating to this right. Further, areas like drinking water and sanitation related health issues as well as occupational health and safety have also been areas of concern. This publication is a compilation of the proceedings of the conferences and meetings organized by NHRC on the subject of health care as a human right including the very important aspect relating to reproductive rights of women.

This work has been carried out by Dr. Balbir Kaur Teja, Consultant, NHRC, in consultation with Shri S.C. Sinha, Member, NHRC, Shri Satyanarayan Mohanty, Secretary General, NHRC and Shri J.S. Kochher, Joint Secretary, NHRC. Dr. Savita Bhakhry, Joint Director and Shri Guljeet Singh, Research Assistant also have assisted in this effort.

I am sure that this publication will be of immense use to the concerned stakeholders in the area of health care, both in government and in non-government sectors.

Justice Cyriac Joseph

New Delhi

10th December, 2015

Content

CHAPTER I

Introduction

National Human Rights Commission

National Human Rights Commission (NHRC) was established on 12 October 1993. Its Statute is contained in the Protection of Human Rights Act (PHRA), 1993 as amended vide the Protection of Human Rights (Amendment) Act, 2006. The constitution of NHRC is in conformity with the Paris Principles that were adopted at the first International Workshop on National Institutions for the Promotion and Protection of Human Rights organized in Paris in October 1991, and endorsed by the General Assembly of the United Nations in Resolution 48/134 of 20 December 1993. The Commission is an embodiment of India's concern for the promotion and protection of human rights.

Functions

The Commission has a wide mandate. Its functions as laid down in Section 12 of the PHRA include:

- Inquire, suo motu or on a petition presented to it by a victim or any person on his behalf or on a direction or order of any court, into complaint of (i) violation of human rights or abetment thereof; or (ii) negligence in the prevention of such violation, by a public servant;
- Intervene in any proceeding involving any allegation of violation of human rights pending before a court, with the approval of such court;
- Visit, notwithstanding anything contained in any other law for the time being in force, any jail or other institution under the control of the State Government, where persons are detained or lodged for purposes of treatment, reformation or protection, for the study of the living conditions of inmates thereof and make recommendations thereon to the Government;

- Review the safeguards provided by or under the Constitution or any law for the time being in force for the protection of human rights and recommend measures for their effective implementation;
- Review the factors, including acts of terrorism that inhibit the enjoyment of human rights and recommend appropriate remedial measures;
- Study treaties and other international instruments on human rights and make recommendations for their effective implementation;
- Undertake and promote research in the field of human rights;
- Spread human rights literacy among various sections of society and promote awareness about the safeguards available for the protection of these rights through publications, the media, seminars and other available means;
- Encourage the efforts of non-governmental organizations and institutions working in the field of human rights;
- Such other functions as it may consider necessary for the protection of human rights;

Since its inception in 1993, National Human Rights Commission has given equal attention to all kinds of rights, be it civil, political, economic, social or cultural. Intrinsic to the dignity and worth of a human being is the enjoyment of the right to health.

Right To Health

Every human being is entitled to enjoyment of the highest attainable standard of health conducive to living a life of dignity. Health does not mean mere absence of disease but physical, mental, psychological and emotional well-being of an individual. This right is indispensable for the exercise of other human rights. It is the duty of the State to promote, protect and preserve the health of all individuals. The Constitution of India upholds 'right to health' as a Fundamental Right under Article 21.

The human right to health is recognized in numerous international instruments. Among them, the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on right to health in international human rights law. Article 12.1 of the Covenant affirms that the States Parties must recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", whereas Article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States Parties….. to achieve the full realization of this right". Additionally, the right to health is recognized, inter alia, in Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, 1965 (ICERD), in Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women, 1979 (CEDAW) and in Article 24 of the Convention on the Rights of the Child, 1989 (CRC).

The right to health has also been proclaimed in the Vienna Declaration and Programme of Action, 1993 as well as in the Programme of Action of the International Conference on Population and Development held at Cairo in 1994 and other international instruments like the Declaration and Programme of Action of the Fourth World Conference on Women held in Beijing in 1995.

The National Human Rights Commission (NHRC) represents India's commitment to human rights. Ensuring the right to health to all is a quintessential aspect of this commitment. Hence, the Commission is closely monitoring right to health in terms of its accessibility, affordability and availability. The NHRC has consistently taken the view that the right to life with human dignity, enshrined in the Constitution and as interpreted by the Supreme Court, must result in strengthening of measures to ensure that the people of this country, and particularly those belonging to economically disadvantaged sections of society, have access to better and more comprehensive health care facilities.

The Commission's efforts to protect and promote right to health has evolved in a variety of inter-connected ways over the past two

decades. The issue of maternal anemia was first identified as a violation of right to life and right to health in 1996-1997. Thereafter, in 2000, it organized a workshop on 'Health and Human Rights in India with Special Reference to Maternal Anaemia'. Another workshop organized by it during 2000 was 'Human Rights and HIV/AIDS'. In 2001, it organized a Regional Consultation on 'Public Health and Human Rights' with a view to bring together the policy makers, public health experts, legal professionals, human rights activists and others to deliberate on issues like nutritional deficiencies, access to health care and tobacco control. These activities were held in collaboration with the Ministry of Health and Family Welfare, Department of Women and Child Development, UNICEF, UNAIDS, WHO, NACO and Lawyers. In the year 2000, the Commission also constituted a Core Advisory Group on Health, consisting of experts in the field on matters relating to 'right to health'. The Core Group has tendered advice to the Commission on a range of issues, such as leprosy, burn injuries, prevention and control of fluorosis, illegal trade in human organs, availability of blood in blood banks and blood transfusion, preventive aspects of health care, access to health care, pre-natal sex selection, and survival and development rights of children.

In 2004, the Commission along with a health service network, held five 'Public Hearings on Right to Health Care' across the country. Through these public hearings, the Commission was able to resolve individual problems and identify systemic problems. Over 1,000 victims from marginalized sections presented their testimonies. These public hearings were followed up with a National-Level Public Hearing that covered a range of issues such as women's and children's right to health care; the right to essential drugs; rights of mentally ill persons; strengthening of the public health system and regulation of the private medical sector; health rights in the context of HIV/AIDS; and occupational and environmental human rights. In the national level public hearing, a National Action Plan (NAP) to operationalize the 'right to health care' was also proposed. The NAP recommended the enactment of a National Public Health Services Act that would recognize and legally protect the health rights of all

sections of the population at the village/community, district, state and national levels.

In order to know the status of implementation of recommendations made by the NHRC on different issues relating to right to health, the Commission convened a review meeting on the 'Recommendations of the Core Group on Health and Public Hearing on Health' in March 2006 and later organized a 'National Review Meeting on Health' in March 2007. The National Review made a series of recommendations, prime among them being – the need to ensure universal provision of guaranteed health services, in particular, services for mental health, child health, emergency medical care, need for Medical Council and Nursing Council of India to have a relook and work out courses for nursing practitioners. MCI to have an in-built compulsory rural attachment for medical students, need for public private partnerships in health care and a regulatory mechanism to ensure quality standards by private partners to fulfill public health goals, need to enact a National Clinical Registration and Regulation Act for running health care facilities and protecting patients' rights, proper drug procurement mechanism to ensure guaranteed availability of all essential drugs at affordable prices, create awareness about the availability of essential drugs by printing a booklet/pamphlet and making it available at PHC/ CHC/District Hospitals, need to develop 'emergency medicines' as a specialty to improve the emergency medical services in the country, efforts to include provision of complete ante-natal and post-natal care and need to take care of key childhood diseases, maternal health services to focus on safe institutional delivery services along with health education concerning safe motherhood, States to enact a Public Health Act and evolve a redressal mechanism to ensure right to health. This Meeting also recommended that silicosis is an occupational health hazard and needs required interventions and convergence of efforts of concerned stakeholders, that is, labour and health departments of the Government, NIOH, NIMH, industries and NGOs.

Some of the recommendations made in the National Review Meeting are also reflected in the Twelfth Five Year Plan (2012-2017) of the

Government of India – reduction of infant mortality rate, reduction of maternal mortality ratio, prevention and reduction of anemia among women aged 15-49 years to 28 per cent, raising child sex ratio in the 0-6 year age group from 914 to 950, prevention and reduction of communicable and non-communicable diseases (including mental illnesses) and injuries and reduction of poor households out of pocket expenditure.

Some of the recommendations made in the National Review Meeting are also reflected in the Twelfth Five Year Plan (2012-2017) of the Government of India – reduction of infant mortality rate, reduction of maternal mortality ratio, prevention and reduction of anemia among women aged 15-49 years to 28 per cent, raising child sex ratio in the 0-6 year age group from 914 to 950, prevention and reduction of communicable and non-communicable diseases (including mental illnesses) and injuries and reduction of poor households out of pocket expenditure.

The Commission is presently concerned with the following issues:

i) **Accessibility/Availability, Quality and Affordability of Health Care :**

It is a known fact that common man in India does not have proper access to health care facilities to the extent his complete well being is ensured. Primary health care may have improved in recent years through more funds being made available under the NRHM towards creation of necessary infrastructure in parts of few states. However, the success of this programme has not been uniform and there are large parts of the country still lacking in adequate primary health care facilities. The deficient health infrastructure, both in terms of quality and quantity is further noticeable in secondary and tertiary health care. Very few hospitals which can boast of having good specialists in different fields of medical sciences are located in rural areas. Even in the cities where these facilities are available, the situation is far from satisfactory. Government

run hospitals, where one can avail of health care facilities at a reasonable cost, there are problems of easy accessibility. One is confronted with long queues while seeking a doctor's consultation in the OPD. Long waiting lists for life saving operations/surgeries and sometimes, even for important diagnostic tests are a common phenomenon at government run hospitals. These problems are more prominently faced by the people belonging to economically weaker sections or those who are otherwise not with powerful connections or influence. It is a fact that these people need these facilities more than those coming from economically better off sections as the latter category can afford to pay for access to treatment at hospitals in the private sector. It is because of the poor accessibility that the poor are driven to private sector hospitals even at the cost of incurring debt or selling off their valuable assets in order to save a life in a family. Thus, when faced with a serious disease to a member, it can be an experience where a family could be driven to poverty.

The doctor to population ratio is low and even the numbers of para-medical staff are lower than necessary. There is acute deficiency of specialists which leads to problems of accessibility. Further, quality of health care also suffers due to pressures on the existing facilities. The number of hospital beds for patients is low compared to the population. Lack of quality in Government hospitals also contributes to people seeking private facilities.

In view of the above situation, there is need to improve our health care system in terms of both, increased health infrastructure as well as quality to enable common man to have easy accessibility to public health facilities. Further, the doctors and staff besides being sufficient in number and proficient need to be committed towards their duties so that the people at large are ensured of their right to health through proper treatment and care. There is also need to adopt available best practices as well as innovative measures

including universal health insurance to deal with the problem of accessibility and affordability.

ii) **Women and Child Health Issues:**

Women and Child Health is a priority area since proper nurturing and care of a child in early years of life goes a long way in ensuring growth and development into a productive adulthood. It is also natural that a healthy mother, especially, during child birth and after has a positive role in determining the health of a child. Moreover, both women and children are vulnerable to ill-health if not provided proper care and timely treatment due to their physiology. They also need clean and hygienic environment and drinking water without contamination. They also need proper nutritious and balanced diet.

Unfortunately, in India, there are large number of problems associated with women and child health. A large percentage of child population suffers from malnutrition. A large number of children suffer from stunted growth. There is prevalence of widespread anamia among both women and children. Adolescent girls and expecting/lactating mothers suffer from iron deficiency and hence anemia. They also suffer from deficiency in other important nutrients.

Government has been implementing several schemes including ICDS which provides for supplementary nutrition for both lactating mothers and children. Adolescent girls with lower than normal weight have also been provided diet. However, the latest available data as per NFHS-3 do not indicate positive results from these schemes. There is need to address the problems associated with design and implementation of these schemes and also ponders over other steps to ensure better health for women and children in India.

Iii) **Ethical issues and illegal practices:**

Professionals working in medical field have of duty towards

humanity. They need to be carrying out their duties with commitment and sincerity. However, there are numerous problems in the country associated with the conduct of medical professionals. The Commission has been recently concerned with the issue of pharmaceutical companies and doctors conducting drug trials on unsuspecting people, largely from among tribals without obtaining proper informed consent.

Medical professionals have also been indulging in unnecessary surgeries on tribal women to avail the benefits under RSBY. There is also problem of drug pricing by pharmaceutical companies to earn huge profits. This affects the affordability of treatment especially in cases life threatening diseases. Doctors also indulge in many other unethical practices including conduct of illegal ultrasound for sex determination.

These practices indicate to the need for better regulation of medical services to save people from exploration in the name of treatment.

iv) **Health, Drinking Water and Sanitation issues :**

The accessibility to clean drinking water and sanitation facilities are closely linked to the health of people. Lack of sanitation facilities and clean drinking water are not only the cause of several diseases on account of associated water borne infections but have also ramifications on the nutritional intake especially, among children. While, the Government has been implementing schemes to provide clean drinking water to the so far uncovered habitations as also to ensure the quality of water, there are still large sections of population who are devoid of potable water. Similarly, there is large number of house-holds without toilet facilities in spite of the total sanitation campaign programme of the Government. As such, there is need for emphasis on this important aspect to improve the health care standards of the people of the country.

v) **Occupational health and Safety:**

The Commission has been concerned with occupational health problems like silicosis, asbestosis etc. as these have been generally affecting the right to life and dignity of people working in unorganized sector without access to any form of social security. It is important that not only the problems of this unorganized labour are addressed and the affected persons and their families are provided not only treatment and medical care but also sustenance amount of funds to ensure them to live a life of dignity. There is also need for preventive steps against such diseases by providing proper awareness among workers about the risks involved as well as use of available technologies to prevent the incidence of these problems. There is a need that States/UTs should acknowledge the existence of these problems and take all necessary steps to address them.

In order to accomplish the task of strengthening the measures to ensure access to better and more comprehensive facilities to people of this country, particularly those belonging to economically disadvantages of section of society, the Commission held a meeting of the Core Advisory Group on Health on 20 June 2013 and National Conference on Health Care as Human Rights on 5 and 6 November 2013. It also held a National Conference on Human Rights of Women - Reproductive Rights of Women on 18 and 19 February 2014 and a meeting on Reproductive Rights of Women and Draft Legislation on subject of Surrogacy 29 April 2014. During these meetings/ conferences, many latest findings on the subject were shared and useful recommendations emanated which are presented in the subsequent chapters.

CHAPTER II

Meeting of the Core Advisory Group on Health

A meeting of the Core Advisory Group on Health was held in the Conference Room of the National Human Rights Commission on 20 June 2013 under the Chairmanship of Shri S.C. Sinha, Member NHRC. The meeting was attended by the members of the Core Advisory Group on Health including Dr. H. Sudharshan, Secretary, Vivekananda Girijana Kalyana Kendra, Prema Ramachandran, Director, Nutrition Foundation of India and Ms. Rekha Sharma, Director, Clinical Nutrition and Dietetics Foundation. Dr. K. K. Talwar, former Director, PGIMS Chandigarh & former Chairperson of Medical Council of India and Dr. Jayashree Gupta, President of Consumers India, New Delhi participated in the meeting as Special Invitees. The officials of the National Human Rights Commission who attended the meeting included Dr. A. Sahu, Secretary General, Shri J. S. Kochher, Joint Secretary and Dr. Savita Bhakhry, Deputy Secretary.

The agenda items discussed in the meeting of Core Advisory Group on Health were:

- Issues for National Conference on Public Health and Human Rights;
- Shortage of Specialists in the Country;
- Towards a New Generation Millennium of Development Goals, 2015;
- High Prevalence of Anaemia;
- Shortage of Psychiatrists and Mental Health Institutions.

Proceedings of the Meeting of Core Advisory Group on Health

Welcoming the Members of Core Advisory Group on Health and Special Invitees, Shri J. S. Kochher briefly highlighted the agenda

issues. He also thanked all the participants for attending the meeting in the Commission despite the short notice given by it.

Speaking on the occasion, Hon'ble Member, once again extended a warm welcome to the Members of the Core Group and the Special Invitees. Elaborating on the agenda issues raised by Shri J.S. Kochher, Hon'ble Member drew the attention of the august gathering towards issues like occupational health, infant mortality, maternal health, health care in rural areas, the shortage of doctors and specialists in the country and overall budget allocated to health sector. The issues stated by him were not exhaustive as there were other issues which needed to be addressed like the existing corruption in the health care system and denial of health services to the needy and poor. He further informed that there is a need to reconstitute the Core Advisory Group on Health and thus requested the Members and the Special Invitees to suggest few names of renowned persons who have excelled in the field of health. With these remarks, he invited the participants to take-up each agenda item and give their valuable suggestions.

Agenda Item No. 1: Issues for National Conference on Public Health and Human Rights

Shri J. S. Kochher informed that the Commission was planning to organize a two-day National Conference on Public Health and Human Rights in September 2013. He stated that one of the issues, which may be taken up for the said conference could be on 'occupational health' and requested Members to suggest other issues which could be taken up in the forthcoming conference.

Dr. H. Sudarshan opined that the issues like access to health care, denial of public health care services, corruption in the existing system of health, anemia, malnutrition, clean water and sanitation and ethical issues like organ trading, hysterectomy, PCPNDT cases need to be addressed in the national conference proposed to be organized by the Commission. He especially talked of the community monitoring which was being carried out in some States and needed to be replicated in other States. As of now, Dr. Sudarshan added

that there is no regulatory body, which could monitor practices like illegal hysterectomy operations nor was this being monitored by the Medical Council of India. Health was a State subject but the State Governments are not taking sufficient steps of improving the health system. He stated that the conference should throw light on the provision of essential drugs free of cost to the needy and poor persons, which was reiterated by Dr. Jayashree Gupta.

Dr. Prema Ramachandran emphasized that for the proposed conference, the Commission needs to look at the existing health mechanism already in place and how the same could be improved. She stated that 'out of pocket expenditure' made by low and middle-income group people for treatment may also include expenditure to be incurred on transportation of the patient and the family members accompanying the patient. She said that while the entire out of pocket expenditure cannot be covered even if a patient is covered by an insurance cover, it does provide assistance and support. Hence, the population coverage needs to be increased. Such issues need to be addressed. Moreover, she stated that there is need to throw light on 'Maternal and Child Health Programme' and 'Communicable Diseases'. She said that it would be beneficial to make use of district specific health data as well as the data released by the Annual Health Survey and draw-up a District Action Plan to ensure decline in IMR and MMR. She further added that emphasis on District based planning was being laid from 10th Five Year Plan onwards and this area needs to be strengthened. The NRHM too, according to her, articulates this view point but its implementation is tardy. It would be worthwhile, therefore, to raise all these issues in the national conference, she said.

Ms. Rekha Sharma reiterated that the issue of 'community monitoring' being done by the State Governments as well as by various NGOs under the NRHM should be taken-up for discussion in the national conference. She then suggested that the conference should lay emphasis on prevention of diseases, especially the non-communicable diseases, through 'Nutrition Education' and 'Train the Trainers' programme.

Dr. Sudharshan suggested that there should be a focus on human rights issues relating to health and as to how there is denial/violation of rights in this area.

Dr. K. K. Talwar articulated that there should be a focus on 'access to affordable health care' for every section of society, strengthening of health manpower at all levels. He especially spoke in favour of compulsory rural postings of MBBS doctors.

Dr. Jayashree Gupta, informed about 150 stores all over the country which were known as Jan Aushadhi outlets in the context of affordable health care. Dr. Ramachandran stated that there are prescribed manuals which cover a range of issues including rational use of medicines and appropriate care. These manuals need to be brought into the public domain. Dr. Savita Bhakhry informed that the Commission had organized a conference on Public Health and Human Rights in the year 2001. This was followed-up by regional and national Public Hearings on Right to Health Care in 2004. During 2005 and 2006, two national level Review Meetings on Health Care were organized. The recommendations of these conferences/meetings could also be looked into for framing issues/themes for discussion in the proposed conference to be organized by the Commission.

Hon'ble Member drew the attention of all toward the issue of budgetary allocations and expenditure in the health sector. Dr. Sudarshan affirmed that while the budget allocated in many States was not a problem, the State Governments have to take the responsibility and need to prioritize health issues. Ms. Rekha Sharma said that there is need to empower the existing doctors, both government and private, in rural and tribal areas.

Agenda Item No. 2: Shortage of Specialists in the Country

Dr. Sudarshan emphasized that ideally Doctors having an MD Degree should be appointed as Specialists. However, in the absence of the same, there is need to evolve Certificate and Diploma Courses in different areas of health. He also suggested initiation of middle level health workers after undergoing a three

year prescribed Diploma Course who could undertake routine medical check-up and also prescribe medicines for common ailments. He was of the view that on completion of three years courses on health, trained health workers could be well-equipped to handle common ailments and control quacks that are flourishing and duping innocent patients in rural/tribal areas. He cited the example of Assam and Chattisgarh where they have successfully implemented this experiment. He also gave the example of his own organization, namely Vivekananda Girijana Kalyana Kendra in Bengaluru where MBBS Doctors were providing emergency obstetric care (EmOC) by conducting c-sections. He also opined that medical education should gear to the need of the State.

Dr. Ashok Sahu, Secretary General, NHRC expressed his concern about the barefoot Doctors who catered to the needs of the local population in remote villages. Dr. K.K. Talwar stated that since India faces severe shortage of specialists both in rural and urban areas, he was of the view that rural and tribal people need more specialists on a priority basis. Currently, posts of specialists, especially surgeons, physicians, paediatricians, gynecologists, etc. at the Community Health Centers (CHCs) are lying vacant.

Dr. Talwar reiterated the points made by him earlier and added that the idea of the three year Diploma Course for middle level health workers would be problematic as it will have to be ensured that all trained middle level health workers are given jobs in rural/tribal areas which should have prospects for their career growth. He rather recommended a one year compulsory rural posting as a mandatory requirement for an MBBS doctor before he could take up an MD course. He informed that 45,000 MBBS doctors get a degree every year and there are 26,000 seats for post graduation. These 45,000 doctors should be made to do a one year practice in rural areas before being eligible for post-graduate studies. He suggested that there is need to attract good students towards medical profession who could be groomed as Specialists in view of the brain-drain of Doctors looking for greener pastures. He highlighted that the MCI has no data about Specialists having different specialization and

this was an area needing attention. The lack of data is due to the problems in the registration of doctors/specialists.

Dr. Talwar also citied some of the best practices of health care from countries like Thailand, Malaysia, Singapore and Sri Lanka. Dr. Prema Ramachandran stated that Sri Lanka has been successful in its health indicators primarily because it has given priority to Primary Health care and importance to Maternal and Child Health. Dr. Sudarshan affirmed that primary health care needs to be given importance in India, especially in tribal and rural areas. According to him, the emphasis on National Health Mission in the 12th Five Year Plan is appropriate as it would take care of rural as well as urban areas. Dr. Sudharshan also suggested that there is need to have a Medical College in every district of the country. It was then informed by Hon'ble Member that six new AIIMS are coming up in different regions of the country. Hon'ble Member, however, stated that the use in the number of hospitals was not keeping up with the population growth.

After the discussion on second Agenda item was over, Hon'ble Member stated that there is a need to prepare a blueprint with the contribution made by all experts in highlighting the areas of concern.

Agenda Item No. 3: Towards a New Generation of Development Goals

Summarizing the gist of her paper, Dr. Jayashree Gupta emphasized on the following major Goals for the Post-MDG Agenda for health care:

Goal 1: Sustain the momentum for health care built by MDGs.

Goal 2: Ensure access to affordable drugs.

Goal 3: Reduce the incidence of non-communicable diseases.

Goal 4: Stop unethical medical practices.

Goal 5: Provide geriatric and palliative care.

Speaking on Goal 1, Dr. Gupta stated that there is a need to sustain

the momentum of health care built through MDGs No. 4 (reduce child mortality), No. 5 (improve maternal health) and No. 6 (combat HIV/AIDS, Malaria and other diseases) and further improve on them through close monitoring. With regard to Goal 2, Dr. Gupta said that as drugs constitutes a major component of health care, there is need to focus on suitable policy of interventions by the Government to ensure easy access to affordable drugs. She then talked about Goal 3 which currently is the leading cause of death worldwide and comprised life¬style diseases like heart disease, cancer, diabetes and chronic lung diseases. There is also need to include parameters for their prevention, control, treatment and access to health care. On Goal 4, Dr. Gupta clarified that it should include suitable parameters for addressing concerns relating to pre-natal sex determination tests, medical negligence and regulation of medical profession including MCI and State MCIs, stopping of unethical clinical trials, misleading advertisements and quackery. On Goal 5, she said that it should include suitable targets including age-friendly environment and housing.

Commenting on Goal 3, Dr. Prema Ramachandran said that it is an unattainable target and therefore has to be carefully worded like 'Life-style Modifications'. Supporting Dr. Ramachandran, Ms. Rekha Sharma said that awareness generation on this particular aspect should start at an early age in schools right from primary level. She also drew the attention towards regulating the contents of advertisements on food items that totally mislead people. Hon'ble Member agreed with their point of view. He also stated that the awareness about non- communicable diseases should start from an early age as part of school education.

With regard to Goal 4, Dr. Sudharshan expressed that MCI and State MCIs should take the onus of putting an end to unethical medical practices. He was of the view that the MCI should be more concerned about regulatory issues rather than concentrating on medical education. Dr. Talwar added that it should be the moral duty of doctors to refuse all kinds of unethical practices like sharing of fees for referring patients to specialists of their own choice, accepting gifts

from drug companies, prescription of particular brands of drugs and referring to diagnostic centers of their choice.

Agenda Item No. 4: High Prevalence of Anaemia

Talking about the issue of anaemia, Shri J.S. Kochher informed that anemia amongst women, adolescent girls and children is a major challenge in the country. Addressing the concern, Dr. Ramachandran said that anemia is best tackled by iron and folic acid supplementation, food fortification and dietary diversification through inclusion of increased vegetables. She emphasized that there is need to advocate iron and iodine fortified supplements as well. She informed that the National Institute of Nutrition is bringing a new variety of salt that will be rich in Iodine and Iron. It is proposed to put into use this salt in place of currently available iodized salt and thus tackle the problem of iron and iodine deficiency:

Ms. Rekha Sharma reiterated that there is need to provide supplementary diet to school children and adolescents to tackle the problem of anemia.

Talking on the issue of Sickle Cell Anaemia, Dr. Sudharshan informed that it was a major problem among the tribals. He suggested that sickle cell anaemia should be made an essential part of the Tribal Health Welfare Scheme. Besides, folic acid supplements should be taken and along with this testing/diagnostic facility should be created for management of the disease. Dr. Sudharshan agreed to share his paper on Sickle Cell anemia with NHRC on the request of Hon'ble Member.

Agenda Item No. 5: Shortage of Psychiatrists and Mental Health Institutions

Dr. Sudharshan said that mental health is very much a neglected issue and the implementation of the District Mental Health Programme is also very poor. In Karnataka, he continued, the PHCs were well-equipped to detect the problem of mental health, though it was not a priority area under the NRHM. There needs to be a system in

place to pick-up mental health patients languishing on the streets for their proper care and treatment. At the same time, there is need to make provision for more number of Psychiatrists and mental health institutions in the country.

Hon'ble Member in his concluding remarks reiterated the need for reconstitution of the existing Core Advisory Group on Health. He also expressed the need to prepare a blueprint which could facilitate NHRC in identifying and addressing areas of concern so that people have access to better health care facilities.

In the end, Dr. A. Sahu, Secretary General, NHRC thanked Hon'ble Member for chairing the meeting and also the participants for their valuable suggestions.

CHAPTER III

National Conference on Health Care as a Human Right

The National Human Rights Commission organized a two-day National Conference on Health Care as Human Right at the India International Centre (IIC), 40 Max Muellar Marg, New Delhi on 05 and 06 November 2013 under the Chairmanship of Justice Shri K.G. Balakrishana, Hon'ble Chairperson, NHRC. The conference was attended by public health experts and health scientists, legal experts, representatives of health NGOs, representatives of civil society, including consumer groups, technical institutions, international organizations, policymakers, representatives of Ministries/Departments of Health and Family Welfare, Women & Child Development, Panchayati Raj, Consumer Affairs, Drinking Water & Sanitation and National/State Commissions and senior officers of the NHRC.

The main objectives of the Conference were to:

1. Discuss ways in which the public health system could be strengthened from the perspective of human rights, especially with regard to accessibility, affordability and quality of health care with the involvement of community and sharing of best practices;
2. Discuss ways to address the problems of health relating to women and children;
3. Discuss the ethical issues involved with a view to addressing the illegal practices being carried out through proper regulation;
4. Discuss strategies to improve the availability of clean drinking water and sanitation facilities with the overall objective of improving health standards of people;
5. Discuss issues related to occupational health like silicosis etc. and ways to ensure the rights of workers involved;

The Programme Schedule of the Conference alongwith some presentations made by resource persons during various sessions (as indicated in annexures)

Recommendations of the National Conference:

The recommendations made during the course of the conference on the following issues include:

Session-I: Accessibility, Quality & Affordability of Health Care

(A) Priority recommendations related to necessary legal frameworks

National and State Governments should adopt following essential legal and accountability frameworks that ensure:

i. Free Access to Health and Health Care Services as fundamental right of all citizens;

ii. Graded norms and standards for health and health care services, including medical, surgical care, diagnostics and other health care services, with a patient's rights charter on services for all levels of health care delivery;

iii. Arrangements for assuring availability of quality essential drugs and supplies free of cost to all patients in need, with essential mechanisms for fair and economic procurement of these, and for rational production, prescription and use of these;

iv. Arrangements for proper regulation of health care and related services, through regulation of providers and establishments, both public and private, based on the specific norms for each of these entities;

v. All other health related human rights that has been agreed upon by the country through different international covenants and agreements;

vi. That all the needy and vulnerable population groups are covered properly through all these initiatives with mechanisms

put in place for their inclusion;

vii. That community has full ownership and oversight on these initiatives through sufficient mechanisms for the same, and platforms to raise their concerns and grievances with responsive mechanisms for grievance redress;

viii. That proper monitoring and information systems are put in place for all the above, with built in feedback and correction loops;

ix. Commitment of state and national governments to ensure adequate and efficient human resources, physical infrastructure and institutional arrangements for ensuring all above;

x. Commitment of the national and state governments for sufficient, efficient and timely provision of finances and other resources required to fulfill the following :

- The High Level Expert Group set up by the Planning Commission on Universal Health Coverage has set out details relating to legal and accountability framework. These details are to be used while formulating these frameworks;
- Existing legal frameworks may be re-examined to avoid contradictions and duplications;
- Implementing this recommendation should not be seen as a limited responsibility of the MoHFW, but of all concerned sections in national and state governments– in order to ensure larger accountability.

(B) Recommendations on different specific areas of health systems

(a) Essential health care service entitlements:

i. Entitlements for all citizens to essential primary,

secondary and tertiary level health care services, to be guaranteed by the governments through appropriate legal instruments; these should include OPD & IPD care for common illnesses, accident and emergency care, obstetric and gynaecologic care, basic surgical care, mental health care, referral transport services, community based care and other essential services. These should also include all essential preventive, promotive and rehabilitative care services. Health care services for different vulnerable populations – women, children, adolescent girls, tribal, people in vulnerable occupations and others should also be prioritized;

ii. Entitlements related to all emergency and essential drugs and supplies should be notified for each level of services;

iii. All OPD and IPD patients belonging to either BPL category or cannot afford without going through financial hardships, to have access to all common diagnostic tests such as pathological tests, X-rays, ECGs etc free of cost. Those who can afford, it will be worthwhile to give them access at subsidized rates so as to generate some resources as in AIIMS & PGI;

iv. These entitlements should be graded for different levels of facilities, based on the capacities and standards for the levels of facilities;

v. Citizens charters to be prominently displayed by all facilities, with clarity for citizens on the available services for their level, in the form of a citizens charter;

vi. Accountability of officials and department or the establishment to be specified and fixed, in case of

failure to meet the commitments as given in citizens charter.

(b) Accountability and grievance redress mechanisms

i. Independent bodies/ authorities at national, state and district levels to enforce the provision of health care entitlements and to lead grievance redress around these- for Government as well as Private Facilities;

ii. Accountability of health care providers to be properly set out, to these bodies;

iii. Arrangements such as Citizens Health Rights Councils at the level of different facilities;

iv. Through regular social mobilization activities with NGO, civil society and elected representatives support;

v. Community based monitoring and public hearings can support the grievance redress bodies for identification of gaps;

vi. All these arrangements to be adequately supported through sufficient HR, physical infrastructure and other resources.

(c) Essential medicines and supplies

i. Availability of all emergency and essential medicines, surgical, sutures and other consumables specific to the level of care should be ensured in all health facilities, free of cost;

ii. Set up transparent mechanisms for fair procurement and supply of drugs for health services such as medical and health supplies corporations, drug warehousing facilities and software-based inventory management arrangements;

iii. Adopt and ensure use of Standard Treatment Guidelines, Essential Drug List, Drug Formulary, Rational Use of Drugs and evidence based medicine;

iv. Ensure price regulation of all essential drugs, based on manufacturing costs;

v. Strengthen the public sector drug and vaccine units in order to ensure quality and availability of vaccines and essential drugs;

vi. Acquisition and mergers of domestic companies by multinational corporations should be disallowed;

vii. Augment production capacity of generic drugs domestically.

(d) Human resources

i. New medical, dental, nursing and pharmacy colleges to be set up limited to needy areas of the country, in public sector, at district level with Zila Panchayat support , with district hospitals as teaching institutions;

- National Government to support states in ensuring competent faculty;
- Local selection of meritorious students, financial support for those poor students;
- 3 year B.Sc courses in community health to be accredited for primary level health care and these Community Health Officers will be posted at sub centre level where there is no position of medical doctor at present;
- For immediate fulfillment of specialties, certificates, diplomas, family medicine and multi-skilling to be

considered;

ii. Nurses, nurse practitioner development to be taken in priority;

iii. Development and deployment of Lab technicians and other paramedical personnel to be focused-with opportunities for professional advancement;

iv. Formulation and strict enforcement of Posting and transfer policies;

v. First posting of staff after education could be based on merit cum choice system, to avoid influences;

vi. Counseling model from Tamil Nadu/Karnataka could be an option;

vii. Matching of infrastructure- human resources and facilities to be done properly, while posting people;

viii. Sufficient wages and adequate incentives for all health care staff; Special cadre for difficult areas with attractive additional wage and incentive packages- to achieve a 'no post vacant' status' at all levels;

ix. Expand the strength of managerial/ leadership workforce at all levels;

x. AYUSH doctors to be involved prominently as caregivers.

(e) Promoting professionalism and excellence

i. Integrate all professional councils such as medical, dental, nursing, pharmacy, etc;

ii. Ensure that best possible medical knowledge and skills are imparted to all the health professionals;

iii. To promote professional conduct and ethics of the highest order and check malpractices;

iv. Ensure continuing medical education through stipulated programmes;

v. Set up periodic evaluation (of competence and skills) and licence renewal mechanisms for all professions registered with the council(s);

vi. Rework the norms for opening new medical colleges so that adequate number of MBBS, specialists and super-specialist doctors are available as required;

vii. At least 1 year compulsory rural posting for undergraduates- posting of these people to be assured in time.

(f) Quality of care

i. Lay down mandatory quality standards for all levels of facilities, for the services entitled for;

ii. Compulsory accreditation in a stipulated period of time, and annual renewal through independent accreditation authority for public and private health care facilities- at national and state levels;

iii. Norms for private and public facilities could be different, based on the objectives of institutions.

(g) Referral system

i. To and fro referral systems to be set up at all level of facilities, to enable health facilities to act as interconnected networks;

ii. Referral cards to support documentation and to facilitate transfer;

iii. Facilities for referral transport;

iv. Charitable hospitals which are supposed to give free services may also act as referral destinations – at par with public institutions.

(h) Public Private Partnership (PPP)/Bringing in private sector for health care services

i. PPPs/Purchased Private Services to be brought under fair procurement processes, with transparent mechanisms put in place;

ii. PPPs should supplement and not substitute the efforts of the government to strengthen the public health systems;

iii. To be adopted in those areas where public facilities are deficient – there should be clear evidence that they improve availability, accessibility and affordability.

(i) Effective regulation of the private sector

i. Ensure appropriate regulation of private and corporate health care providers;

ii. Clinical Establishment Act to be enacted and implemented by all states in a stipulated timeframe;

iii. Standards for infrastructure, HR, services, costs and quality of care to be enforced for all private and corporate providers;

iv. Private and corporate facilities to be brought in under the grievance redressal mechanisms.

v. Enforce private or charitable hospitals which got land or any other public aid to provide free and concessional services for the deprived as committed by them.

(j) Physical infrastructure

i. Availability of health facility based on both distance and population norms for health facilities to be included in the entitlement package; difficult areas, as envisaged in the national health policy, to have differential norms;

ii. Primary Health facilities to be made available to people within 3-5 km of travel;

iii. Mechanisms to ensure adequate and timely maintenance and proper cleanliness of physical infrastructure.

(k) Monitoring and remedial action

i. Set up an IT based Health Management Information System;

ii. To ensure periodic monitoring of actual availability of health services, access, quality of services and outcomes;

iii. Monthly monitoring and feedback loops;

iv. Coupled with evaluation, prompt and effective remedial measures in case of service break down;

v. Bio metric attendance device to be deployed in health facilities to ensure timely reporting and check work absenteeism;

vi. To create state level live health care database of hospitals, HR, services and caseload- to ensure rational allocation of resources;

(C) Cautions

(a) Infrastructure

i. Proper analysis required before sanctioning new facilities- existing resources should not be splintered or duplicated;

ii. GIS mapping of existing infrastructure prior to declaring new ones;

(b) Financing

i. While considering financing options for reimbursing private service providers, public financing models to be considered- full care to be taken to avoid insurance programmes managed by profit making bodies that leads to partial usage of public money earmarked for the purpose and pilferage;

ii. Karnataka Government's public institution based non-insurance, risk pooling arrangement (Suvarna Arogya Trust) could be a way for reimbursing the private;

iii. Independent watch on existing arrangements to audit and to ensure public interest.

Session-II : Woman and Child Health – Important Issues

(A) Policy:

i. Independent watch on existing arrangements to audit and to ensure public interest;

ii. A rights based approach as against a Welfare or Beneficiary based one;

iii. Removal of two child norm as an incentive / disincentive for all policies;

iv. Removal of distinction between APL and BPL for access to health care;

v. Integration and convergence of State and central child and maternal health schemes;

vi. All social and economic health determinants need to be addressed for a holistic approach. Structural factors that perpetuate discrimination against women and impact access to health care and should be factored into policy;

vii. Legislative enablement to fill human resource gap, trained professional mid wives/nurses trained in delivery/MBBS doctors without specialization requirements. Public Health Service and Public Health Cadre needed;

viii. Registration of all births and deaths. Effective policy needs data;

ix. Unconditional wage equivalent maternity allowance to be made available to women three months before and six months after childbirth;

x. Home-based deliveries should not fall off the policy map. Training for home based neo-natal and maternal care;

xi. Focus on high priority districts / talukas at policy level;

xii. National policy for children refers to all children up to the age of 18 years. It should be the same in health policy.

(B) Implementation:

i. Facilities for delivery should be made available in at

least a 15 km radius of remote areas with provision of mobile health clinics where there are no PHCs;

ii. Proactive tracking of pregnant women to ensure planning and preparation. Mapping at PHC level of Expected Date of Delivery;

iii. Blood storage facility should reach at least up to First Response Unit (FRU) level;

iv. Up-grading of technological facilities at FRU. Implementation of technical guidelines;

v. Assured supply of Vitamin A and Iron Folic Acid tablets to be available at PHC level;

vi. Data tracking, monitoring and up to date record keeping essential;

vii. More flexibility in State PIP process of NRHM;

viii. Linkage with private sector and professionals, including contracting in and contracting out. Mechanism to be evolved in private hospitals/colleges for providing free services to poor people;

ix. Facility for transfer of PHC card from one unit to another;

x. Proactive transport arrangement;

xi. Maternity kit as provided in Karnataka;

xii. Identification and tracking of the most vulnerable and acutely malnourished women and children;

xiii. Similar provisions for the acutely malnourished children;

xiv. As provided in the Food Security Act, hot cooked food

to be served to all women during pregnancy and six months after child birth through the local Aganwadis to meet the minimum nutritional standards specified in Schedule-II of the Act;

xv. Capacity building/training of ANMs (who is responsible for what) and education of families;

xvi. Inter-generational inequities among women to be assessed and addressed and convergence of various programmes ensured to this end;

xvii. Menstrual health and sanitation to be addressed;

xviii. Training staff in soft skills.

(C) Accountability and redressal:

i. Management and regulatory structures at the top inadequate;

ii. Accountability at all levels;

iii. Independent data monitoring and review boards at district and state levels;

iv. Need to address problem of absenteeism – monitoring and accountability;

v. Health ombudsperson in every district to ensure accountability;

vi. Regular assessment of effectiveness of input schemes and course corrections accordingly.

Session-III : Clean Drinking Water, Hygiene and Sanitation

People for whom the government programmes are made are largely unaware of these programmes. Need of organised means of sharing information and group to support people

on the ground so that they can avail the benefits of these programmes.

(A) Clean drinking water:

i. Equitable distribution of water to all irrespective of economic status, castes, religions;

ii. Protection of existing water bodies so that they can be used for potable purposes;

iii. Use locally appropriate and available technology for providing safe drinking water especially to people residing in far off areas like primitive tribal groups;

iv. Tapping and protection of springs is a good source of drinking water at hilly areas. The use of this resource and its protection should be propagated;

v. Action to be taken against the unauthorised tapping of water since this leads to contamination of water;

vi. System of monitoring quality of water not only at the source level but also at user level. Regular and periodic check-up of drinking water is essential;

vii. Steps should be taken for inter-sectorial collaboration and coordination between different uses and users;

viii. Strict action to be taken against those responsible for contamination of water and for assuring its quality;

ix. People should also be educated and exhibit responsible behaviour with use and misuse of water;

x. Prevention of over exploitation of ground water by industries. Before licensing industry should disclose its water regeneration plan.

(B) Sanitation:

i. Sanitation will only be successful if there is water available within or close to the toilets. Water must be made available;

ii. Operation and maintenance of school toilets should be the responsibility of the school authorities. The students must be encouraged and motivated to clean the school toilets in tune with dignity of labour and without showing any discrimination;

iii. Bathing room should be provided so that woman can maintain personal hygiene and dignity;

iv. Personal hygiene needs more focus. Awareness programme for children should be developed thorough curriculum. Stress should be laid on hygiene including personal hygiene;

v. Government should provide drinking water and toilet facilities to all, irrespective of title of the land. Title of the land should not be an impediment for constructing community toilet for the use of the marginalised people who are living in unauthorized areas;

vi. NHRC and SHRC should play a more proactive role in the eradication of manual scavenging;

vii. Campaign to educate/aware slum dwellers about sanitation;

viii. Health care facility should have adequate water and sanitation facilities;

ix. Appropriate and enabling legislation for universal and equitable access to drinking water and sanitation

should be brought forward.

Session-IV: Occupational Health and Safety

A special report on the prevalent of silicosis was prepared by NHRC and was forwarded to the Ministry of Home Affairs far back in 2011. In the National Conference organised by the NHRC on health care as human rights the issue of occupational health and safety was discussed in detail. After deliberations with resource persons, officials attached to the respective department of the government and representative from various NGOs, the Commission recommends the following on the issue of occupational health and safety:

i. It is recommended that as per section 2(C) of the Factories Act 1948 necessary rules can be made by the State Governments in exercise of the powers u/s 85 of the Factories Act, 1948 to bring the following units/ work place under the purview of the Factories Act, 1948 where one or more workmen are employed. During the deliberation it is brought to the notice of NHRC that rules are in terms of Section 85 to bring the units where one or more workers are employed who are suffering with various occupational diseases. For example units like:- Ramming Mass (Quartz grinding), Stone crusher, Iron ore crusher, bauxite grinding, sponge iron plants, refectories foundries, gems and jewellery;

ii. Though the Employees Compensation Act mainly deal with the payment to the workmen, keeping in mind the immediate and required medical facilities shall be made available to the workmen injured and suffered any illness due to the workload. It is recommended that necessary rules can be framed by the State. Making the employer to provide such immediate and re-

quired medical treatment to the workmen concerned;

iii. Considering the structure of the Employees Compensation Act the commission recommends that necessary rules can be framed by the State, fixing time limit for the disposal of application filed by the workmen and the compliance of the orders by the Commissioner;

iv. It is recommended that the appropriate Governments shall make rules for the health and safety of the children covered under the Child Labour (Prohibition and Regulations) Act, 1986, keeping in mind sub section (2) of section 13;

v. Though Section 26 of the Bonded Labour System (Abolition) Act, 1976 empowers the Central Government to make rules, the said rules do not cover provisions for affording medical facilities to the rescued bonded labourers and no rules have been framed so far. Therefore, it is recommended the relevant provisions of the Bonded Labour (Abolition) Act, 1976 shall be suitably amended enabling the Central Government to make rules in this regard;

vi. After deliberations and discussions, it is recommended to the Government that the following provisions of the various Acts are to be strictly complied with:

- Sections 7, 7(A), 8, 9, 10, 11 to 20, 41(B), 41(C), 41(F), 85, 87, 89, 90, 91(A), 101(A), 113 of the Factories Act;
- Sections 2(J), 5 to 9, 11, 16, 22, 9(A), 23, 25, 26, 27, 48 of the Mines Act. It is also recommended that the Mines Worker Welfare Board should also

include all minor minerals;

- Section 3 of Employees compensation Act, 1923;
- Sections 2(8), 51(A), 52(A) of ESI Act, 1948.

vii It also recommended that the Government shall make a provision for appointment of Doctors, Para medical technicians, support staff and opening of separate occupational disease detection centre in all Government and ESI hospitals with suitable infrastructure.

These recommendations were forwarded to the concerned Ministries /Departments and various stakeholders for taking necessary actions.

CHAPTER IV

National Conference on Human Rights of Women - Reproductive Rights of Women

Background

Ts per the 2011 Census, the total number of 586.47 million women accounted for 48.46 percent of the total population of the country. In view of the significant role played by women in the overall development and progress of the country, the Constitution of India has enshrined the principal of gender equality in its Preamble and through the Fundamental Rights, Directive Principles of State Policy and Fundamental Duties, it has not only granted equality to women, but has also empowered the state to adopt measures of positive intervention in favour of women.

The National Human Rights Commission (NHRC) represents India's commitment to ensure human rights to women. Ever since its inception in October 1993, it has evolved a variety of inter-connected ways to protect and promote the rights of women including their reproductive rights.

The NHRC has also considered the violation of the rights women from the angle of health and the issue of maternal anaemia identified as a rights issue in 1996-97. In 2000, it focused on human rights and HIV/AIDS and Public Health and Human Rights and covered issues impacting on the rights of women. In 2000- 2001, it analyzed the human rights dimensions of Census 2001, commenting on the male: female sex ratio in the country, particularly where the ratio was especially low. It called for a concentrated effort to end the misuse of sex – determination tests which encouraged the evil practice of prenatal sex selection. In 2003, it organized a Colloquium on Population Policy, Development and Human Rights and took up the issue of incentives/disincentives in the population policies of state Government/Union Territories vis-à-vis the National Population

policies. During 2007-2008, it undertook a collaborative research with UNFPA entitled “Research and Review to Strengthen Pre-Conception and Pre- Natal Diagnostic Techniques (Prohibition of Sex Selection) Act’s implementation across key States”.

The International Conference on Population and Development (ICPD) recognized women’s rights to reproductive and sexual health as being key to women’s health. The basis for these rights can be found in various articles of the CEDAW. Rights to reproductive and sexual health include the right to life, liberty and the security of the person; the right to health care and information; and the right to non-discrimination in the allocation of resources to health services and in their availability and accessibility. Of central importance are the rights to autonomy and privacy in making sexual and reproductive decisions, as well as the rights to informed consent and confidentiality in relation to health services. Sexuality and reproduction are vital aspects of personal identity and are fundamental to human well being.

The ICPD prompted a paradigm shift in reproductive and sexual health programmes of the country as it led to introduction of National Rural Health Mission (NHRM) and a national level Reproductive and Child Health Programme II (RCH II) both of which were launched in 2005. Reproductive and sexual health programmes must place emphasis on improving access to quality health services by gender sensitive providers. It needs to be ensured that every woman has access to health services throughout her lifecycle, especially during pregnancy and childbirth.

Many of the recommendations accepted by the Government of India during the second universal periodic review (UPR) in 2012 relate to women’s sexual and reproductive health rights, including improved maternal health, access to safe abortion and prevent criminal mature of pre-natal sex selection which call for action on the part of the Government.

UPR- 2 Recommendations – pertaining to Sexual and Reproductive Rights of Women

[The recommendations relating to sexual and reproductive rights of women accepted by the Government of India during the first and second UPR process include the following:

- Take further practical steps to reduce the high level of maternal and child mortality, inter alia, through better access to maternal health services. (Austria)

- Further efforts towards addressing the challenge of maternal and child mortality. (Egypt)
- Take further measures to ensure that all women without any discrimination have access to adequate obstetric delivery services and sexual and reproductive health services, including safe abortion and gender-sensitive comprehensive contraceptive services. (Finland)
- Strengthen its efforts to improve maternal health and act to effectively balance the skewed sex-ratio among children, including by combating female foeticide. (Norway)
- Intensify its efforts to sensitize and train medical professionals on the criminal nature of pre-natal sex selection with a view to ensuring stringent enforcement of the legal prohibition of such practice. (Liechtenstein)
- A fully integrated gender perspective in the follow up of this UPR. (Norway)
- Continue working on the welfare of children and women. (Nepal)

The Commission besides other women related issues is deeply concerned with women Sexual and Reproductive Health Rights. In order to look into issues related sexual and reproductive rights of women, the Commission took up this subject for detailed discussion in the National Conference on Human Rights of Women held on 18-19 February, 2014.

Recommendations of the National Conference

The recommendation relating to sexual and reproductive rights of

women including provisioning of incentives and disincentives for adopting small family norms are given below:

1. India being a signatory to the International Conference on Population and Development (ICPD) in 1994 should be adhering to the principles laid down in the ICPD Programme of Action in letter and spirit by accepting that choice of the individual has to be respected and appropriate mechanisms should be created to fulfil those choices.

2. NHRC declaration made at a National Colloquium organized during 9-10 January, 2003 and attended by representatives of State Governments and civil society acknowledged the reproductive rights, set on the foundation of dignity and integrity of an individual. It encompassed several aspects such as:-

   - The right to informed decision-making, free from fear and discrimination.
   - The right to regular accessible, affordable, good quality and reliable reproductive health care services;
   - The right to medical assistance and counseling for the choice of birth control methods appropriate for the individual couples; and
   - The right to sexual and reproductive choices, free from gender-based violence.

   The above aspects of the declaration need to be reaffirmed.

3. Enforcement of a two child norm and coercion or manipulation of individual fertility decisions through the use of incentives and disincentives violate the principle of voluntary informed choice and the human rights of the people, particularly the rights of the child. Keeping this in view, there is a need for a review petition in the Hon'ble Supreme Court on its verdict in the case of Fakir Chand Vs. State of Haryana. In this judgment, the Supreme Court upheld the legislation enforcing two child

norms for eligibility to contest election to the Panchayat, which is against the National Population Policy as well as the ICPD principles.

4. Reproductive justice, covering a range of services including facilities for safe abortion as a right, should be ensured as this will create enabling conditions for promotion and safeguarding of reproductive rights.

5. Regulation of the practice of commercial surrogacy is required to protect the interest and rights of surrogate women. In this regard, enactment of the pending Assisted Reproductive Technology (ART) Bill should be undertaken with necessary amendments after a consultative process with all the concerned stakeholders.

6. Rights of sexual minorities (LGBT) to avail of all health services without any bias or discrimination and their right to exercise independent sexual and reproductive choices must be affirmed.

7. The right of an adult to marry a person of his/her choice is often infringed by extra constitutional authorities. Couples who are under threat of such infringement should be provided supportive measures including protection by law enforcement agencies.

8. A large scale campaign needs to be launched to sensitize all stakeholders including judiciary, police, policy-makers, law-makers regarding the right to free choices of marriage and living with dignity without infringement.

9. Proper implementation and strict enforcement of Medical Termination of Pregnancy Act, 1971 is required since a large number of unauthorised and ill-equipped abortion centres are existing which leads to possibility of large scale abortions carried out under unsafe conditions. State Governments should take the responsibility to provide properly licensed/

authorised and well-equipped abortion facilities which are accessible and affordable to women.

10. After nearly two decades of the enactment of the PCPNDT Act, widespread illegal sex determination and subsequent sex selection is taking place across the country as is evident from the skewed child sex ratio. Hence, proper and strict implementation of the PCPNDT Act by making the Appropriate Authorities at the State and the District level fully accountable is required.

11. Other related laws that empower women and safeguard their interest like Dowry Prohibition Act, Inheritance Laws, and Protection of Women from Domestic Violence Act also need to be effectively implemented to counter “son preference”.

12. Age appropriate gender sensitive, sexuality and reproductive health education should be provided in schools, especially for the adolescents. Similar attention needs to be given to the children who are out of school also.

13. Poorna Shakti Kendras set up under the National Mission for Empowerment of Women needs to be strengthened as one stop window for providing various services for women.

14. Appropriate Governments should ensure that individuals, irrespective of their marital status are not denied access to contraceptive facilities at public health care centres.

15. The need for proper, acceptable and affordable reproductive health services for men as a target group should be equally addressed in the population policy as neglect of these needs may have repercussions on the rights of the women. The needs of other group such as childless women, unmarried women, single women also need to be equally addressed.

16. Comprehensive affordable and acceptable health services for women during the entire life cycle needs to be in place as against just concentrating on the reproductive stage. The problems faced by women during pre and post menopause

would include lifestyle diseases, psychological problems etc.

17. Violence against women can have implication on her health including physical, mental, sexual and reproductive health. Hence, there is need for one stop crisis centres in preferably, public hospitals, with the involvement of the Gram Panchayat/other local bodies for attending to their needs such as psychological counselling, medical and other social assistance. Sensitization and training of the Gram Panchayat along with other village level functionaries should be taken up on priority for responding to incidents of violence.

18. Periodic capacity building of the functionaries of the State Human Rights Commissions and State Women Commissions and all other stakeholders on the issues relating to reproductive and sexual health rights should be undertaken by National Human Rights Commission.

These recommendations were forwarded to the concerned Ministries /Departments and various stakeholders for taking necessary actions.

CHAPTER V

Meeting on Reproductive Rights of Women and Draft Legislation on the Subject of Surrogacy

The National Human Rights Commission organized a meeting on 'Reproductive Rights of Women' and draft legislation on the subject of surrogacy on 29 April 2014 in the Commission under the chairmanship of Justice Shri Cyriac Joseph, Hon'ble Member, NHRC. The meeting was attended by Ms. Ena Singh Assistant Representative, UNFPA; Dr. Abhijit Das, Director, Center for Health and Social Justice; Mr. Subhash Mendhapurkar Founder Director, SUTRA; Ms. Nirmala Buch, President, Mahila Chetna Manch; Ms. Deepa Venkatachalam, SAMA (NGO); Ms. Shobhana UNFPA and Officials of the NHRC including Shri J.S Kochher, Joint Secretary (Trg&Res), Dr. Savita Bhakhery, Joint Director (Research) and Mr. Shahanshah Gulpham, Research Consultant.

Shri J.S. Kochher, Joint Secretary (T&R), NHRC welcomed the participants and apprised them about the issues relating to Reproductive Rights of Women and draft legislation on the subject of surrogacy. Justice Shri Cyriac Joseph, Hon'ble Member also welcomed the participants and requested each participant to express their views.

Ms. Ena Singh, Assistant Representative, UNFPA articulated that enforcement of a two child norm and coercion or manipulation of individual fertility decisions through the use of incentives and disincentives violate the principle of voluntary informed choice and the human rights of the people, particularly the rights of the child. Keeping this in view, there is a need to file a review petition in the Hon'ble Supreme Court on its verdict in the case of Fakir Chand Vs. State of Haryana. In this judgment, the Supreme Court has upheld the legislation enforcing two child norms for eligibility to contest election to the Panchayat, which is against the National Population Policy (NPP) as well as the ICPD principles. A letter was addressed

to States by the then Minister of Panchayati Raj, Shri Mani Shankar Aiyar, at the request of the civil society.

Smt. Nirmala Buch, Director, Mahila Chetna Munch, Bhopal also reiterated that two child norm should not be made a condition as made a condition as it is against the NPP. Every couple/individual have a right to decide freely about the number of children they want. Having done extensive work in this area, Smt. Buch assured the Hon'ble Member that she would provide to the NHRC a comprehensive list of States/UTs which were enforcing two child norm through the use of incentives and disincentives.

Dr. Abhijit Das, Director, Centre for Health and Social Justice, New Delhi, spoke about strengthening of family planning service delivery system as it was not able to address the high proportion of unmet needs. He further emphasized that there was need to lay emphasis on spacing methods.

Shri Subhash Mendhapurkar, Director, SUTRA, stated that enforcement of two child norm led to declining sex ratio and had adverse consequences on women.

Ms Deepa Venkatachalan from SAMA, New Delhi gave an overview about the Assisted Reproductive Technology (ART) Bill and pleaded that the practice of commercial surrogacy be regulated to protect the interest and rights of surrogate women and children borne by them with respect to their after delivery services, health care, other issues like compensation, etc. for complications if any.

The main decisions emanated following the deliberations are mentioned below:

(i) NHRC will write to Chief Minister of all the States/UTs calling for action taken on the recommendations and declaration adopted in the two-day Colloquium on Population Policy-Development and Human Rights organised by the Commission in New Delhi on 9 & 10 January 2003 reiterating that two child norm is against the population policy objectives.

(ii) Based on the assessment of the responses received from the

States/UTs, NHRC will consider filing a Writ Petition in the Supreme Court of India challenging the existing laws including State Population Policies promoting incentives/disincentives which are violative of the reproductive rights of vulnerable sections including women and children. The requisite information including statistics for filing of the petition will be provided to the commission by Ms Ena Singh, Dr. Abhijit Das, Shri Subhash Mendhapurkar and Smt Nirmala Buch.

(iii) NHRC may organize a consultation on ART Bill. A consultative process of this kind with all the concerned stakeholders will facilitate in knowing the need and desirability of such a Bill.

(iv) SAMA to procure a copy of the ART Bill, 2013 from the Ministry of Health and Family Welfare and forward it to NHRC along with a Background Note on rights being violated by the ART Bill.

(v) NHRC to consider constituting a Core Advisory Group on 'Reproductive Health and Rights'.

The meeting ended with a vote of thanks to the chair.

CHAPTER VI

Meeting of the Expert Group on Emergency Medical Care

The National Human Rights Commission organized a meeting of the Expert Group on Emergency Medical care on 17 July 2015 in the Commission under the Chairmanship of Shri S.C. Sinha, Hon'ble Member, NHRC. The minutes of the meeting are as under:

1. Shri Satya N. Mohanty, Secretary General, NHRC welcomed the Members of the Expert Group. Thereafter, the Members were requested to provide their suggestions for improving the emergency medical care in the country.

2. Dr. P. Ravindran, Addl. DDG, Ministry of Health and Family Welfare, Government of India conveyed that the earlier report of NHRC Expert Group in 2004 was useful to give a boost to the emergency medical care in the country. As a result, this area was given emphasis and more than 16,000 ambulances are in place, of which more than 7,700 are under dial 108 scheme for critical care and more than 8,600 under the 102 scheme for pregnant women and children. In addition, there were 140 hospitals to be covered for emergency care under the Eleventh Five Year Plan out of which 39 hospitals are already operational. For 95 hospitals, the buildings are complete but the operationalisation is yet to be completed. In the remaining, construction is in progress. Out of the identified 140 hospitals, the trauma centres in 118 hospitals are funded under the Trauma Scheme. Twenty hospitals are to be funded under the Pradhan Mantri Swasthaya Suraksha Yojna (PMSSY) scheme and 2 trauma centres are to be developed with their own funds.

3. Dr. Ravindran also informed that for the Twelfth Plan, a Sub-Committee was constituted to identify the gaps in the emergency medical care system and strengthening of the district hospitals for this purpose. It was conveyed that the

basic shortcoming in the area of emergency medical care system is the lack of human resources.

4. It was also conveyed that there is a problem because most people who can assist are not legally mandated to attend to patients requiring emergency care. Only doctors can carry out invasive interventions. The Members suggested that there was need to build up a cadre of emergency medical technicians as in the western countries, who would be legally mandated to provide such emergency care. They also suggested that there is need to have Para Medical Council of India on the lines of Medical Council of India.

5. Dr. Suresh S David, Medical Director and Professor, HOD of Emergency Medicine, Pushpagiri Medical College Hospital, Tiruvalla, Kerala conveyed that trauma care constitutes only 20 per cent of the overall emergency care. However, in India, emphasis has only been laid on trauma care and the remaining part of the emergency care was neglected, which also needs to be attended.

6. Hon'ble Member, Shri S.C. Shina enquired whether there was any visible trend in accidental deaths having come down as a result of the increase in the number of ambulances and other trauma related services. The Expert Group Members replied that while the downward trend could be felt and especially in private sector, the emergency medical care in the country is lopsided. Dr. David stated that picking up and bringing the patient to the hospital was not sufficient as long term care also needs to be provided. Not only pre-hospital but also institutional care was necessary.

7. It was conveyed that pursuant to the suggestions made by the Sub-Committee constituted for the Twelfth Plan in the Ministry of Health and Family Welfare, there was a suggestion from the EFC that an authority for emergency care should be created. The other important suggestions in this area were:

i) Pre-hospital care should continue under NHM.

ii) There is need for strengthening district hospitals.

iii) Need for proper referral system.

iv) Need to address the lack of manpower.

v) Emergency care should also be an area of emphasis in the medical colleges.

vi) Need to have short term courses, which could equip the para-medics to attend to emergency care.

8. It was also brought out that Government of Gujarat had come out with an Emergency Medical Services Act, 2008. It was explained that the Law Commission in its report had prepared a Model Act which was used by the Gujarat Government for this purpose. However, according to Shri Subodh Satyavadi, CEO, GVK Emergency Medical Relief Institute, the Act was not implemented and the Rules were not framed and the legal situation remains the same. It was again emphasized that while lot of progress has been made on pre-hospital care/ transfer, there was lack of facilities in the subsequent hospital care.

9. Secretary General, NHRC suggested that there could be a National Emergency Medical Services Act, which could be legislated by the Ministry of Health and Family Welfare.

10. Dr. Sanjeev Bhoi, Additional Professor and Incharge Jai Parkash Narayan Apex Trauma Centre, AIIMS talked about the need for training protocols at PHC level. He also suggested that medical colleges could hand hold the district hospitals who could in turn support the community health centres. It was agreed after detailed discussion that there should be focus on strengthening the district hospitals for emergency care and later, efforts could be made for emergency health facilities improvement at the sub-district level.

11. It was also suggested that there could be courses on emergency care for nurses, since they need to be empowered more than the doctors in order to improve the services.

12. Dr. Atul Saxena, Professor, Department of Emergency Medicine, Government Medical College, Baroda, Gujarat raised the issue of need for emphasis on maintenance of equipment. Secretary General, NHRC suggested that the equipment maintenance policy could be put in place by the Ministry of Health and Family Welfare.

13. Dr. Sanjeev Bhoi also handed over three important papers prepared in the AIIMS, New Delhi on the subject of emergency medical care for consideration of the Expert Group.

14. The meeting ended with the Hon'ble Member requesting the Expert Group Members to provide written inputs on the subject, after which one more meeting could be convened. He thanked the Expert Group Members for sparing time and attending the first meeting.

Annexure-I

Programme Schedule

Day 1	
09:30 – 10:00 hrs.	**Registration**
10:00 – 10:45 hrs.	**Inaugural Session**
	● Welcome by Joint Secretary, NHRC ● Opening Remarks by Justice Shri K.G. Balakrishnan, Chairperson, NHRC ● Address by Shri Manoj Jhalani, Joint Secretary, Ministry of Health and Family Welfare, Government of India ● Keynote Address by Dr. Devi Prasad Shetty, Chairman, Narayana Hrudalaya Hospital, Bangalore on 'Dissociating Health Care from Affluence'. ● Vote of Thanks
10:45 – 11:00 hrs.	**Tea Break**
11:00 – 13:15 hrs.	**SESSION – I - Chair : Shri S.C. Sinha, Member, NHRC**
	Availability, Accessibility, Quality and Affordability of Health Care Services in India – Need for Universal Health Care
	● Innovative Measures for Universal Health Coverage in India (Annexure-I) Dr. V.R. Raman, Principal Fellow, Health Governance, Public Health Foundation of India. ● Strengthening Medical Education Quality for Universal Health Care Delivery (Annexure-II) Dr. K. K. Talwar, Chairman, Department of Cardiology, Max Healthcare, Delhi

	● Provision of Adequate Health Services in India – Reaching the Unreached Dr. H. Sudharshan, Member, NHRC Core Advisory Group on Health ● State Presentations by Secretaries, Department of Health (i) Rajasthan; **(Annexure-III)** (ii) Kerala; **(Annexure-IV)** (iii) Tamil Nadu; **(Annexure-V)** (iv) Uttar Pradesh **(Annexure-VI)**
13:15 – 14:15 hrs	**Lunch**
14:15 – 15:45 hrs.	**SESSION-II - Chair: Shri Satyabrata Pal, Member, NHRC**
	Women and Child Health – Important Issues
	● Maternal and Child Health from Human Rights Perspectives **(Annexure-VII)** Dr. Dilip Mavalankar, Director, Indian Institute of Public Health, Gandhi Nagar, Gujarat ● Application of Human Rights Based Approaches for Prevention of Maternal Mortality and Morbidity **(Annexure-VIII)** Ms. Jashodhara Dasgupta, Coordinator, SAHYOG, Delhi ● Right to Maternal and Child Health Care: Strengthening of Institutional Arrangements **(Annexure-IX)** Dr. Abhijit Das, Director, Centre for Health and Social Justice, Delhi ● Maternal and Child Malnutrition : Need for Nutrition Education and Capacity Development **(Annexure-X)** Ms. Rekha Sharma, Member of the NHRC Core Advisory Group on Health
15:45 – 16:00 hrs	**Tea Break**
16:00 – 17:30 hrs	**SESSION-III**
	Working Group Discussions
	Group I – Chair : Shri S.C. Sinha, Member, NHRC ● Accessibility, Quality & Affordability of Health Care
	Group II – Chair : Shri Satyabrata Pal, Member, NHRC ● Women and Child Health – Important Issues

Day 2	
10:00 – 11:15 hrs.	**SESSION IV - Chair : Justice Shri Cyriac Joseph, Member, NHRC**
	Clean Drinking Water, Hygiene and Sanitation : A Step Towards Better Health Care
	● Water, Hygiene and Sanitation – The Forgotten Foundations of Health **(Annexure-XI)** Dr. S. K. Thakur, Consultant, Gastroenterology, Moolchand Medcity, Delhi. ● Drinking Water, Hygiene and Sanitation: A Step Towards Better Health Care: The Gram Vikas Experience (Annexure-XII) Shri Joe Madiath, Executive Director, Gram Vikas, Odisha ● Access to drinking water, sanitation and hygiene as human rights: Perspectives from the ground. (Annexure-XIII) Dr. Indira Khurana, formerly with Water Aid India and an expert on water and sanitation issues. ● WASH in Schools for Health Learning and Equity Ms. Mamita Thakkar, UNICEF India, Delhi ● Policies and Programmes of Government of India on Water and Sanitation Issues including Nirmal Bharat Abhiyan. (Annexure-XIV) Shri Satyabrata Sahu, Joint Secretary, Ministry of Drinking Water and Sanitation
11:15 – 11:30 hrs.	**Tea Break**
11:30 – 13:30 hrs.	**SESSION V – Chair : Justice Shri D. Murugesan, Member, NHRC**
	Occupational Health and Safety
	Occupational and Other Work-Related Diseases Shri Rana Sengputa, Managing Trustee & CEO, Mine Labour Protection Campaign Trust, Jodhpur, Rajasthan
	Management of Occupational Health and Safety Through Use of Technology & Capacity Building **(Annexure–XV)** Dr. S. S. Waghe, Director (Medical), DGFASLI, Mumbai
	Governance Challenges for Implementation of Workers' Rights in Hazardous Industries : A Study of Alang-Sosiya Ship-Breaking Yard, Gujarat **(Annexure-XVI)** Dr. Geetanjoy Sahu, Assistant Professor & Chairperson, TISS, Mumbai

13:30 – 14:30 hrs.	**Lunch**
14:30 – 16:00 hrs.	**SESSION – VI**
	Working Group Discussions
	Group III – Chair : Justice Shri Cyriac Joseph, Member, NHRC ● Clean Drinking Water, Hygiene and Sanitation
	Group IV – Chair : Justice Shri D. Murugesan, Member, NHRC ● Occupational Health and Safety
16:00 – 16:40 hrs.	**Chair : Justice Shri K. G. Balakrishnan, Chairperson, NHRC**
	● Presentation and Finalization of Recommendations
	● Remarks by Shri Keshav Desiraju, Secretary, Ministry of Health and Family Welfare, Government of India
	● Final Remarks by Chairperson, NHRC
16:30 hrs	**Tea**

Annexure-II

Building Universal Health Care as a Road to Health Rights in India: Innovative measures

National Conference on
"HEALTH CARE AS A HUMAN RIGHT"
National Human Rights Commission
New Delhi, 5-6 November 2013

Raman VR
Principal Fellow
Public Health Foundation of India

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Working towards a healthier India

Context

- Recommendations from different expert committees, field experiences, Alma Ata Declaration and National Health Policy 1983
- Various Peoples forums and demand for health rights
- The 2001 Consultation by National Human Rights Commission (http://nhrc.nic.in/Documents/Publications/publichealthText.pdf)
- The Right to Health Care Campaign by NHRC.
- Discussions around National Public Health Act, and the Draft.
- Various initiatives under NRHM 2005-2012, 11th 5 year plan
- HLEG processes (2011), 12th 5 year plan (2012), National Advisory Committee processes (2013).
- Formulation of NUHM (2009 onwards), and then the joint NHM (2013 onwards).

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UHC: Road To Health Rights and Equity Health as a basic human right;

- **Right to Health:** right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health. (UN, CESCR Gen Comm 14)
- **Right to Health Care:** right to avail all essential health care services, essential medicines, as entitled essential services to all; monitoring/ accountability rights
- **All to lead towards inclusion by means of:**
- Improving access and usage; through participation and ownership especially of poor and marginalised
- Gender focus to address female exclusion

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UHC: Road To Health Rights and Equity

- **Legislation/Constitutional commitments:** Right to information/ employment/ education/ Food has already come in India:
- Right to HEALTH and Health Care? Though supported by Article 47 and 21 of Indian constitution, a separate articulation is still absent.
- **UHC:** NO alternative to Right to Health, but a key step towards it.
- Continuing the spirit of WHO constitution 1948 which declares health as a fundamental right and Alma Ata Declaration 1978, wherein equity is paramount.

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Universal Health Coverage: Definition by HLEG

Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.

HLEG, Planning Commission, India (2011)

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Essential Innovative Thinking: Shifting the UHC Discourse

- For Ensuring Availability, Accessibility, Quality and Affordability of Health Care Services in India, it is important to realise that:
- UHC is NOT just a financing issue.
- UHC to be seen as a key step towards achieving health as a fundamental right..
- Strengthening Public Health Systems should be seen as the primary focus towards this..
- Adequate financing with competent institutional mechanisms is a core requirement for this

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UHC as a Road to Human Rights: Choices for India by HLEG

Ongoing Debates	HLEG Choices
Welfare approach vs. Right based approaches	Right based approaches
Tax based Financing vs. insurance based financing	Tax based financing
Nationalisation vs. Privatisation Vs. PPP vs. Need based approaches	Bringing in Private as required, with essential regulations put in place
Insurance model vs. risk pooling model vs. Systems strengthening model	Systems strengthening Model
Medico/hospital-centred vs. community/ people centred	People centred, however with emphasis on strengthening health facilities
Centralisation vs. decentralisation	Decentralisation
Profitability/ market based commodity model vs. non-negotiable/ essential provision model	Non-negotiable essential provision model

Possible Innovative Strategies for UHC

Many of them have been identified and suggested by HLEG

Possible Innovative Measures: Service Delivery

- Strengthening Sub-centres as the first contact point for curative care: Adding caregivers with basic training to the current set up
- AYUSH primary level care and referral linkages at this level
- Panchayat based Vs. Population based Health Sub-Centres
- Governable Size of Panchayats, an issue:
- Locally selected caregiving personnel
- Strengthened District Hospitals
- Basic Service Norms and standards for all levels, supported by systems and supplies
- Private to be brought in as needed
- Regulation: differential norms for public and private sectors, based on known strengths and weaknesses

Possible Innovative Measures: Health Work Force

- Numbers to be adequate- competence too: not an area to compromise, or to reduce expenditures
- All India and State Level Public Health Service Cadres
- Integrated Council- essential for HRH Development and Regulation
- All States to Have Health Science Universities and new institutions:
- District hospitals as key teaching institutes, amongst other new institutions
- Local Selection to ensure retention

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Possible Innovative Measures: Health Work Force

- Considering evidence for short-term trained health professionals for first level contact care
- Upgrading of available professionals through short-term Trainings on higher level of skills (already ongoing, needs strengthening)
- Enhancing roles of CHWs and ensuring them proper rewards and returns
- Strengthening roles of Allied Health Professionals
- District Knowledge Institutes for training and capacity building
- Supported by State and Regional HFW Institutes

Possible Innovative Measures: Health Information Systems

- National Health Information Technology Network
- Health Worker Assistance as goal of HIS
- Ensuring essential data for the level specific
- Inter-operability of data between data systems
- Analysis and feedback loop
- Scope for differential indicators?
- Expanding and strengthening AHS and NFHS
- Community monitoring: need expansion and internalisation as an essential measure
- Initiatives such as Swasth Panchayats (Chhattisgarh)
- Triangulation as opened up by NRHM : a need ..

Possible Innovative Measures: Access to Essential Medicines and Supplies

- National Drug Regulatory and Development Authority (NDRDA)
- Price Control and price regulation of essential drugs
- Public sector strengthening, to meet domestic drug and vaccine requirements
- Essential Drug List, rational use of drugs
- Strengthen role of MoHFW in drug regulation
- National and State Drug Supply Logistics Corporations
- Mix of TN's institution model & Rajasthan's access model
- Health Technology Assessment- Institution similar to NICE?
- Strengthening protection measures provided by Indian Patent's Law

Possible Innovative Measures: Ensuring Health Determinants

- Localised Indexes positioning health on its larger social and development contexts
- PRI level, urban local body level, Legislative Assembly/ Parliament constituency level indexes, with intra-unit and inter unit comparison measures
- Addressing Vulnerabilities in focus while deciding indices
- Bringing both peoples representatives and officials to accountability
- Health Councils may monitor these
- Awards and Rewards, planning, additional support associated

Possible Innovative Measures: Financing

- Providing Personnel to manage finances
- Block Health Units and District Health Systems
- Strengthening systems for proper utilisation- Lessons from NRHM
- Strengthening community level systems- though viable and economic, it is not 'cheap'; need more investment
- How to build in accountability measures?
- Block, District, State, National Level Annual Report to the People?

Possible Innovative Measures: Financing

- Adequate public investment, though not an innovation
- In light of systems strengthening, does it call for a rethinking on society based financing?
- Financing and budgeting systems to streamline fund flow
- Planning in advance, with adequate scrutiny and allocation periods
- Performance based differential Financing for districts and states
- Additional support for the weaker and prompt encouragement for the stronger

Possible Innovative Measures: Achieving Good Health Governance

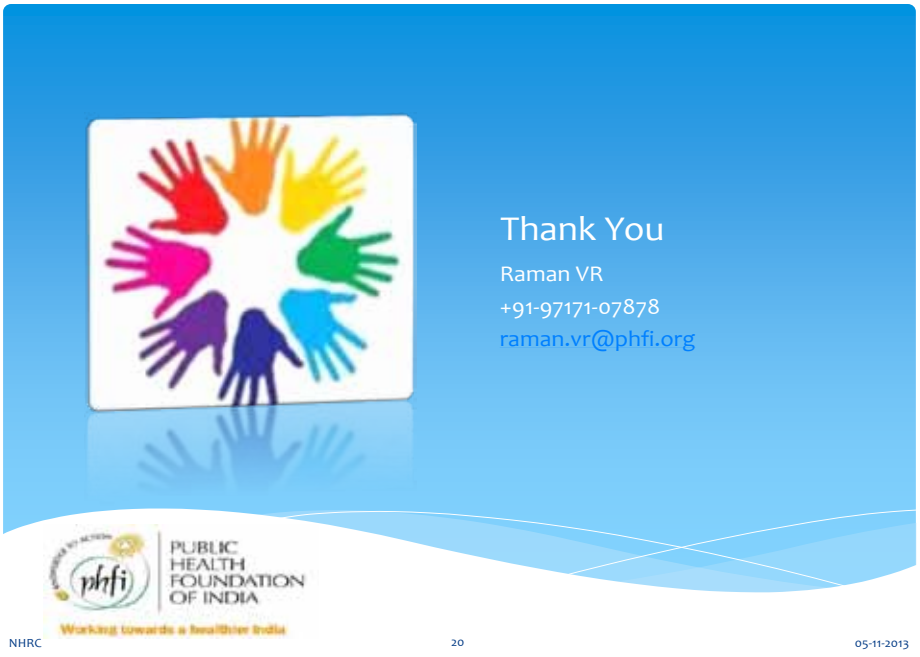
- Inbuilt technical support organisations for facilitating good governance:
- Principles to follow: Equity, social justice, legitimacy and voice, direction, performance, accountability, transparency, fairness, accessibility, availability, affordability, Laying down essential institutional foundations for each of the reform area
- Planning institutional frameworks for different reforms: mandate, governance structure, organisational framework, HR, physical infrastructure, finances, essential competence requirements, norms and rules.
- Ensuring timely and adequate allocation of resources as per planning
- Essential capacity building
- Expansion plans and phasing out
- Governance Toolkits: supporting the states for crossing the essential thresholds

Possible Innovative Measures: New Institutions for Good Health Governance

- Focus on strengthening people's leadership and Institutions-
- VHSCs as community health institutions with adequate support
- Health Councils to review health programmes and to redress grievances
- Developing Health Systems Accountability Charter to PRIs and Urban Bodies
- National Health Promotion and Protection Trust
- National Health Regulatory and Development Authority
- Health Systems Support Unit: stds, protocols, norms, QA methods
- National Health and Medical Facilities Accreditation Unit: Accreditation and certification
- The Health System Evaluation Unit: assessing performance

Possible Innovative Measures: New Institutions for Good Health Governance

- Drug Regulatory and Development Authority
- Integrated HRH Council
- State Health Science Universities
- District Knowledge Institutes
- National and State Public Health Service Cadre
- Health Information Technology Network
- Financing and Budget Systems
- HR Management Systems and Norms
- Platform to support health policy and systems research



Annexure-III

Strengthening Medical Education Quality for Universal Health Care Delivery

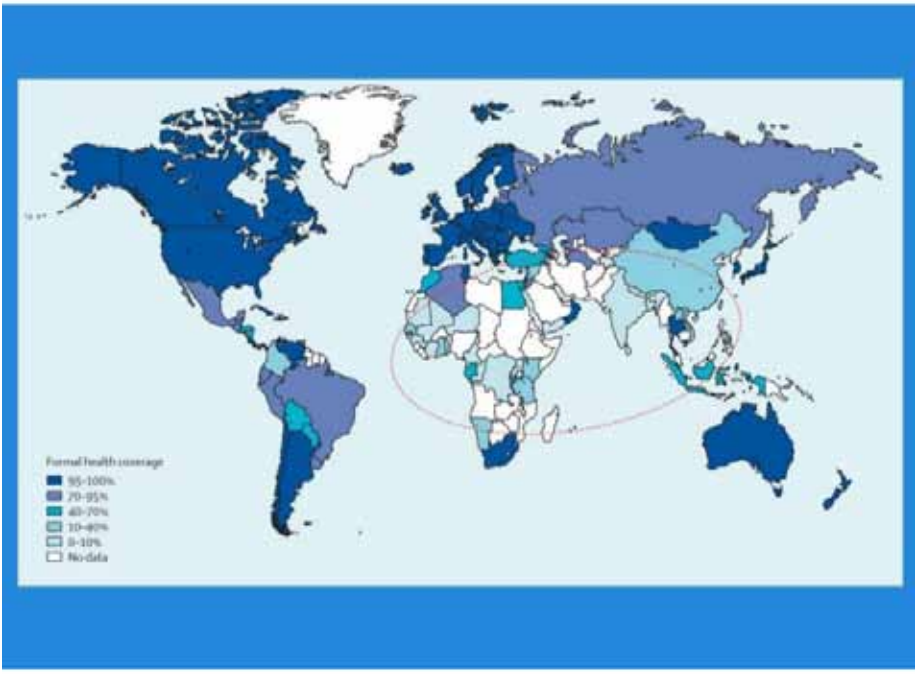
Prof. KK Talwar

Chairman, Dept. Of Cardiology, Max Healthcare Institute Ltd. New Delhi
Former Professor & Head Dept. Of Cardiology, AIIMS, New Delhi
Former Director, Professor & Head, Department of Cardiology PGIMER, Chandigarh
Former Chairman, Board of Governors, MCI
Former President, National Academy of Medical Sciences

Medical Education/Healthcare

- The Human Rights Declaration states that “Everyone has a right to standard of living adequate for health and well being of himself and of his family including food, clothing, housing and necessary medical and social services.”

  (United Nation 1948)



Public/Private Contribution to Health Care

WHO (2012)

- 60% of Health Care is paid by common man.
- 39 million are pushed to poverty because of ill health.
- 30% rural India did not go for any treatment for financial constraints.
- 47% & 31% of hospital admission (rural & urban) financed by loan and sale of assets.

Challenges to be overcome to achieve UHC by 2022

- largest disease burden in the world
- Reproductive health and gender equality
- Malnutrition and child health problems
- Inadequate research to achieve health-care
- Unregulated health sector severe natural disasters, lack of inter-sectoral co-ordination
- Poor availability of trained human resources in health

Human Resources for health

- Only quantity is not enough
- A bad doctor is worse than having no doctor
- Doctor is only one part of the chain of HRH required for universal health care delivery
- Need to strengthen the system as a whole including nursing, paramedics, middle level health workers

The nature and scope of the problem

- High Level Expert Committee Report (HLER) - India needs 6-7 lac more doctors by 2025
- Needs careful estimation on requisite increase in number, and ensuring no compromise in the quality of education
- India already has over 370 medical colleges (highest number as compared to any other country) admitting over 50,000 medical graduates every year

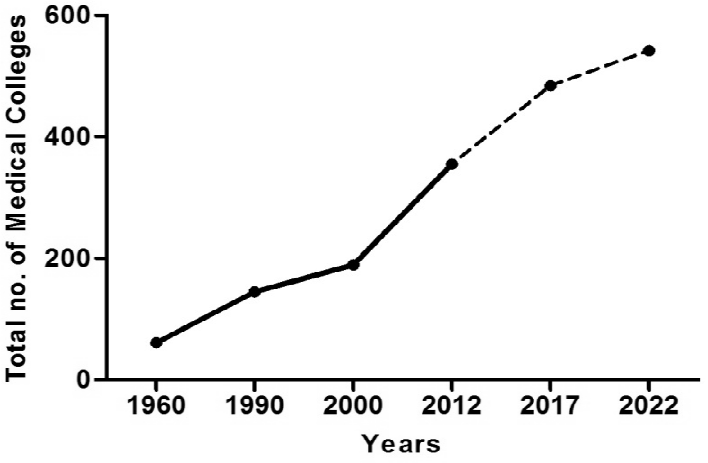
Indian Medical Register (IMR)

- Over 8.5 lac Medical Doctors (How many migrated or no more in active practice)
- Some duplication in registration
- Specialists/Super specialist not strictly tabulated.
- MCI initiated efforts to address this issues.

Indian Scenario

- Planning Commission Task Force (HLEG)- recommended minimum doctor population ratio of 1:1000
- India has doctor-population ratio 1:2000 persons

  (Doctors from Alternative system not included)
- uncertainty about the specialists in each branch
- skewed distribution of the existing medical professionals, more doctors being available in/around urban areas, and very few in the rural areas
- Malaysia (1:1800) and Sri Lanka (1:1400), achieved much better health care indices, matching western standards



Growth of medical colleges till 2012 and recommended increase by HLEG Planning commission (dotted line)

Sudden expansion of the medical colleges in the last 15 yrs resulted in the

- recruitment of poor quality teachers, affecting seriously the quality of training
- Most of them are in the private sectors & adopting irregular means in admission processes leading to meritorious students being deprived of admission
- Most of the Govt. colleges also have not upgraded their facilities & infrastructure for a long time, and this has led to deterioration in the teaching standards in the Govt. Sector
- Addition of such a large number of colleges, without addressing these concerns, may lead to a further decline in standards.

Quality of Medical Education/Training

- Increasing quantity, without improvements in quality - serious negative consequences and lead to wasted manpower and resources
- quality of medical professionals has deteriorated for various reasons
  - medical profession does not appear to attract the best and brightest among the youth anymore
  - privately run institutions has limited patients for medical students to learn the essential skills
  - Shortage of teaching faculty

Suggestions to improve quality of Medical education

- Existing colleges should be provided with good infrastructure and faculty to ensure quality training
- Implement measures to revive the status of the profession so as to attract bright youngsters back to the profession.

- Increase seats from 100/150 to 200/250, with the addition of infrastructure and facilities in order to cut down need for new colleges
- New colleges should be opened in underserved regions or states which lack educational facilities to strengthen health services
- Mandatory rural posting for graduating doctors before joining MD/MS

Steps to improve quality of education

- Making efforts to motivate our 'brain drain' professionals settled in Europe and America to come back and join various medical colleges/ institutes
- AIIMS/PGI like institutions be linked with adjoining medical colleges to strengthen the training programmes
- Strengthening of telemedicine facilities to use tele-education from training programmes is also required
- Regular updating the teachers in new methods of training

Telemedicine and Tele-education

Education Session through Videoconferencing

Admission

- Regulation of policies of admission and fee structure of private colleges
- Pvt. Colleges becoming source of political and financial power
- All India Common Entrance Test for all students (NEET)
- Self-financing Medical colleges should announce their fees in their prospectus
- Use of IT to increase transparency and efficiency in the admission, administration, teaching, content delivery and other related processes

Quality

Curriculum

- All institutions must constitute Curriculum Committee to follow laid curriculum.
- Integrating Clinical and basic courses.
- Integration of ICT in the learning process is essential
- New skills-management, health economics bioinformatics and ethical aspect
- Regular review/revision of course content.

- Independent and standardized National Exit Examination at the end of 4½ years of study
  - To conduct national level assessment of skills and knowledge
- Internship assessment
  - To ensure skill development
  - Compulsory rotation from teaching hospital to community and district hospital
  - PG entrance based on pre & post-internship examinations
- Required to undergo re-certification process every 5 years (Continuing Medical Education)

Faculty Development

Teaching

- Attracting and retaining quality faculty
- Providing opportunities to attend international conferences, due promotions and dissociating remuneration from Govt. Pay scales

Research

- Encouraging research in medicine
- Facilitating set up of research centres in medical colleges

National Knowledge Commission recommendations

Regulatory body

- MCI- neither adequate nor appropriate
- Constitution of Standing Committee within Independent Regulatory Authority for Higher Education (IRAHE)
  - Ensures updated and revised medical practice & teaching regularly
  - Minimal quality standards
  - Manpower planning and development based on disease – profile, doctor-population ratio and skill-mix ratio
  - Members include faculty from recognised universities, practising physicians, members of civil society, students & director from autonomous institution
  - Chairman and members of the standing Committee would be accountable to IRAHE

Health Care System in India, 2012

- By March, 2011, there are

  613 district hospitals

  985 sub divisional hospitals

  4,809 CHC's

  23,887 PHC's

  1,48,124 sub centres and

  1825 mobile medical units

Manpower Recommended Under Indian Public Health Standards (IPHS)

S.No	Man power	Existing pattern	Recommended	Number present
1	**Medical Officer**	**1**	**3 (at least one female)**	**26,329**
	PHCs			**23,887**

CHCs (n=4809)

S.No	Man power	Existing pattern	Number present	Number required
1	General Duty Medical Officer	6	11,798	28, 854
2	General Surgeon	1	1018	4,809
3	Physician	1	819	4,809
4	Obstetrician / Gynaecologist	1	1389	4,809
5	Paediatrics	1	1041	4,809
6	Anaesthetist	1	NA	4,809
7	Eye Surgeon	1	NA	4,809
		Total		**57,708**

Registered members from various specialities

Speciality	Registered members
Obstetric and Gynaecology Association	25000
Paediatric Association	23000
Anaesthetic Association	6517
Surgical Association	18000
Orthopaedic Association	9000

Specialists and Super specialists

- >70% of specialist positions in the CHCs and district hospitals are lying vacant
- This gap is because of imbalanced & asymmetric distribution, coupled with the lack of attraction for these jobs
    - Make steps to make these positions attractive and also ensure optimum infrastructure in the hospitals
- We need to make family medicine attractive amongst the medical students

MD in Family Medicine

- All UG be encouraged to enrol for MD(Family Medicine)
- Those working for 5 years- Course may be reduced to 2 years
- Steps to create department of Family medicine in Medical Colleges
- Faculty be drawn from the allied discipline like Medicine, Surgery, Orthopaedic, Gynae & Paediatrics in the beginning

Concept of Middle level Health Workers

Nurse Practitioner

- Basic Nursing degree but in addition has master level degree in areas as Family health, cancer care, child health, new born care etc.

  (on the model USA, Canada, Australia, UK)

- Community Health Officer (B Sc. CH)

Networking or Health Care Linkage of Secondary and Tertiary Health Care with Primary Health Care

- Referral system should be properly implemented and strengthened
- over the years, due to the lack of facilities at most of the primary and secondary sectors, common people crowd into the few existing public sector referral institutes (AIIMS, PGI etc.)
- Dire need to strengthen the health care delivery in other medical colleges and district hospitals
    - Each state can upgrade one or two of their medical colleges to the level of an AIIMS like institute that could serve as a nodal medical college for others

- All medical colleges should be equipped to provide the standard of care available in a tertiary care centre and should be linked to district hospitals
- District hospitals should be integrated with CHCs/PHCs
- Effective referral system - communication and coordination between the different levels of care
    - Telemedicine play an important role in integrating health care delivery

Attracting Doctors to the Public Sector Healthcare System

- Providing Attractive packages, encourage qualified doctors to join public sector institutions
  - salary increases, reservation for postgraduate seats in return for rural service, improved housing, transport and other facilities
  - Networking with district hospitals & medical colleges to gain professional growth
  - Permitting private clinics within the hospital

Brain Drain

- Many doctors, nurses, and technicians emigrate from India, contributing shortage of health workers
- Indian doctors constitute the largest number of foreign trained physicians in the USA (4.9%), and third largest in Canada (2.1%)
- Our doctors abroad can be considered our ambassador/ asset to help other countries attain global health outcomes
- Innovate means for discouraging migration of medical professionals

Compulsory Rural Posting

Advantages

- To expose them to rural environment and Medical issues
- To provide training/experience for handling these diseases.
- Mentoring by Medical Colleges/District Hospital during these period
- To make aware of the various immunization and National Programmes.
- Each PHC shall have 1-2 doctors
- Allocation to state be done by Central Health Ministry

Medical Education

- Quality, quantity, distribution and availability of human resources for health sector- needs to be improved/ strengthened
- Health related education and training
  - Urban oriented, doctor-centric and technology driven
  - Needs to be nationally sensitive and globally competitive
  - Needs radical reforms

Medical Education/Health Care

- Adequate infrastructure and facilities of Health care establishment.
- Adequate equipment consumable/drug.
- Affordable care to all.
- Public private participation for public.
- Regulate private sector.

Conclusion

- Optimally use the available resources, and to adopt a holistic & multi-pronged strategy to best tackle the problems of Human Resources.
- Any expansion without planning proportional and optimum facilities in the PHC, CHC and district hospitals would be wasteful and futile.
- It is high time to undertake the necessary reforms, without any further delay, to treat the ailing medical education and healthcare system.

Conclusion-UHC

- Goal achievable
- Need effective implementation/ close independent monitoring.
- Polio free society (Success Story).

- "Universal coverage is the ultimate expression of fairness".

  "Universal coverage is the single most powerful concept that public health has to offer".

Dr. Margaret Chan

WHO Director-General

65th World Health Assembly 2012


Thank
You

Annexure-IV

HEALTH FOR ALL

Declaration of Alma-Ata, 1978

International Conference on Primary Health Care, Alma-Ata, Kazakhstan, 1978

By:
Dr. Samit Sharma IAS
MD, RMSC & Joint Secretary to Govt of Rajasthan
drsamitsharma@yahoo.co.in

Enhancing

ACCESS TO TREATMENT IN RAJASTHAN

through two flagship schemes

मुख्यमंत्री नि:शुल्क दवा योजना

FREE MEDICINE SCHEME..

मुख्यमंत्री नि:शुल्क जाँच योजना

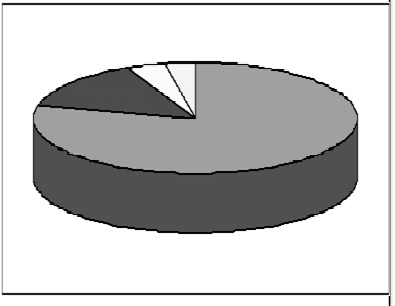
FREE DIAGNOSTICS SCHEME..

Problem : 1 Medicines are beyond the reach of our people.

- As per WHO 65% of the Indian population lacks regular access to essential medicines.
- The expenditure on health is the second most common cause for rural indebtedness.
- Over 23% of the sick don't seek treatment because they are not having enough money to spend.
- Over 40% of hospitalized patients has to borrow money or sell their assets to get them treated.

Problem : 2 Expenditure on medicines make people poor.

Private out of pocket expenditure	79%
State govt.	14%
Central govt.	4%
Private investment	3%
Private insurance	0 – 1%



- Expenditure on drug constitute about 50-80% of the health care cost.
- Expenditure on health is responsible for 3% shift from APL to BPL every year.
- A study by World Bank shows that as a result of single hospitalization 24% of people fall below poverty line in India.

Problem: 3 Medicines are overpriced.

(COMPARATIVE PRICES OF GENERIC AND BRANDED DRUGS)

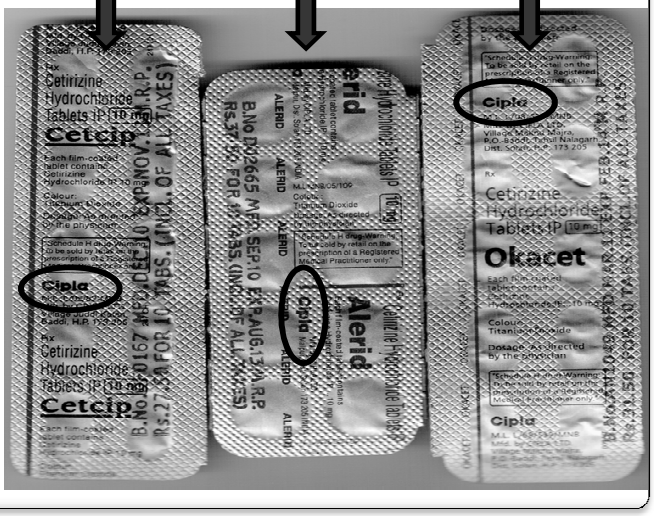
Use	Name of Drug	Pack size	Equivalent Popular Brand	MRP (Rs.)	RMSC Tender price (In Rs.)
ANALGESIC	DICLOFENAC SODIUM TABLET IP 50 MG	10 TAB STRIP	VOVERAN	31.73	1.24
CHOLESTEROL LOWERING	ATORVASTATIN TABLET IP 10 MG	10 TAB STRIP	ATROVA (ZYDUS)	103.74	2.98
BLOOD THINNING DRUG	CLOPIDOGREL TABLET IP 75 MG	14 TAB STRIP	PLAVIX (SANOFI AVENTIS)	1615.88	8.54
DIABETES	GLIMEPIRIDE TABLET IP 2 MG	10 TAB STRIP	AMARYL (AVENTIS)	125.00	1.95

Problem : 4 Differential Drug Pricing

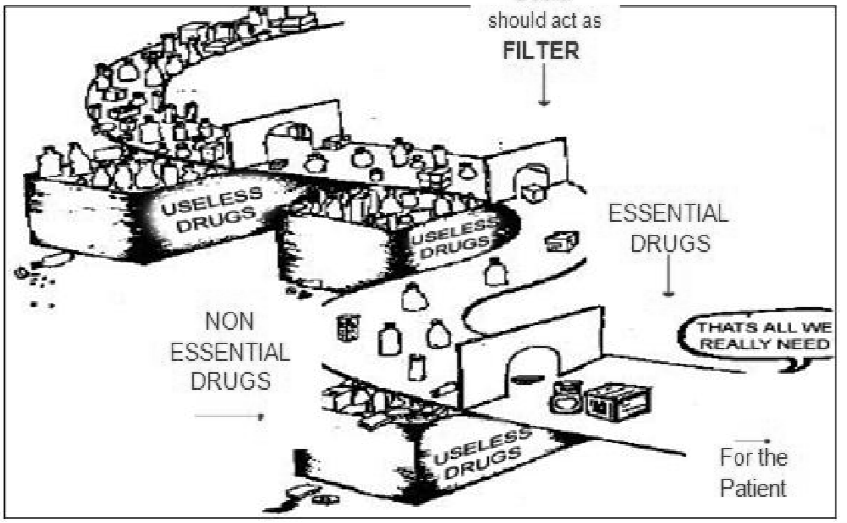
MRP for 10 tabs	**Rs. 27.50**	**Rs. 39.30**	**Rs. 31.50**
Purchase price for 10 tabs	**Rs. 2.02**	**Rs. 23.70**	**Rs. 2.27**

Manufacturer is Cipla for all the three brands

One branded & Two generic



Problem : 5 Promotion of Non essential drugs



Solution

मुख्यमंत्री नि:शुल्क दवा योजना

MUKHYAMANTRI NIHSHULK DAVA YOJNA

AN INITIATIVE.....
TO SAVE LIVES

COMPONENTS OF FREE MEDICINES SCHEME	
(Hardware Component) **A. TO MAKE DRUGS AVAILABLE IN GOVT. HOSPITALS.**	(Software Component) **B. TO CHANGE PRISCRIPTION BEHAVIOUR OF DOCTORS.**
1. Establishment of autonomous centralized procurement agency : Rajasthan medical services corporation.	1. Sensitization and orientation about rational use of drugs (RUD).
2. Identification of drugs for free essential drug list (EDL)	2. Write prescription on self carbonated prescription slips
3. Procurement through a two-bid transparent e-tendering process	3. Diagnosis must be written
4. Drug Warehouse at every district	4. Write Generic / Salt names
5. Empanelled laboratories for quality testing	5. Use out of Essential Drug List
6. System for transportation of drugs	6. Follow Standard Treatment Guidelines
7. System for storage and distribution of drugs in all hospitals	7. Constitution of Drug and Therapeutics Committee (DTC).
8. e-Aushadhi Software for Inventory management	8. Prescription Audit.
9. Transparent and prompt payment system	9. Computerized drug dispensing up to PHCs.
10. Sufficient funds.	10. Patient counselling

COMPONENT-1

STEPS TO MAKE DRUGS AVAILABLE IN GOVT. HOSPITALS.

1. Autonomous centralized procurement agency.

ESTABLISHMENT OF
RAJASTHAN MEDICAL SERVICES CORPORATION

PROCUREMENT

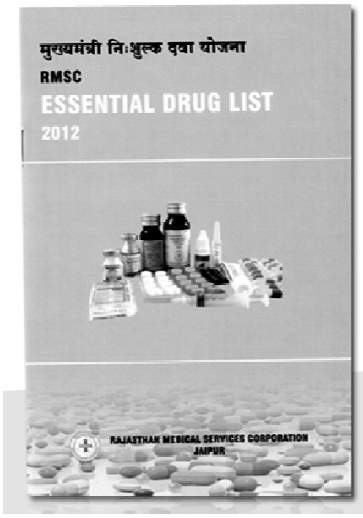
SUPPLIES

QUALITY CONTROL

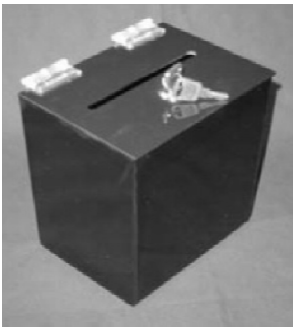
IT CELL

2. Identification of drugs for free essential drug list (EDL)

Technical Advisory Committee has developed the procurement list of RMSC (EDL).



3. A two-bid open transparent tendering process.



- Only manufacturer/importer can participate.
- Only those bidder can participate who have annual turnover more than Rs.20 Cr.
- GMP Certificate.
- Non-conviction certificate.
- Only e-procurement from 1st April 2012.

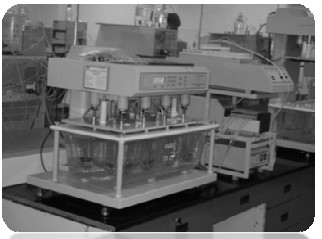
4. Warehouse at every district.

← Warehouse

Walk in Cooler →

5. Empanelled laboratories for quality testing.

- Drugs are received at DDW with manufacturer's test report.
- They are stored in quarantine area.
- Sample are sent to QC cell at RMSC head office.
- Samples are coded & sent to empanelled labs.
- RMSC has empanelled 6 NABL accredited / schedule L1 compliant labs.
- Examination of samples is carried out as per pharmacopeias.
- If sample is found "as of standard quality" then only drugs are issued to hospitals.

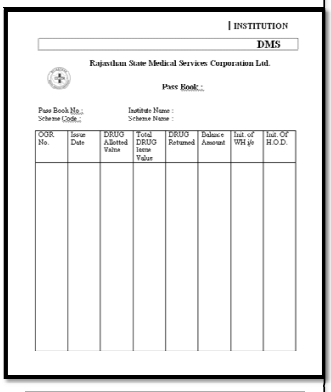


6. System for transportation of drugs

7. System for storage and distribution of drugs in all hospitals

8. e-Aushadhi Software for Inventory management

Computerized inventory management through e-Ausahdhi Software.


INSTITUTION

DMS

Rajasthan State Medical Services Corporation Ltd.

Pass Book :-

Pass Book No. :
Scheme Code :

Institute Name :
Scheme Name :

OGR No.	Issue Date	DRUG Allotted Value	Total DRUG Issue Value	DRUG Returned	Balance Amount	Init. of WH i/c	Init. Of H.O.D.

Drugs are issued using passbook system.

9. Transparent and prompt payment system.

- Payment either through CBS (Core banking solution, anywhere banking), or NEFT (National Electronic Fund Transfer) up to 1.00 Lac or RTGS (Real Time Gross Settlement) if more than 1.00 Lac.
- e-Processing of suppliers payment through e-Aushdhi Software.
- Physical Cheques are not issued to any suppliers.
- Centralized payment to all stakeholders viz suppliers, H.Q./DDWs staffers.
- TDS and other statutory dues etc through e-payment.

10. Sufficient funds.

FY 2011-12 - Rs.180 Cr.
FY 2012-13 - Rs.240 Cr.
FY 2013-14 - Rs.300 Cr.

COMPONENT-2

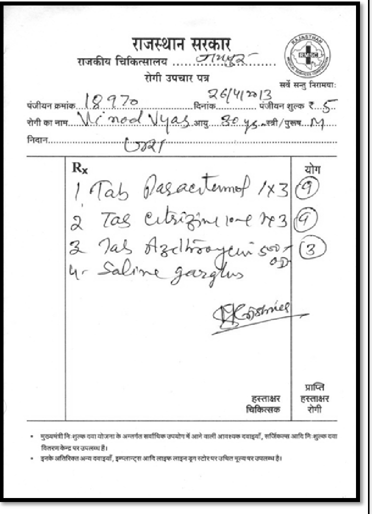
STEPS TO CHANGE PRESCRIPTION BEHAVIOUR OF DOCTORS.

1. Sensitization about the poor and orientation of Doctors about rational use of drugs (RUD).

Seminars,
Conferences
&
Review meetings

2. Write prescription on self carbonated double prescription slip.

3. Diagnosis must be written



राजस्थान सरकार

राजकीय चिकित्सालय ......जोधपुर......

रोगी उपचार पत्र

सर्वे सन्तु निरामया:

पंजीयन क्रमांक 18970 दिनांक 26/4/2013 पंजीयन शुल्क ₹ 5

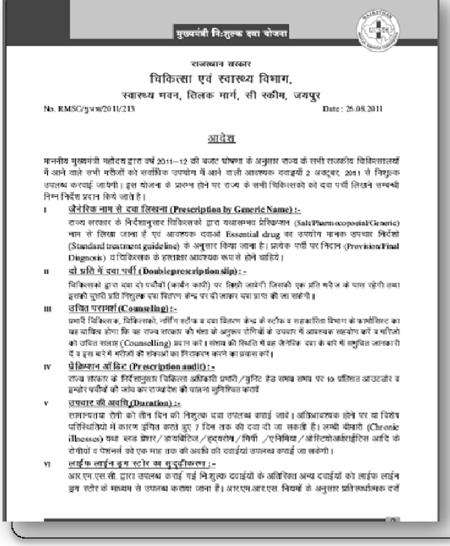
रोगी का नाम Vinod Vyas आयु 80 ys स्त्री/पुरुष M

निदान URI

Rx	योग
1 Tab Paracetamol 1x3	9
2 Tab Cetrizine 10mg 1x3	9
3 Tab Azithromycin 500 OD	3
4 Saline gargles	
हस्ताक्षर चिकित्सक	प्राप्ति हस्ताक्षर रोगी

- मुख्यमंत्री निःशुल्क दवा योजना के अन्तर्गत सर्वाधिक उपयोग में आने वाली आवश्यक दवाइयाँ, सर्जिकल्स आदि निःशुल्क दवा वितरण केन्द्र पर उपलब्ध है।
- इनके अतिरिक्त अन्य दवाइयाँ, इम्प्लान्ट्स आदि लाइफ लाइन ड्रग स्टोर पर उचित मूल्य पर उपलब्ध है।

4. Write Generic / Salt names.



मुख्यमंत्री निःशुल्क दवा योजना

राजस्थान सरकार

चिकित्सा एवं स्वास्थ्य विभाग,

स्वास्थ्य भवन, तिलक मार्ग, सी स्कीम, जयपुर

No. RMSC/मुदयो/2011/213 Date : 26.08.2011

आदेश

माननीय मुख्यमंत्री महोदय द्वारा वर्ष 2011–12 की बजट घोषणा के अनुसार राज्य के सभी राजकीय चिकित्सालयों में आने वाले सभी मरीजों को सर्वाधिक उपयोग में आने वाली आवश्यक दवाइयाँ 2 अक्टूबर, 2011 से निशुल्क उपलब्ध करवाई जायेगी। इस योजना के प्रारम्भ होने पर राज्य के सभी चिकित्सकों को दवा पर्ची लिखने सम्बन्धी निम्न निर्देश प्रदान किये जाते है।

I जैनेरिक नाम से दवा लिखना (Prescription by Generic Name) :-
राज्य सरकार के निर्देशानुसार चिकित्सकों द्वारा यथासम्भव प्रेस्क्रिप्शन (Salt/Pharmacopoeial/Generic) नाम से लिखा जाना है एवं आवश्यक दवाओं Essential drug का उपयोग मानक उपचार निर्देशों (Standard treatment guideline) के अनुसार किया जाना है। प्रत्येक पर्ची पर निदान (Provision/Final Diagnosis) व चिकित्सक के हस्ताक्षर आवश्यक रूप से होने चाहिये।

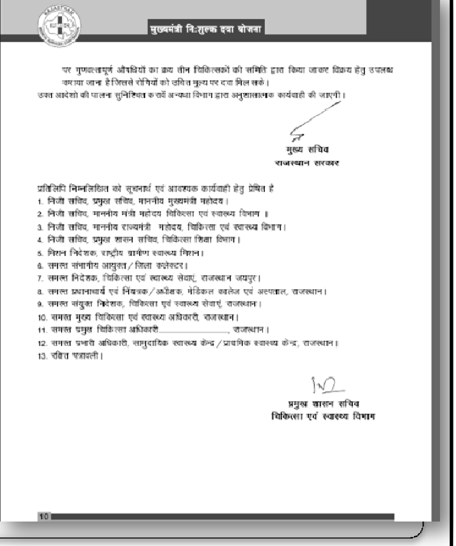
II दो प्रति में दवा पर्ची (Doubleprescription slip) :-
चिकित्सकों द्वारा दवा दो पर्चीयों (कार्बन कापी) पर लिखी जायेगी जिसकी एक प्रति मरीज के पास रहेगी तथा इसकी दूसरी प्रति निशुल्क दवा वितरण केन्द्र पर दी जाकर दवा प्राप्त की जा सकेगी।

III उचित परामर्श (Counseling) :-
प्रभारी चिकित्सक, चिकित्सकों, नर्सिंग स्टॉफ व दवा वितरण केन्द्र के स्टॉफ व सहकारिता विभाग के फार्मासिस्ट का यह दायित्व होगा कि वह राज्य सरकार की मंशा के अनुरूप रोगियों के उपचार में आवश्यक सहयोग करें व मरिजो को उचित सलाह (Counselling) प्रदान करें। संशय की स्थिति में वह जेनेरिक दवा के बारे में समुचित जानकारी दें व इस बारे में मरीजों की शंकाओं का निराकरण करने का प्रयास करें।

IV प्रेस्क्रिप्शन ऑडिट (Prescription audit) :-
राज्य सरकार के निर्देशानुसार चिकित्सा अधिकारी प्रभारी/यूनिट हेड समय समय पर 10 प्रतिशत आउटडोर व इन्डोर पर्चीयों की जांच कर राज्यादेश की पालना सुनिश्चित करायें

V उपचार की अवधि (Duration) :-
सामान्यतया रोगी को तीन दिन की निशुल्क दवा उपलब्ध कराई जावे। अतिआवश्यक होने पर या विशेष परिस्थितियो में कारण इंगित करते हुए 7 दिन तक की दवा दी जा सकती है। लम्बी बीमारी (Chronic illnesses) यथा ब्लड प्रेशर/डायबिटिज/हृदयरोग/मिर्गी/एनिमिया/ओस्टियोआर्थराईटिस आदि के रोगीयों व पेंशनर्स को एक माह तक की अवधि की दवाईयां उपलब्ध कराई जा सकेगी।

VI लाईफ लाईन ड्रग स्टोर का सुदृढीकरण :-
आर.एम.एस.सी. द्वारा उपलब्ध कराई गई निःशुल्क दवाईयों के अतिरिक्त अन्य दवाईयों को लाईफ लाईन ड्रग स्टोर के माध्यम से उपलब्ध कराया जाना है। आर.एम.आर.एस. नियमों के अनुसार प्रतिस्पर्धात्मक दरों



मुख्यमंत्री निःशुल्क दवा योजना

पर गुणवत्तापूर्ण औषधियों का क्रय तीन चिकित्सकों की समिति द्वारा किया जाकर विक्रय हेतु उपलब्ध कराया जाना है जिससे रोगियों को उचित मूल्य पर दवा मिल सके।

उक्त आदेशो की पालना सुनिश्चित करावें अन्यथा विभाग द्वारा अनुशासनात्मक कार्यवाही की जाएगी।

मुख्य सचिव
राजस्थान सरकार

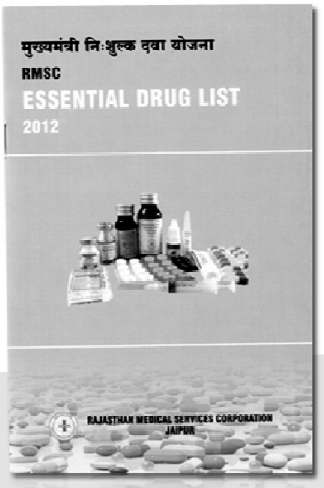
प्रतिलिपि निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित है

1. निजी सचिव, प्रमुख सचिव, माननीय मुख्यमंत्री महोदय।
2. निजी सचिव, माननीय मंत्री महोदय चिकित्सा एवं स्वास्थ्य विभाग।
3. निजी सचिव, माननीय राज्यमंत्री महोदय, चिकित्सा एवं स्वास्थ्य विभाग।
4. निजी सचिव, प्रमुख शासन सचिव, चिकित्सा शिक्षा विभाग।
5. मिशन निदेशक, राष्ट्रीय ग्रामीण स्वास्थ्य मिशन।
6. समस्त संभागीय आयुक्त/जिला कलेक्टर।
7. समस्त निदेशक, चिकित्सा एवं स्वास्थ्य सेवाएं, राजस्थान जयपुर।
8. समस्त प्रधानाचार्य एवं नियंत्रक/अधीक्षक, मेडिकल कालेज एवं अस्पताल, राजस्थान।
9. समस्त संयुक्त निदेशक, चिकित्सा एवं स्वास्थ्य सेवाएं, राजस्थान।
10. समस्त मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, राजस्थान।
11. समस्त प्रमुख चिकित्सा अधिकारी________________, राजस्थान।
12. समस्त प्रभारी अधिकारी, सामुदायिक स्वास्थ्य केन्द्र/प्राथमिक स्वास्थ्य केन्द्र, राजस्थान।
13. रक्षित पत्रावली।

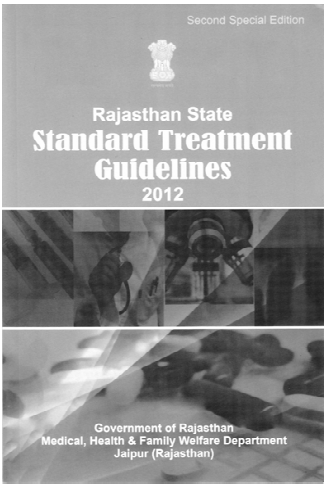
प्रमुख शासन सचिव
चिकित्सा एवं स्वास्थ्य विभाग

10

5. Use out of Essential Drug List.



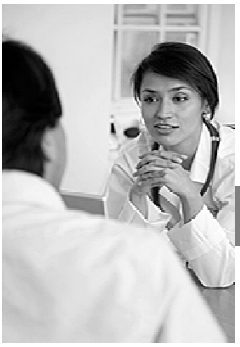
6. Follow Standard Treatment Guidelines.



7. Constitution of Drug and Therapeutics Committee.

8. Prescription Audit.

9. Computerized drug dispensing up to PHCs



10. Patient counselling

DRUG AVAILABILITY

WHAT DO WE GIVE CURRENTLY ?

Institutes	Drug Items	Surgicals	Suture items
Medical College Hospitals	410	70	72
District / Sub-dist / Satellite Hospitals	375	60	62
CHCs	150-225	50	50
PHCs/Dispensaries	75-150	25	25
Sub Centers	20-30	0	0

Along with 71 National Program Drugs supplied by GoI

Institutions (Medical & Health Department)

S.No.	Type of Institutions	No. of Institutions
1	Medical College Hospitals	28
2	District hospitals	34
3	Satellite Hospitals	5
4	Sub-Divisional Hospitals	17
5	CHCs	543
6	PHCs	2112
7	Dispensaries	198
8	Sub Centers	14365
9	Aid Posts	13
10	MCWC	118
11	Mobile surgical units	7

Continue...

Institutions (Other)

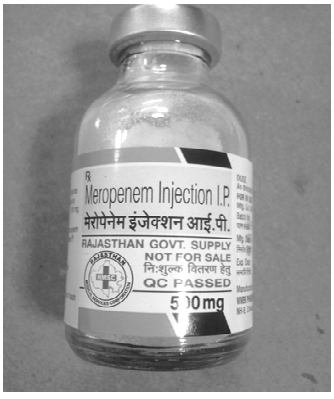
S.No.	Type of Institutions
	Law enforcement agencies
1	Jail Dispensary
2	RAC battalion (Rajasthan Armed Constabulary)
3	Police dispensaries
	Others
1	Anganwadi (ICDS)
2	Schools (Education department)
3	NVBDCP
4	Rajasthan State Mines & Minerals Ltd.
5	Rajasthan University
6	AIIMS Jodhpur (Government of India)

Continue...

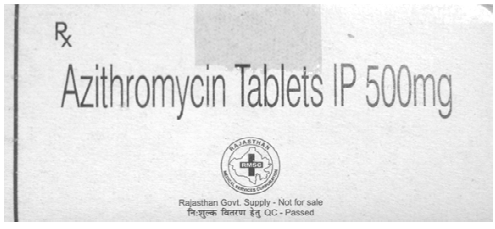
Institutions (NGOs/Trusts)

S.No.	Type of Institutions
	Private Hospital
1	Mahesh Hospital Jaipur
	NGOs/Trusts
1	SWARC, Tinolia
2	Tabbar
3	Kuhad trust jaipur
4	MMBWSS Apna ghar, Bharatpur
5	Khejri
6	Piramal trust
7	Aarth Udaipur
8	Social welfare charitable trust

30 types of ANTIBIOTICS

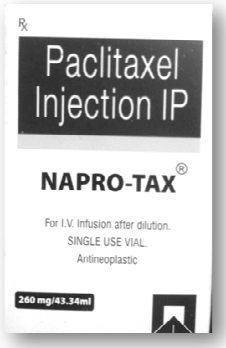


Inj. Meropenam 500 mg (1 vial)
Price Rs.113.74



Tab. Azithromycin 500 mg (10 Tabs)
Price Rs.58.80

25 ANTICANCER DRUGS

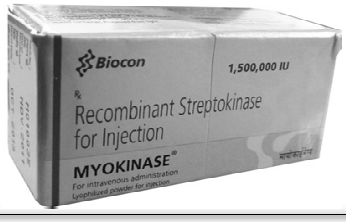


Inj. Paclitaxel 260 mg (1 vial)
Price Rs. 714.40

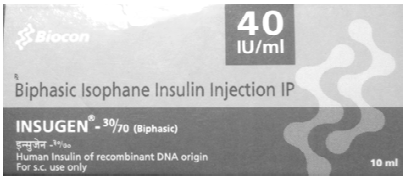
Name of Drug	Price (in Rs.)
Cap. Cyclosporin 25 mg (1 pack)	602.18
Inj. L-Asparginase (1 vial)	712.98

35 DRUGS FOR HEART DISEASE

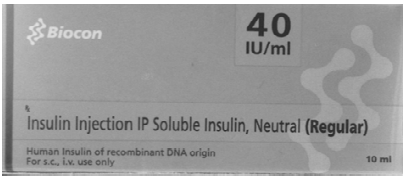
Name of Drug	Price (in Rs.)
Inj. Streptokinase 15 Lac units (1 vial)	470.00
Inj. RH-Erythropoetin 10000 IU (1 vial)	447.76
Inj. Human Albumin 20% (1 bottle)	2000.00



DIABETES

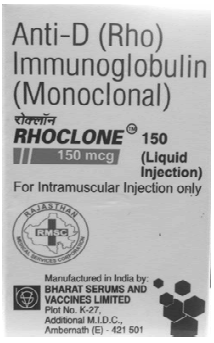


Inj. Biphasic Insulin 30/70
(10 ml vial)
Price Rs. 46.5

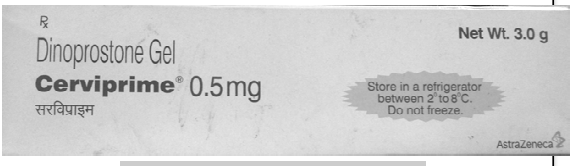


Inj. Insulin regular
(10 ml vial)
Price 46.93

For PREGNANT WOMEN

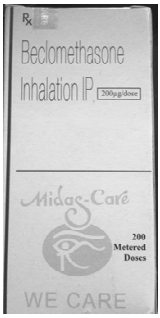


Inj. Human Anti D
Immunoglobulin
150 mg
Price Rs.1207.50

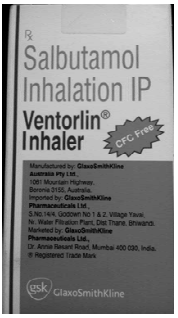


Dinoprostone Gel 0.5 mg
(in syringe)
Price Rs.173.25

12 drugs for RESPIRATORY DISEASE & ASTHAMA



Beclomethasone Inhaler (200 doses) Price Rs. 129.95



Salbutamol Inhaler (200 doses) Price Rs. 52.34

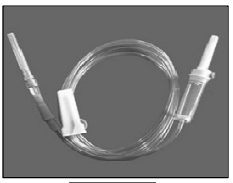
Budesonide Nebulizer Suspension (2 ml amp) Price Rs. 11

ANTI RABIES & ANTI SNAKE VENOM Injections

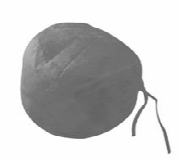
Name of Drug	Price (in Rs.)
Rabies Vaccine Human 2.5 IU (1 ml vial)	185.64
Rabies Antiserum IP (Equine) (5 ml vial)	303.45
Human Anti rabies Immunoglobulin Inj. 150 IU (2 ml vial)	4640.00
Anti Snake Venom (10 ml vial)	207.90

SURGICALS & SUTURE ITEMS

Disposable Syringe

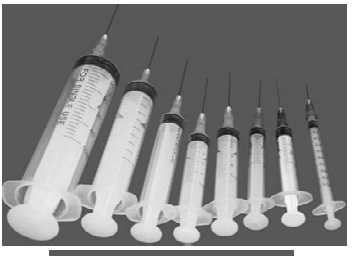


IV Set



Surgical Cap

Gloves



Disposable Syringe

IMPACT

1. INCREASE IN NUMBER OF PATIENTS IN GOVT. INSTITUTES
From 2nd Oct 2011 to 31st March 2012

Before	After MNDY
44 Lac patients per month	72 Lac patients per month

IMPACT

2. DECREASE IN OUT OF POCKET EXPENDITURE

- Everyday we are giving drugs to more than 2 Lac patients
- The average cost per patient is around Rs.12 - 30
- Otherwise the cost of drugs purchased from the market use to cost around Rs.300 - 500.

IMPACT

3. OUT OF POCKET EXPENDITURE SAVINGS

RMSC cost	Rs. 507 crore
Market cost	Rs. Over 3000 crore
Savings to the Govt.	Approx Rs. 2500 crore

Due to procurement by generic name

IMPACT

4. Comparison of costs of treatment using generic v/s branded drugs. (in Rs) *Contd...*

Disease	Branded drugs	Generic Drugs
OPD treatment of 30 days		
Depression /Mixed anxiety disorder	**799.00**	**45.59**
Schizophrenia	**1093.80**	**100.77**
Mania	**1962.30**	**227.49**
Hypertension	**435.60**	**29.28**
Diabetes mellitus	**481.20**	**17.19**
OPD treatment of 3 days		
Diarrhoea and vomiting	**190.81**	**17.73**
ARI	**118.19**	**12.39**

IMPACT

4. Comparison of costs of treatment using generic v/s branded drugs (in Rs)

Disease	Branded drugs	Generic Drugs
Indoor medical/non surgical cases		
Myocardial Infarction	**9381.78**	**2195.73**
Enteric fever	**2953.40**	**426.50**
Pneumonia	**2102.77**	**381.09**
Stroke/ CVA	**3636.29**	**635.32**
Diabetic ketoacidosis	**3192.41**	**502.83**

IMPACT

5. SMILING PATIENTS & THOUSANDS OF LIVES SAVED

dna OF jaipur 12-04-2013

Poor man's pocket now immune to med expense

Free health schemes saving precious money of poor people

Lalit Sharma

The government's free medicine scheme has considerably reduced the financial burden on poor patients who earlier had to sell their assets to avail medical care.

After the launch of this scheme, the Rajasthan Medical Services Corporation (RMSC) has distributed generic medicines worth Rs230 crore to the people.

The market cost of these medicines is Rs1,000 crore, which would otherwise had been out of pocket expenditure (OOPE)/ for the patients. The OOPE means direct outlay of cash which may or may not be later reimbursed to the people.

A report says that about 40% of indoor patients admitted in hospitals in India used to sell their land or assets to buy medicines for their treatment and 25% of the poor people could not visit a doctor due to their poor financial condition.

While 2% of the people above poverty line (APL) change themselves to below poverty line (BPL) to get free medicines and treatment.

Real AID

But after the launch of free medicine scheme in the state in October 2011, the report submitted by district collectors and chief medical officers has revealed that the number the underprivileged patients has increased. The patients include girls below six years of age, old people and women.

Rajasthan Medical Services Corporation MD Samit Sharma said, "Since the free medicine scheme's launch, there is an increase in poor and underprivileged patients who earlier wouldn't buy medicines or avail treatment."

A doctor on the condition of anonymity said, "On an average, every person falls sick three to five times a year, and in India 78% people have to spend OOPE for their treatment. But due to free medicine and free medical schemes, the financial burden on poor people has gone down significantly."

IMPACT

6. INCREASING PATIENTS IN GOVERNMENT HOSPITALS

राजस्थान पत्रिका 7
जयपुर, रविवार, 7 जुलाई 2013

एसएमएस के ओपीडी में दो गुना बढ़े मरीज

जयपुर. एसएमएस अस्पताल में पिछले दो वर्षों के दौरान आउटडोर, इनडोर मरीजों और जांचों की संख्या में काफी बढ़ोतरी हुई है। अस्पताल प्रशासन ने तीन साल के आंकड़े जारी किए, जिसमे सामने आया कि निःशुल्क दवा व जांच योजना शुरू होने के बाद अस्पताल पर मरीजों का भार बढ़ गया। अस्पताल अधीक्षक डॉ.वीरेन्द्र सिंह ने बताया कि मई 2011 में निःशुल्क दवा योजना शुरू होने से पहले आउटडोर मरीजों की संख्या 76593 थी। यह मई 2013 में 1 लाख 79 हजार 171 तक पहुंच गई। आईपीडी में मई 2011 में मरीजों की संख्या 12269 थी, जो मई 2013 में 15579 हो गई। तब रक्त जांचों की संख्या 2 लाख 58 हजार 994 थी, यह अब 3 लाख 92 हजार 498 हो गई है।

IMPACT

THE TIMES OF INDIA, JAIPUR
SATURDAY, SEPTEMBER 21, 2013

Time of India

Odisha to follow Raj free med scheme

Syed Intishab Ali | TNN

Jaipur: Taking a leaf out of Rajasthan's book, Odisha will now follow the state's model for distribution of free medicines.

The state has been providing free medicines since October 2, 2011 under the Rajasthan medical services corporation (RMSC). While Odisha recently formed its Odisha Medical Services Corporation (OMSC). A team of Odisha government including Roopa Mishra, mission director (National Rural Health Mission), Odisha and managing director, OMSC, was in the city for past three days to study the scheme.

Before leaving the state, Mishra told TOI, "Odisha has been distributing free medicines since 1998 through the state drug management unit as the budget was less. Now, the state has decided to adopt medical services corporation model. Since Rajasthan has already formed RMSC for procuring and distributing medicines to patients, Odisha will follow the same model."

She pointed that that they are already following 80% of Rajasthan's model but after coming here they learnt about the working of RMSC. Information technology model and how the drug distribution counters function.

The Odisha team at the city drug testing lab

Hoping that the model will help revolutionize the free medicine scheme in Odisha, she said, "We are planning to implement the corporation model from January next year."

Odisha has recently formulated its drug policy and for the sixth time revised the essential drug lists since 1998. Mishra said, "Now, we have 550 drugs in the essential drugs list. Also, the budget for drugs has increased from Rs 30 crore to Rs 200 crore. "The team visited various drug warehouses, drug testing laboratories and drug distribution counters in various hospitals of the city. Mishra also appreciated Rajasthan's drug management system.

Nepal invites state medical team to provide inputs

TIMES NEWS NETWORK

Jaipur: Rajasthan free medicine scheme has garnered appreciation in Nepal as the officials of Rajasthan Medical Services Corporation (RMSC) have been invited by the government of that country to provide policy level inputs for National Health Policy along with WHO and World Bank teams.

RMSC managing director Samit Sharma on Thursday made a presentation before the officials of the Nepal government on how free drugs are being provided to people in the state. Sharma gave details about the chief minister free medicine scheme including information about drug warehouses, drug testing labs, quality checks of drugs, and drug distribution counters. The conference is being held in Kathmandu. On the occasion, Nepal Health Secretary Praveen Mishra, senior officials of the ministry, WHO, WB, NGOs and health economists were present.

RMSC sources said that some senior government officials from Nepal may come to Rajasthan to study the affordable healthcare model

RMSC sources said that some senior government officials from Nepal may come to Rajasthan to further study the affordable healthcare model of state. WHO, WB and RMSC have suggested providing essential drugs in government hospitals in the ongoing expert and core group consultations, which is also examining the insurance-based system.

SIDE EFFECT

MAY 01, 2012

hindustantimes

CM's scheme hits drug sales, 100 stores wind up

FEELING THE HEAT Chemists say sales of medicines have declined by 50-60%, ask govt to show some mercy

P Srinivasan
p.srinivasan@hindustantimes.com

JAIPUR: Sales of medicines at chemist shops have declined due to the success of the chief minister's free medicine scheme.

RB Puri, president, Rajasthan Chemist Association (RCA) said about 30 to 40 medical shops in rural and remote areas have already been closed down, as business was hit by the free medicine scheme.

Mahaveer Sogani, vice president, Jaipur Chemist Association said "Sales of medical stores situated opposite government hospitals have been affected. They have declined by 50%-60% and a few shops in Jaipur have closed down."

He said the scheme of the chief minister is good and patients are now getting medicines. "Chemists request the chief minster to help us in some way, so that we too get employment. We want the chief minister to have a soft corner for us," he said.

Sogani suggested that if any patient wants to buy branded medicines from chemists, the government should allow doctors to prescribe them, so that their business continues.

Chemists request the chief minster to help us so that we too get employment
MAHAVEER SOGANI
Vice president
Jaipur chemists association

Samit Sharma, managing director, Rajasthan Medical Services Corporation said the free medicine scheme is gaining popularity and about 100 medical shops have closed down in the state. Sales have declined by 60%.

Chemists should not charge exorbitant rates for medicines and the chemist associations can resolve to re-establish their credibility, he added.

The scheme was launched in Rajasthan on October 2, 2011. Initially there were problems like medicines not being available at drug distribution centres, stocks getting over. But now the situation has improved and medicines are available in sufficient quantities. The number of medicines has increased from 300 to around 375.

The closed private medical shops at Sawai Man Singh Hospital on Monday. SP SHARMA / HT PHOTO

SIDE EFFECT

सत्यमेव जयते

मुख्यमंत्री नि:शुल्क जाँच योजना

MUKHYAMANTRI NISHULK JANCH YOJNA

Scheme for Free Basic Diagnostic Services
at
Public Health Institutions

ESSENTIAL COMPONENTS OF HEALTH SERVICES

Component of health service	Provision
Hospital infrastructure	provided free
Consultation by a doctor & nursing care	provided free
Surgical and sutures items	provided free
Diagnostic Services	Paid

- Services available at the token money for registration at OPD for Rs.2/- or Rs.5/- and in IPD for Rs. 10/-.
- Patients pay only for tests whereas other components are provided free of cost.

GROUPING OF DIAGNOSTIC TESTS.

BASIC TESTS (FREE) Required for diagnosis of common illnesses by >90% of patients at Primary & Secondary care hospitals.	**SPECIALISED TESTS (PAID)** Required for <10% of patients at Tertiary care hospitals
Pathology – Blood for HB, TLC, DLC, TEC, T-RBC, ESR, PBF, Malaria AG, Platelet Count, BT, CT, PCV, CBC, etc .	CT Scan
Bio-Chemistry –B Sugar, Creatinine, Urea, Uric Acid, S-phosphorus, Calcium, Total Protein, Bilirubine, SGOT, SGPT, S alk-phosphatase, LDHCPK,CPKMB, GGT, Amylase, Lipase, Total lipid Profile, S. Electrolyte.	MRI
Microbiology – Widal test, VDRL, ASLO Titre, CRP, RF, Pregnancy Test, HBS – AG, etc.	ECHO Cardiography
Urine Complete, stool examination, CSF, Pleural fluid etc.	EEG
X-Ray	
ECG	

PACKAGE OF FREE TESTS AT VARIOUS LEVEL OF HEALTH CARE.

S.No.	Level of care	Medical Institutions	No. of free test proposed	Start Date
1	**Primary**	PHC(1507) Dispensaries (198)	15	15-Aug-13
2	**Secondary**	CHC (431)	28	01-July-13
		DH/SDH/SH (52)	44	07-April-13
3	**Tertiary**	MCH (28)	57	07-April-13

BASIC COMPONENTS FOR STRENGTHENING AND MODERNIZATION OF LABORATORIES

1. **Infrastructure**
2. **Manpower**
3. **Equipment & instruments**
4. **Supply of essential reagents and consumables.**

1. CIVIL WORK

S.No.	Civil work
1	Repairs & renovation of existing laboratories.
2	Need based additional civil work/space at DH/MCH
3	Construction of shelves & cabinets to store reagents
4	Platform, Basin ,sink and other sanitary fittings
5	Counters for sample collection and report dispatch
6	Equipment installation work
7	Office furniture – chair, table, rack, almirah etc.
8	Electric fitting and appliances - Refrigerator, Incubator, ups etc.

2. MANPOWER

S.No.	Manpower
1	Utilization of existing staff after sensitization & training (MOs and LTs).
2	New recruitment (need based) & training.
3	Contractual recruitment through RMRS.
4	Computer operators as per FD circular through RMRS one at CHC lab and three at SH/SDH/DH for data collection recording and reporting.
5	Technical staff • GNM for SC, LT for others and trained nurses for radiology and ECG Supervisory & Monitoring staff • SS/JS/MOPG or Six months trained pathologist, microbiologist/ radiologist/biochemist etc.
6	Training of other cadres like ANMs, MOs and LTs

3. EQUIPMENTS & INSTRUMENTS. – *Contd..*

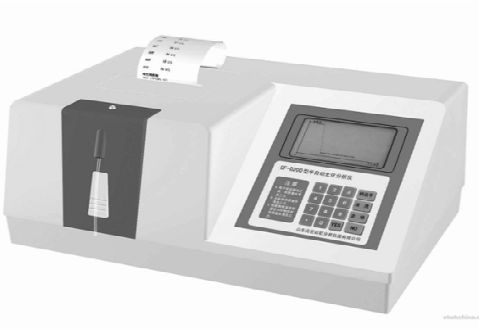
S.No.	Equipment & instruments.
1	Utilization of existing equipments after one time repair
2	EPM cell will execute annual R/C for equipments and Other regularly required materials
3	Gap analysis and procurement of new equipments
4	Equipment maintenance and repair centers
5	Repair and maintenance management through EMRC Of RMSC

3. EQUIPMENTS & INSTRUMENTS. - *Contd..*

226 X-Ray Machines

352 ECG Machines

3. EQUIPMENTS & INSTRUMENTS.- *Contd..*



223 Semi Auto Analyzer

454 Three part hematology Analyzer (CBC)

3. EQUIPMENTS & INSTRUMENTS. - *Contd..*

Incubator

Centrifuge machine

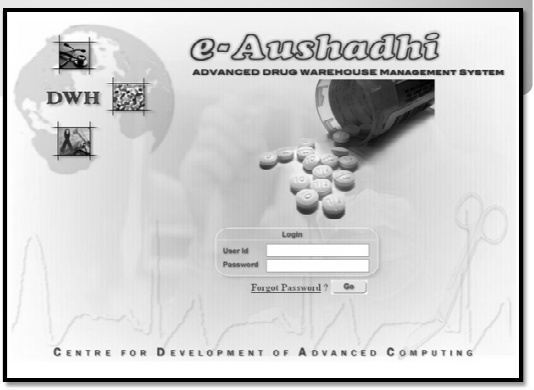
4. REAGENTS & CONSUMABLES

OTHER ACTIVITIES

1. **TRAINING & CAPACITY BUILDING**
2. **PRINTING OF STATIONARY**
3. **LABORATORY SAFETY PROGRAM**
4. **LABORATORY BIO-WASTE MANAGEMENT**
5. **QUALITY ASSURANCE**

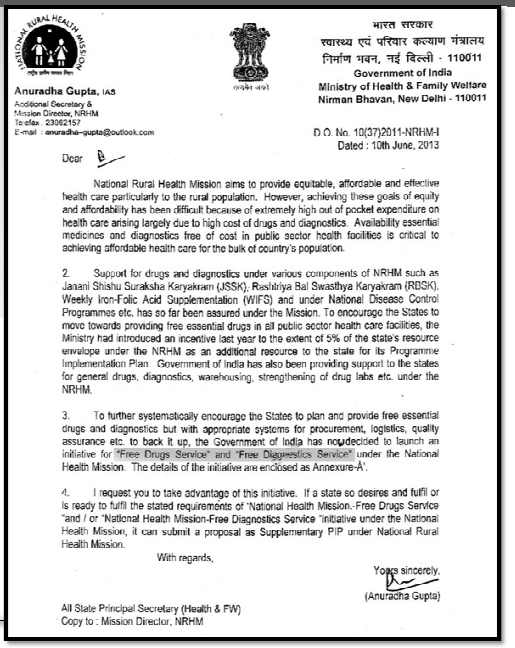
E-AUSHADHI - BIO MEDICAL EQUIPMENT MANAGEMENT SOFTWARE WEB BASED APPLICATION

1. **Equipment inventory module.**
2. **Equipment maintenance module.**
3. **No. of investigations reporting module.**



RECENT DEVELOPMENTS AT GOVERNMENT OF INDIA LEVEL

Scheme for support of "Free Medicines & Free investigations for All" in Public Health Facilities



NATIONAL RURAL HEALTH MISSION

Anuradha Gupta, IAS
Additional Secretary &
Mission Director, NRHM
Telefax : 23062157
E-mail : anuradha-gupta@outlook.com

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

D.O. No. 10(37)2011-NRHM-I
Dated : 10th June, 2013

Dear

National Rural Health Mission aims to provide equitable, affordable and effective health care particularly to the rural population. However, achieving these goals of equity and affordability has been difficult because of extremely high out of pocket expenditure on health care arising largely due to high cost of drugs and diagnostics. Availability essential medicines and diagnostics free of cost in public sector health facilities is critical to achieving affordable health care for the bulk of country's population.

2. Support for drugs and diagnostics under various components of NRHM such as Janani Shishu Suraksha Karyakram (JSSK), Rashtriya Bal Swasthya Karyakram (RBSK), Weekly Iron-Folic Acid Supplementation (WIFS) and under National Disease Control Programmes etc. has so far been assured under the Mission. To encourage the States to move towards providing free essential drugs in all public sector health care facilities, the Ministry had introduced an incentive last year to the extent of 5% of the state's resource envelope under the NRHM as an additional resource to the state for its Programme Implementation Plan. Government of India has also been providing support to the states for general drugs, diagnostics, warehousing, strengthening of drug labs etc. under the NRHM.

3. To further systematically encourage the States to plan and provide free essential drugs and diagnostics but with appropriate systems for procurement, logistics, quality assurance etc. to back it up, the Government of India has now decided to launch an initiative for "Free Drugs Service" and "Free Diagnostics Service" under the National Health Mission. The details of the initiative are enclosed as Annexure-A'.

4. I request you to take advantage of this initiative. If a state so desires and fulfil or is ready to fulfil the stated requirements of 'National Health Mission-Free Drugs Service "and / or "National Health Mission-Free Diagnostics Service "initiative under the National Health Mission, it can submit a proposal as Supplementary PIP under National Rural Health Mission.

With regards,

Yours sincerely,
(Anuradha Gupta)

All State Principal Secretary (Health & FW)
Copy to : Mission Director, NRHM

RMSC motto

- All essential medicines and
  - Basic diagnostic tests.
    - At all public health institutions
      - At all times

so that

No human being dies for want of treatment

THANK YOU

Annexure-V

AVAILABILITY, ACCESSIBILITY, QUALITY & AFFORDABILITY OF HEALTH CARE SERVICES

KERALA MODEL

Dr K Ellanagovan, IAS
Secretary (Health)
Government of Kerala

- WARM GREETINGS FROM KERALA

STRUCTURE OF PRESENTATION

- Overview of Kerala
- Health Infrastructure
- Health Indicators
- Milestones in health services
- State Initiatives
- Way forward
- Conclusion

GOD'S OWN COUNTRY

Kerala

Area

- (In 1000 Sq Km)
- India :3287
- Kerala : 39
- 1.1 %

Population (In millions)

- India :1002.1
- Kerala:32.4
- 3.23%

Population density is 819 persons per Sq.Km
Second only to West Bengal

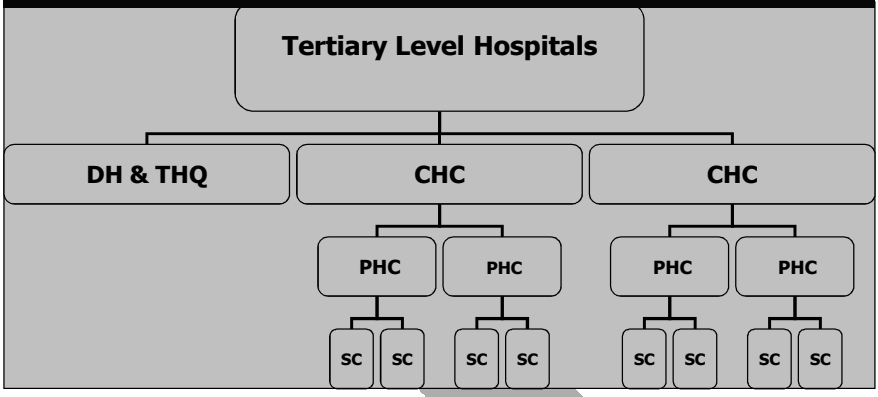
Kerala-2011 census

Indicator	Kerala
Population	33,387,677
Female Literacy	91.98%
Crude Birth rate	14.9
Crude Death rate	6.9
Total fertility rate	1.7
Sex Ratio	1084
Sex ratio 0-6	959
Growth Rate	8.0

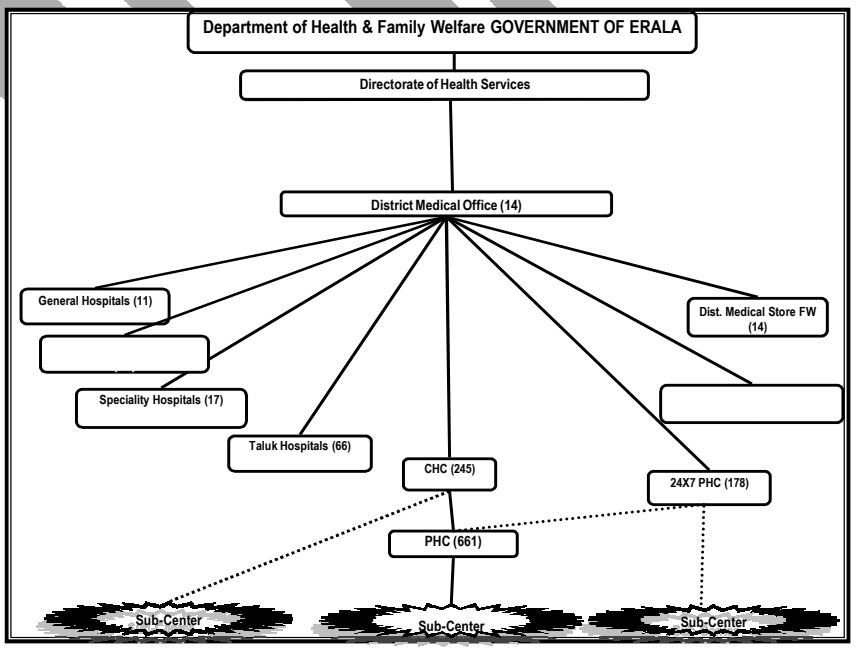
Health Indicators

Indicator	Kerala	India
Infant Mortality Rate	12	55
Access to ante-natal care	93.6%	52%
Institutional Delivery	99.4%	42.4%
Maternal mortality ratio	81	254
Immunization coverage	75.3%	43.5%
Anemia in reproductive age	32.8%	55.3%

Different levels of Care



Under the Sub Centres,
Anganwadi Centers of Social Welfare Dpt.
ASHA Volunteers.



Health Infrastructure (Public Sector)

General Hospitals	11
District Hospitals	15
Speciality Hospitals	19
TB Clinic	17
THQH	80
CHC	230
24 x 7 PHC	175
PHC	660
Others	73
Total	**1279**

Health Infrastructure

	Number of SCs	5403
	Number of Aanganwadi Centres	25382

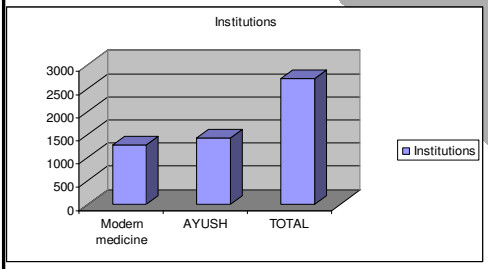
AYUSH

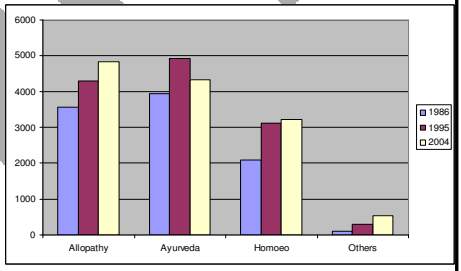
Government

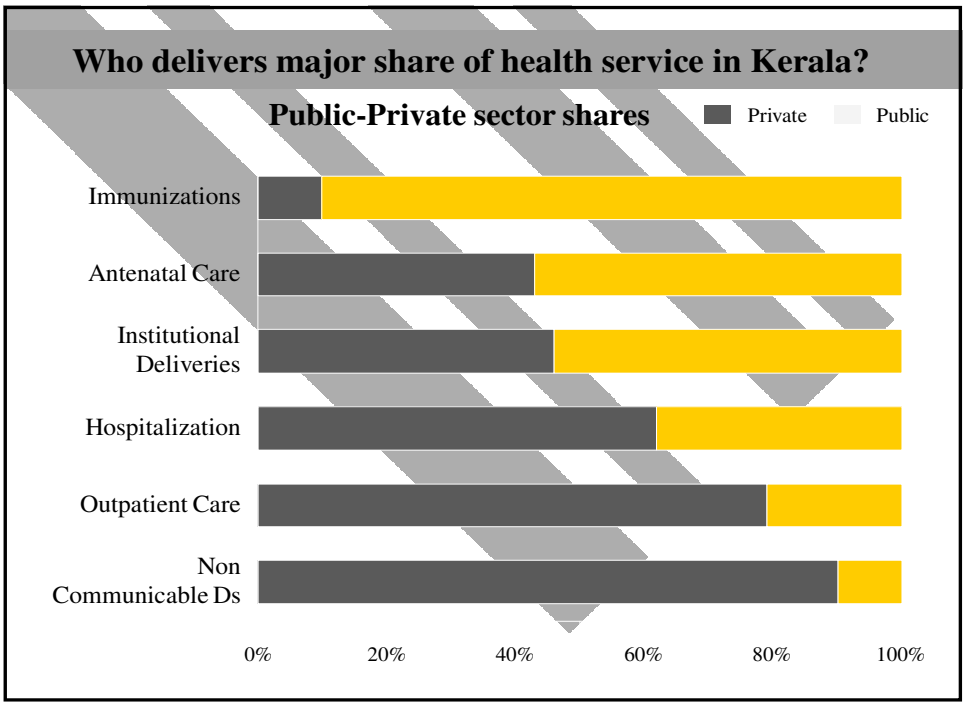
System of Medicine	Institutions	Percentage	Beds (2005)
Allopathy	1279	47 %	45405
Ayush	1432	53 %	5110
TOTAL	2711	100 %	50515

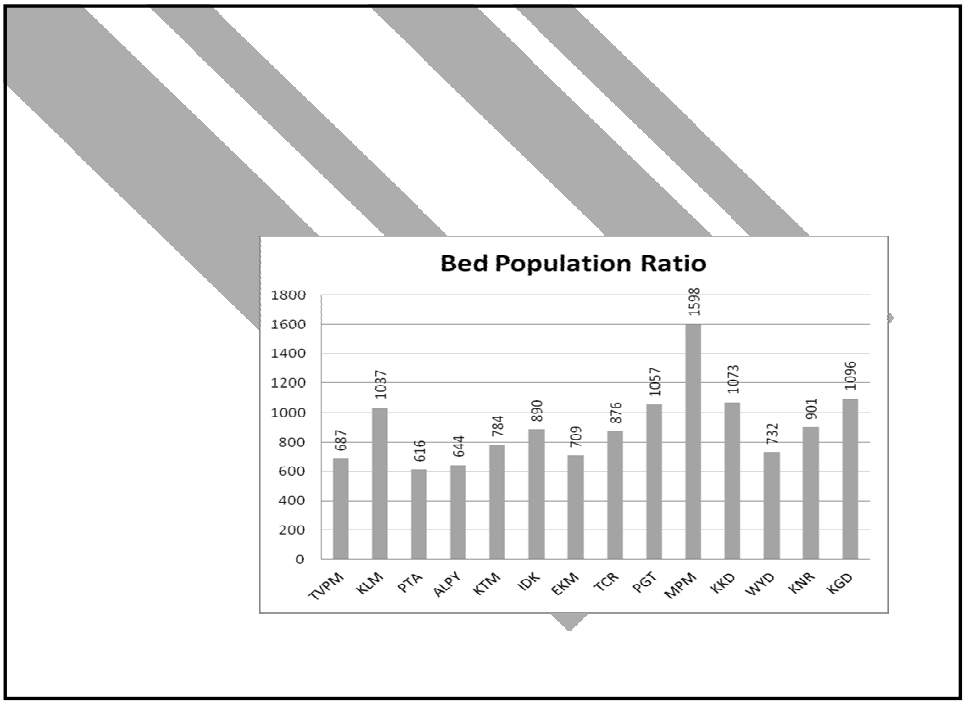
Private

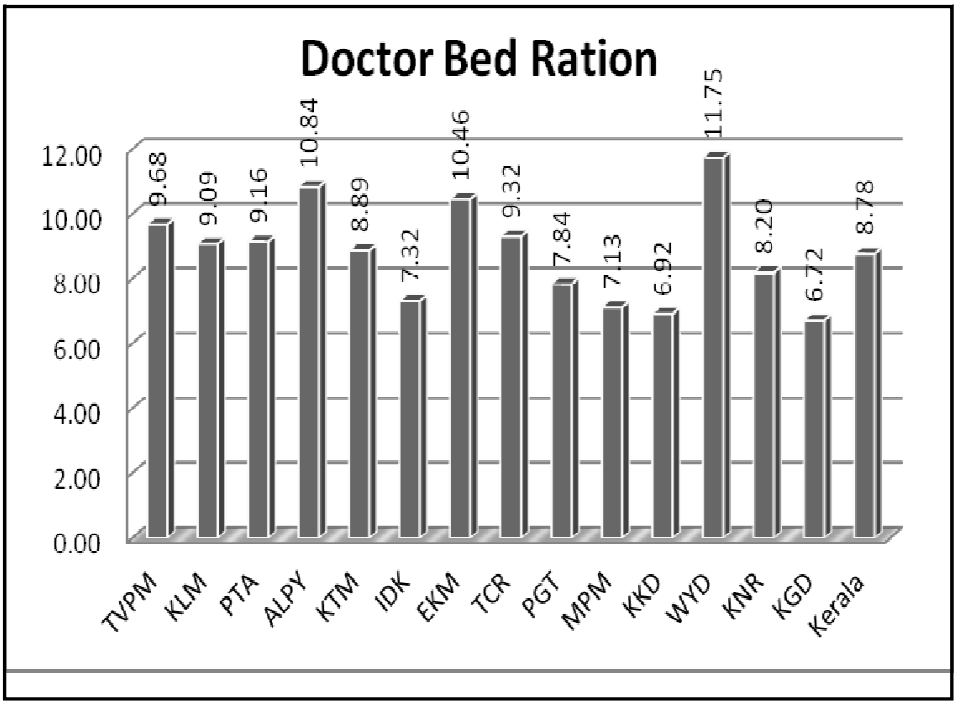
System of Medicine	Year		
	1986	1995	2004
Allopathy	3565	4288	4825
Ayurveda	3925	4922	4332
Homoeo	2078	3118	3226
Others	95	290	535
Total	9663	12618	12918

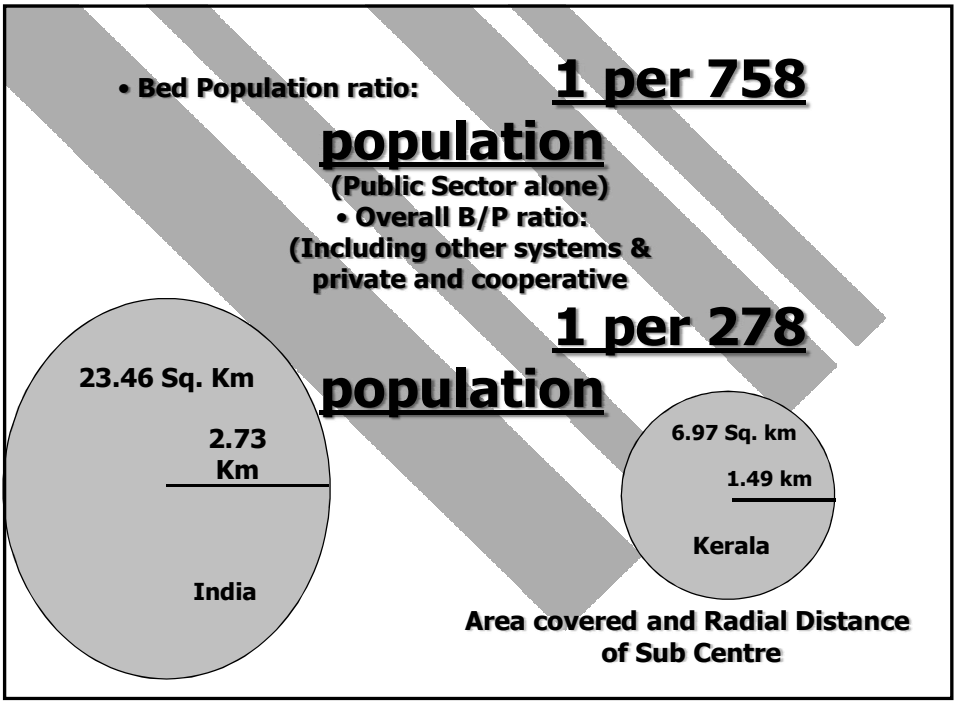





Who delivers major share of health service in Kerala?
Public-Private sector shares
Private
Public
Immunizations
Antenatal Care
Institutional Deliveries
Hospitalization
Outpatient Care
Non Communicable Ds
0%
20%
40%
60%
80%
100%


Bed Population Ratio
1800
1600
1400
1200
1000
800
600
400
200
0
687
1037
616
644
784
890
709
876
1057
1598
1073
732
901
1096
TVPM
KLM
PTA
ALPY
KTM
IDK
EKM
TCR
PGT
MPM
KKD
WYD
KNR
KGD


Doctor Bed Ration
12.00
10.00
8.00
6.00
4.00
2.00
0.00
9.68
9.09
9.16
10.84
8.89
7.32
10.46
9.32
7.84
7.13
6.92
11.75
8.20
6.72
8.78
TVPM
KLM
PTA
ALPY
KTM
IDK
EKM
TCR
PGT
MPM
KKD
WYD
KNR
KGD
Kerala


• Bed Population ratio: 1 per 758 population
(Public Sector alone)
• Overall B/P ratio:
(Including other systems & private and cooperative
1 per 278 population
23.46 Sq. Km
2.73 Km
India
6.97 Sq. km
1.49 km
Kerala
Area covered and Radial Distance of Sub Centre

HEALTH AND FAMILY WELFARE DEPARTMENT

- Directorate of Health Services
- Directorate of medical education.
- Directorate of India System of Medicine.
- Directorate of Ayurvedic Medical Education
- Directorate of Homeopathic Medicine.
- State drug control organization.

OTHER ORGANIZATIONS

18

An over view of major category of staff

Director of Health Services	**1**
Addl. DHS	**14**
DD/DMO/Supdt.	**45**
Civil Surgeon	**805**
Assistant Surgeon	**2888**
Dental Surgeon	**80**
Other Medical Officers	**29**
Total	**3862**
Nurses	**8738**
Total Para medical staff	**25185**
Total Health staff	**50002**

History

1811 – Modern Medicine Introduced

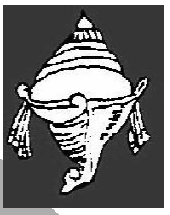
1813 – vaccination against smallpox introduced in Travancore

1817/1837 – Charitable dispensary started & upgraded to a charitable hospital

1848- Hospitals was started

1865 –General Hospital Established in Trivandrum

History



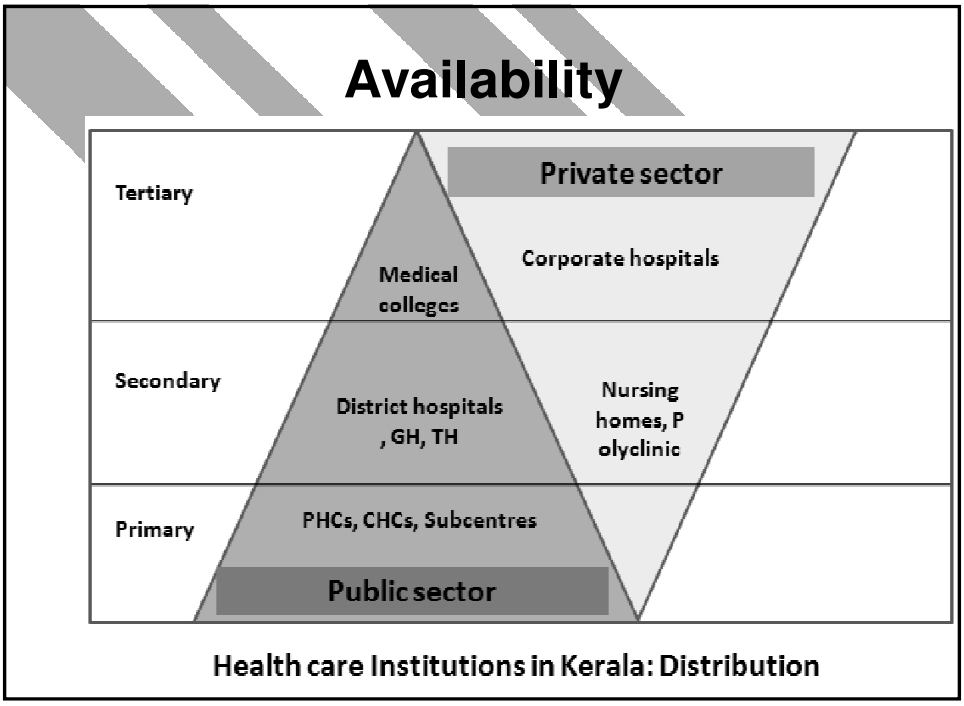
- Vaccination made compulsory for public servants in 1859
- Public surveys conducted in 1928 against Hookworm & Filariasis
- 1935– First PHC established by HH Shri Chithra Thirunal
- Late 30's & 40's – Network of Health Centres established

At the time of formation of the present Kerala state, the foundation for an accessible medical care system was already laid

In addition

- Small but highly populous state of India
- Highly literate population, esp. women
- Decentralisation
- Social equity
- Early political activism
- Missionary activities
- Women empowerment
- Land reforms
- Indigenous Systems of Medicine
- Excellent Public Distribution System

...an excellent Healthcare Delivery Network



Health care Institutions in Kerala: Distribution

- **INITIATIVES**

DECENTRALISATION

- Panchayathi Raj – 1994
- “29 Functions Transferred”
- Five Year Plans-295 Crores
- Political commitment
- Communitisation-ASHA,KUDUMBASREE
- 5% Mandatory for Disability
- 5% mandatoryfor Palliative Care and geriatric
- Trauma care

Comprehensive Health Action Plan (CHAP)

- LSG & HSD
- Incentive –arogyapuraskaram-criteria –health indicators
- Ayush Hospitals-750
- Public Health Labs -250
- Sub Centres - 100

Missionaries & NGO's

- Remote/Inaccesible areas
- Free/Low Cost Health Care
- Awareness Programme
- Literacy Programme
- Charitable hospitals

Intersector Convergence

- Social Justice Department
  - ICDS
  - Social Security Mission
    - MMR Vaccine
    - Rubella
    - Thalolam-free treatment for children below 18years for c/c diseases
    - Cochlear Implantation and hearing aid
    - Cancer suraksha

Intersector Convergence

- Education Department
  - School Health Programme
  - School Mental Health Programme
  - Arogyatharakam Quiz
  - Mid Day Meal
  - WIFS

Intersector Convergence

- Labour Department
  - Insurance Scheme-RSBY-NRHM
  - CHIS PLUS-CHIAK
- Lottery department
  - karunya benovolent scheme
- Tribal department

State Initiatives

- Free Generic Medicines(518 EDL and 318 RDL)
- Centralized Drug/Equipment Procurement Agency (KMSCL)
- Karunya Pharmacy Outlets
- Strengthening Food Commissioners Office
- E-Governance
  - E-Health
  - E-Drug Licence

State Initiatives

- Quality Assurance Programme
  - NABH-3hospitals one blood bank,two in pipeline
- NABL-started and essentialsstandards for all labs
- KASH-8 hospitals

State initiatives

- New Born Screening-4 diseases
- Community Mental Health Programme
- One Stop Crisis Cell-gender based violence management centre(home,legal,SJ,HSD,LSG,)

Redressal Mechanism

DISHA -1056

- 24 hour telephone redressal mechanism
- 24 hours doctor on call

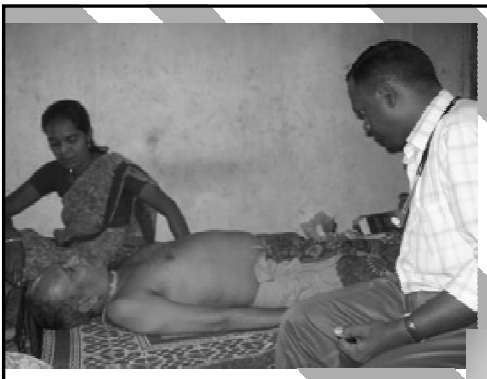
- Palliative Care Policy
- LSG,HSD,NRHM,NGOS
- Home care

2 Pain and Palliative Care

- one and a half lakh bedridden and incurably ill patients
- Most of them do not have access to the much needed medical, nursing and social support facilities
- Non Governmental organizations active in the field
- Government of Kerala Palliative Care Policy in 2008

Pain and Palliative Care

- First government in Asia to have a palliative care policy
- Emphasises community based home care
- Gives guidelines for the development of services with community participation



NRHM in Kerala

- Strengthening Physical Infrastructure
- Bridging Manpower requirements
- Innovative Programmes
- Fund Availability & Flexibility
- People Centered Activities
- To reach the unreached has met with tremendous success by functioning mobile clinics, Floating dispensaries
- More institutions provided with 24 X 7 services

CHALLENGES IN SUSTAINING HEALTH EXCELLENCE

- Increased **out-of-pocket expenditure**
- **Limited resources** for health developmental activities
- Twin burden of **communicable** and **second generation diseases**
- **Over-medicalisation (drugs & diagnostics)**
- **Unregulated private sector**

Emerging Health Issues

- Highest per capita road accidents - Trauma care
- Mental Health Issues- 3 times more Suicide rate than India
- Aging Population related disease burden
- Natural Calamities- Disasters – High Density of Population
- Environmental degradation
- Problems of industrial, biomedical and domestic waste
- Urban, Coastal and Tribal Health issues
- Anemia – (NFHS 3 – Women 33 %, Men 8 %, Children 45 %)

Way forward……

- Health Policy-Draft
- Clinical Establishment Act
- Public Health Cadre
- Universal Health Coverage
- Organised Trauma Care Network
- Establishment of Haemophilia cntre

KERALA

- Small state
- Well connected
- Strong historical backup
- Wide net work of health care institutions
- high Literate
- Health awareness and health seeking behaviour
- Robust panchayati raj
- Quality driven policy
- Political committment

Kerala Model of Health System

- The health development of Kerala has its roots in both health sector interventions and social economic factors that lie outside the health sector
- This achievement in health sector was termed as “Good Health at Low Cost”

Doing small things in great way is quality

"We may never have the opportunity to do great things in a great way, but we have the chances to do small things in a great way."

-

- **PROVIDING**

  - All the time
  - AVAILABILE
  - ACCESSIBILE
  - QUALITY CENTRED
  - AFFORDABILE
  - HEALTH CARE SERVICES

- Kerala – the healthy state
- Internationally renowned
- KERALA MODEL HEALTH

Thank You

Annexure-VI

State of Tamil Nadu

Department of Health & Family Welfare

"Best Practices"

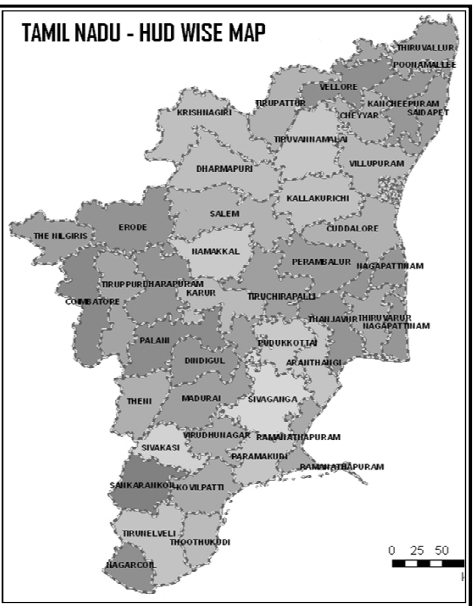
Rajendra Ratnoo IAS

MD TNMSC Ltd

ADMINISTRATIVE SETUP

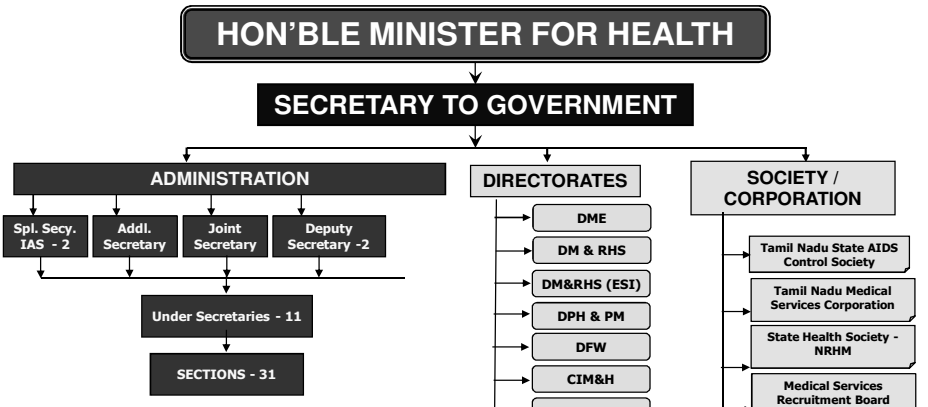
32 DISTRICTS

TAMIL NADU - HUD WISE MAP



42 HEALTH UNIT DISTRICTS

ORGANISATION STRUCTURE

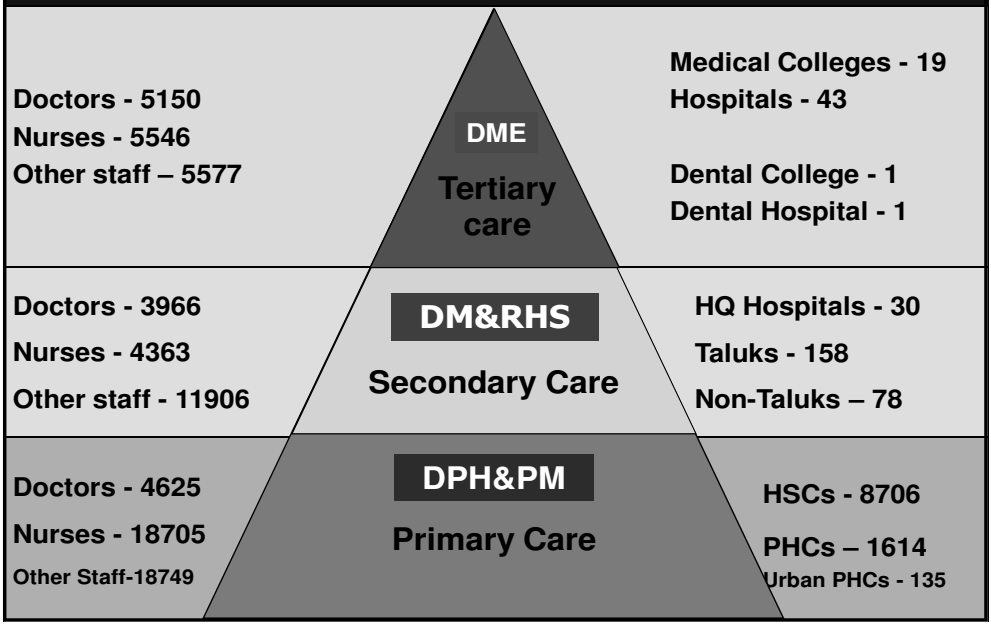


Spl. Secy.	Special Secretary
DME	Director of Medical Education
DM&RHS	Director of Medical and Rural Health Services
DM&RHS (ESI)	Director of Medical and Rural Health Services (ESI)
DPH&PM	Director of Public Health and Preventive Medicine
DFW	Director of Family welfare
CIM&H	Commissioner of Indian Medicine and Homoeopathy
DCA	Drug Control Administration
TNHSP	Tamil Nadu Health Systems Project
SHT	State Health Transport
NRHM	National Rural Health Mission

STATE PROFILE – TAMIL NADU

Indicator		Tamil Nadu	India
Population 2011 Census (in Millions)		**72.1**	1210.2
Decennial Growth Rate (2001-2011) (%)		**15.6**	17.6
Sex Ratio (females per 1000 males) (2011)		**995**	940
Crude Birth Rate (2012)		**15.7**	21.6
Crude Death Rate (2012)		**7.4**	7.0
Infant Mortality Rate (2012)		**21**	42
Maternal Mortality Ratio (2007-09)		**97**	212
Total Fertility Rate (2011)		**1.7**	2.4
Literacy Rate (2011 census)	Male	**86.8**	82.1
	Female	**73.9**	65.5

GOVERNMENT HEALTH CARE FACILITIES



INSTITUTIONAL SERVICES IN GOVERNMENT HEALTH FACILITIES AVERAGE PER DAY (2012-13)

S. No	Service	DPH	DMS	DME
1	Out Patients Treated	2,42,537	2,15,631	71,753
2	In Patients Treated	3,900	20715	25,188
3	Deliveries conducted	667	489	661
4	Family Planning done	173	248	87

PERFORMANCE IN CRITICAL HUMAN DEVELOPMENT INDICATORS VIS-A-VIS INDIA

Indicator	Target	Current status	
		India	Tamil Nadu
Maternal MortalityRatio (MMR-per 1 lakh live births)	100 by year 2012	212	73
Infant Mortality Rate (IMR-per 1000 live births)	30	42	21
Total Fertility Rate (TFR)	2.1	2.4	1.7

Tamil Nadu has achieved UN mandated Millennium Development Goals and plan targets and is being cited as an example for other states

POLICY BACKGROUND RESPONSIBLE FOR THESE ACHIEVEMENTS

- Health budget raised by 67 % in the last three budgets
- 24 hour delivery care provided in all PHCs
- 341 PHCs upgraded to 30 bedded hospital since 2001 at the rate of one PHC per block.
- Established 24 hours Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services in the year 2004
- Birth companion scheme started in July 2004

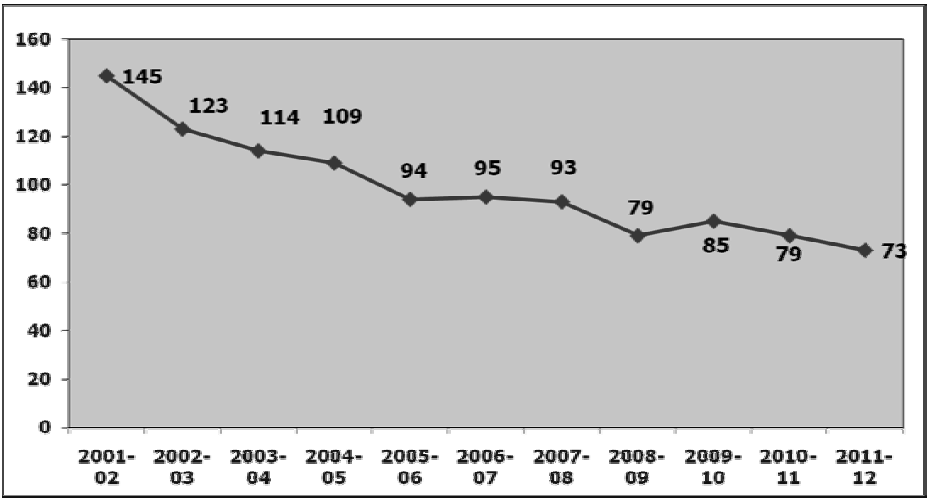
POLICY BACKGROUND RESPONSIBLE FOR THESE ACHIEVEMENTS

- Maternal death audit being done from July 2004
- TNMSC started in 1994
- Dr. Muthulakshmi Reddy scheme amount raised to 12,000 per delivery and linked to conditions
- Hospital on Wheels
- Providing free inter-facility transfer and free drop back services

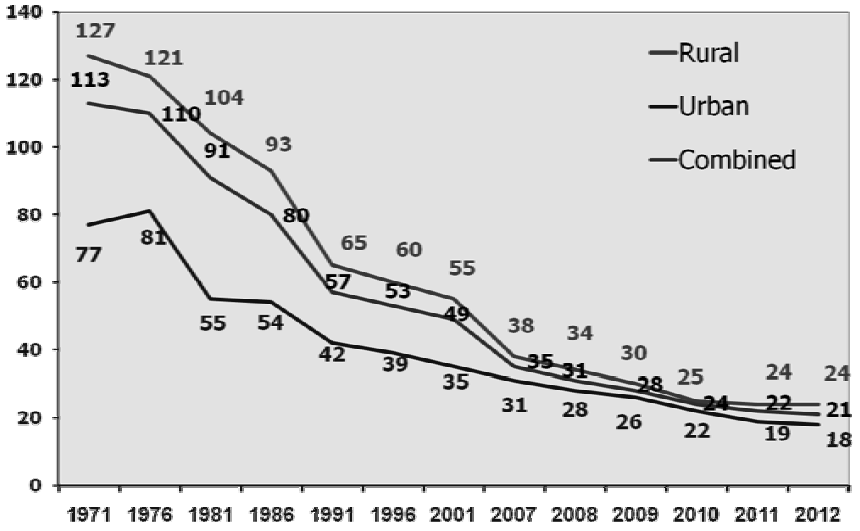
IMPORTANT PROGRAMMES, SCHEMES, MISSIONS AND PROJECTS

Hon'ble CM Insurance Programme
Dr. Muthulaksmi Reddy Maternity Benefit Scheme
Menstrual Hygiene Programme
National Rural Health Mission
TN Health Systems Project
Universal Immunisation programme
TN State AIDS Control Society
National Vector Borne Diseases Control Programme
Revised National TB Control Programme
National Blindness Control Programme
National Leprosy Eradication Programme

MATERNAL MORTALITY RATIO IN TAMIL NADU 2001-02 TO 2011-12

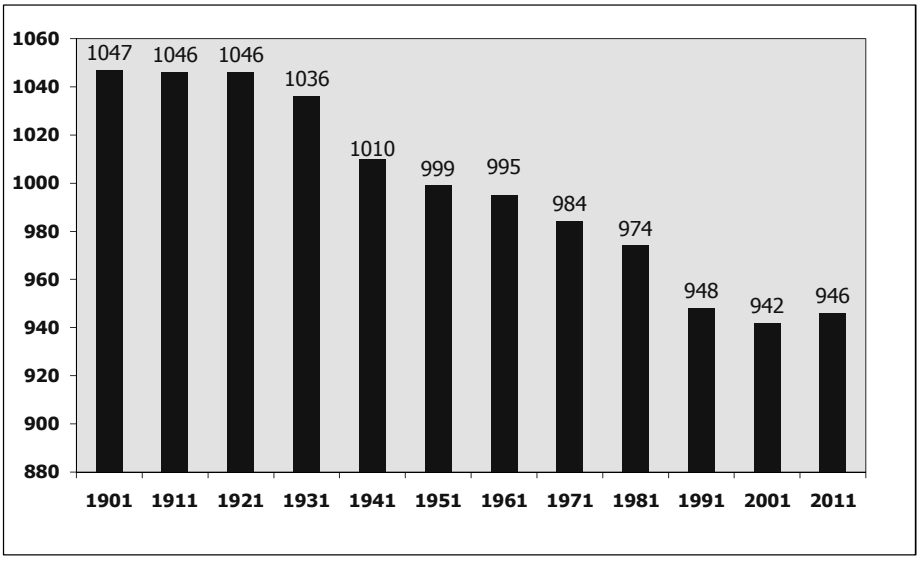


TRENDS IN IMR IN TAMIL NADU

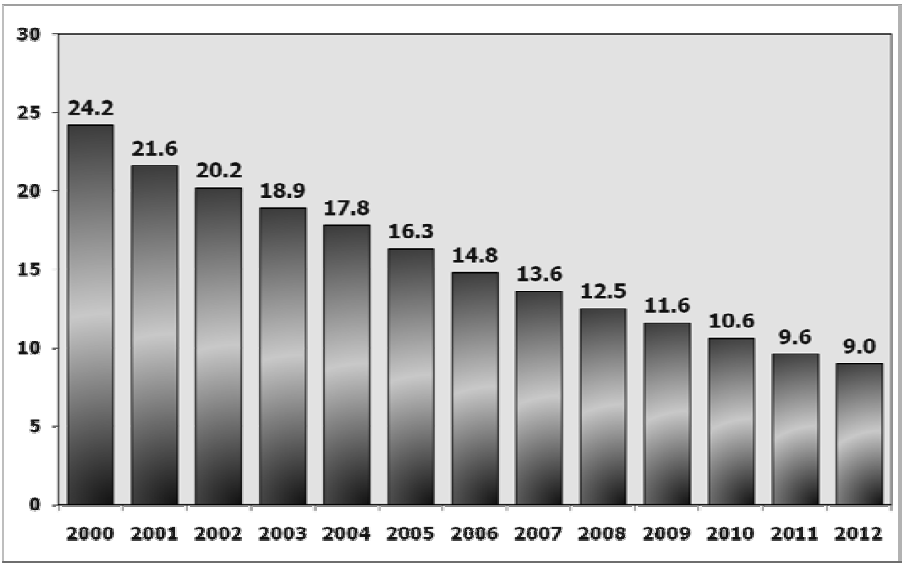


Source: SRS

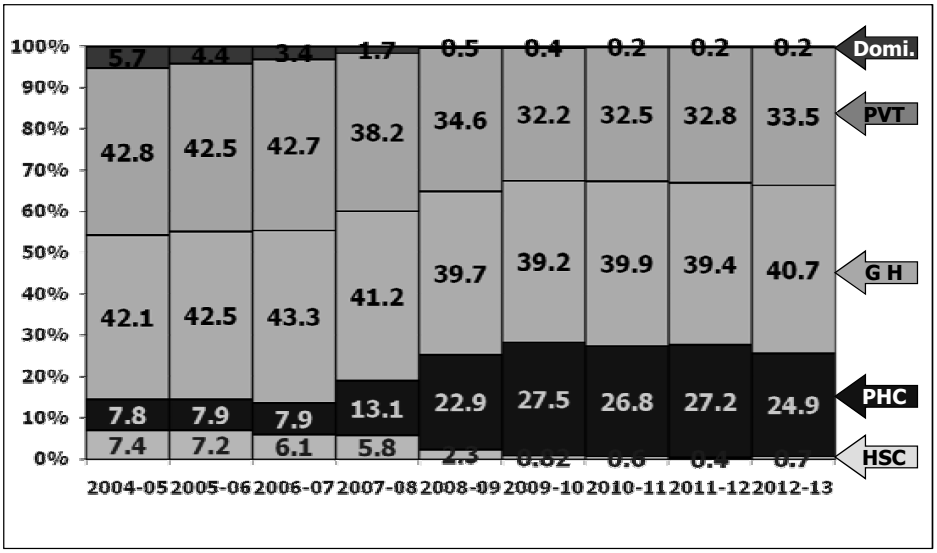
TRENDS IN CHILD SEX RATIO IN TAMIL NADU



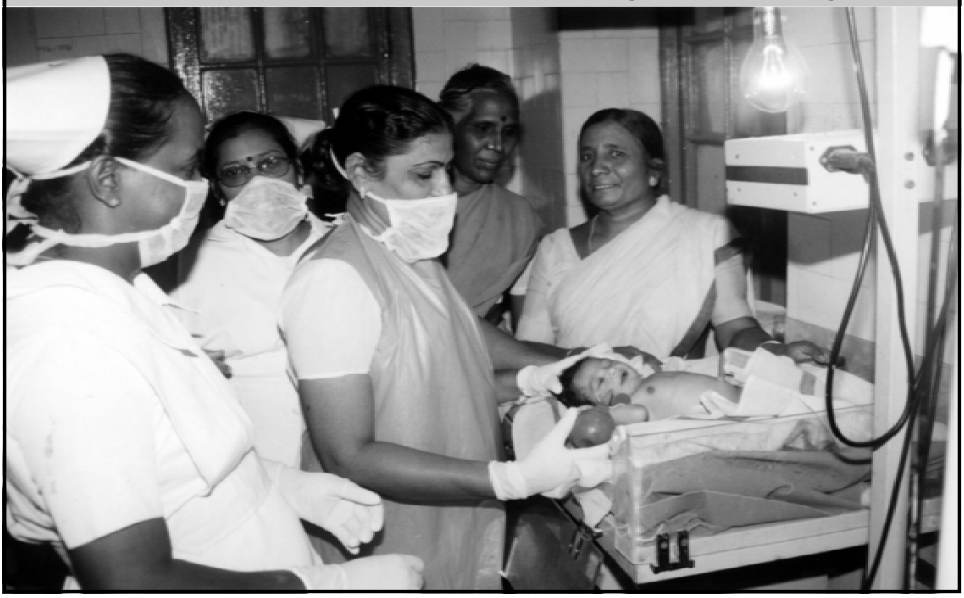
% OF HIGHER ORDER OF BIRTH (3 & ABOVE) IN TAMIL NADU



INSTITUTIONAL CONTRIBUTION IN DELIVERIES (%)

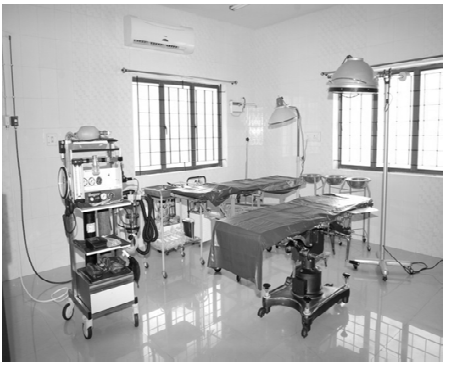


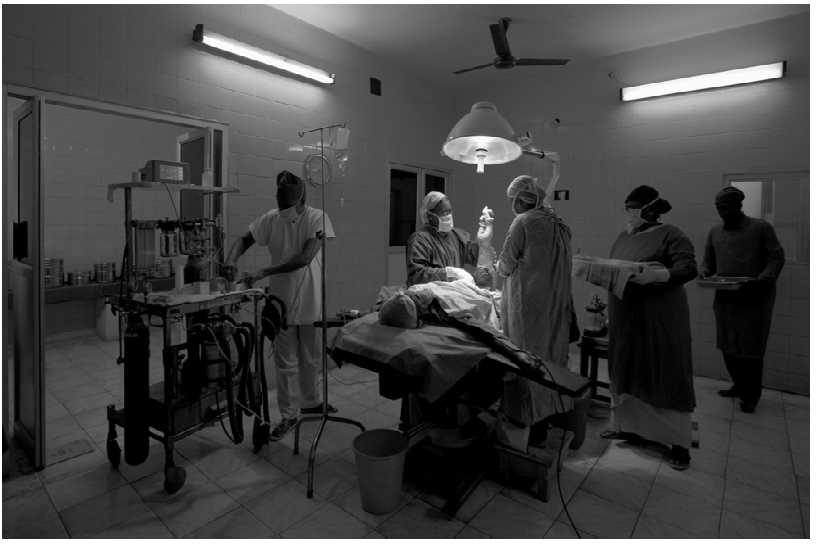
Comprehensive Emergency Obstetric and Neonatal Care Services (CEmONC)



Newborn Intensive Care Units (NICU)

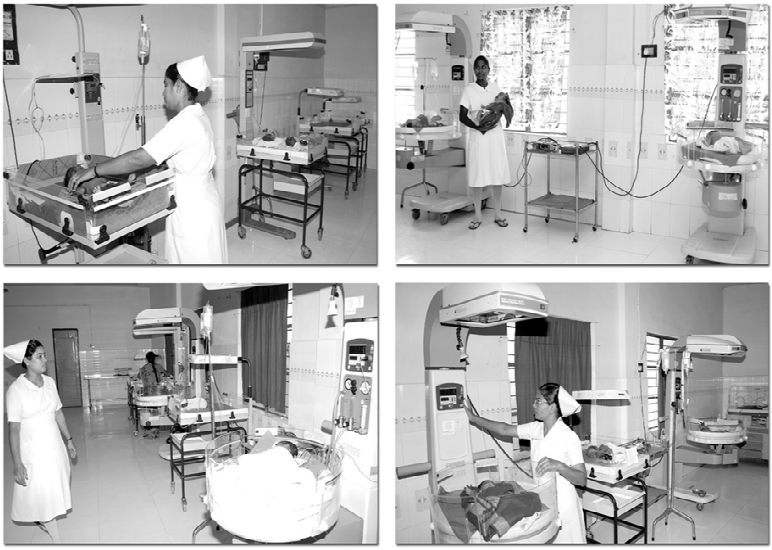
Infrastructure Upgradation





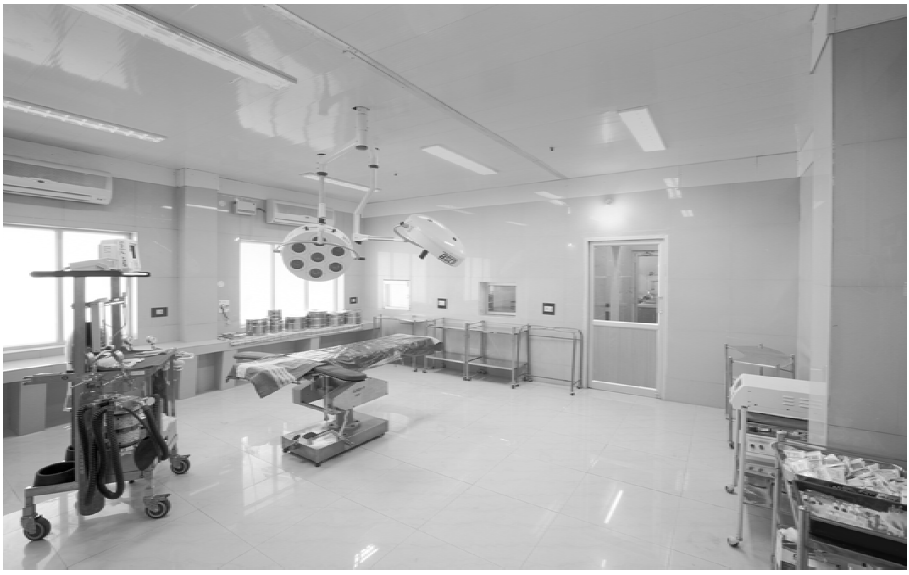
Caesarean Operation in Progress, Periyakulam GH

24 Hrs Blood Bank



Neonatal ICU

Neonatal Intensive Care Unit



Operation Theatre, Padmanabhapuram GH

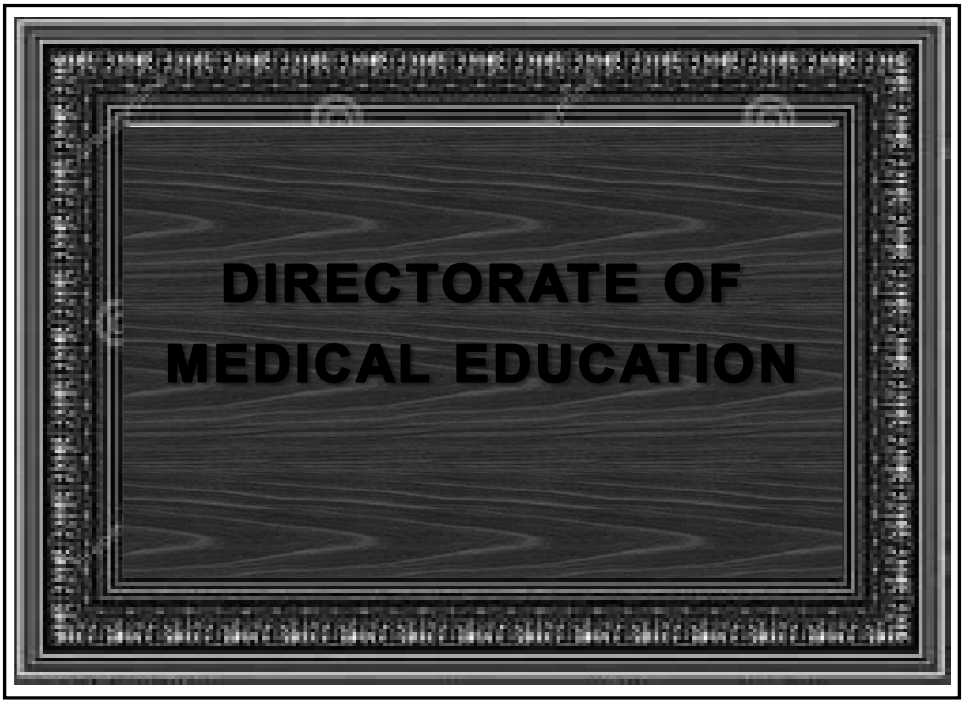
New Born Stabilization Unit (NBSU)

Neonatal Ambulance

Regular 108 Ambulance Van Interior

Mortuary Van

Tribal Outreach Services



DETAILS REGARDING THE AVAILABILITY OF SEATS WITH BREAK-UP FOR UG AND PG COURSES

Courses	Total Seats	State Quota seats	All Quota seats	Number of colleges
[UG]		**85%**	**15%**	
I.GOVT. COLLEGES				
MBBS	2555	2172	383	19
BDS	100	85	15	1
II. SELF FINANCING				
MBBS	1710	993	717	13
BDS	1545	937	608	17
[PG]		**50%**	**50%**	
GOVT. COLLEGES				
MD/MS/Dip	1160	584	576	13
MDS	38	20	18	1

UNDER GRADUATE SEAT MATRIX

S. NO	NAME OF THE COLLEGE	NUMBER OF SEATS Existing	increase of seats during 2013-14
1	Madras Medical College, Chennai.	250	85
2	Stanley Medical College, Chennai.	250	100
3	Madurai Medical College, Madurai.	155	
4	Thanjavur Medical College, Thanjavur.	150	
5	Kilpauk Medical College, Chennai.	150	
6	Chengalpattu Medical College, Chengalpattu	100	
7	Tirunelveli Medical College, Tirunelveli.	150	
8	Coimbatore Medical College, Coimbatore.	150	
9	Government Mohan Kumaramangalam Medical College, Salem.	100	25
10	Government KAP Viswanatham Medical College, Trichy.	150	50
11	Thoothukudi Medical College, Thoothukudi.	150	50
12	Kanyakumari Medical College, Kanyakumari.	100	
13	Government Vellore Medical College, Vellore.	100	
14	Government Theni Medical College, Theni.	100	
15	Government Dharmapuri Medical College, Dharmapuri.	100	
16	Government Villupuram Medical College, Villupuram.	100	
17	Government Thiruvarur Medical College, Thiruvarur.	100	
18	Government Sivagangai Medical College, Sivagangai	100	
19	Government Thiruvannamalai Medical College, Thiruvannamalai	100	100
TOTAL		**2555**	**410**

SEAT MATRIX - BDS

NAME OF THE COLLEGE	NAME OF THE COURSE	NO. OF SEATS
Tamil Nadu Government Dental College, Chennai.	B.D.S	100

SEAT MATRIX - MDS

Name of the College: Tamil Nadu Govt. Dental College, Chennai.

Name of the Course	Existing MDS seats	Increased in 2013-14
1. Peridontics	6	
2. Oral and Maxillo Facial surgery	6	
3. Conservative Dentistry	6	
4. Orthodontics	6	
5. Prostodontics	6	
6. Oral Medicine and Radiology	5	3
7. Preventive Dentistry and community Dentistry	1	
8. Oral Pathology	2	
Total	**38**	**3**

NEW PG COURSES FROM THE ACADEMIC YEAR 2013-14

Name of the college	Name of the course	No. of seats permitted
Stanley Medical College	**MD Radiology**	**2**
Kilpauk Medical College	MD Forensic Medicine	2
	MD Community Medicine	2
	MD Psychiatry	2
	MD TB & Chest Diseases	**2**
Chengalpattu Medical College	MD Physiology	2
	MD Pharmacology	2
	MD Pathology	2
	MD Microbiology	2
Tirunelveli Medical College	MD TB & Chest Diseases	2
Coimbatore Medical College	MD Anaesthesiology	3
	MD Radiology	**2**

NEW PG COURSES FROM THE ACADEMIC YEAR 2013-14

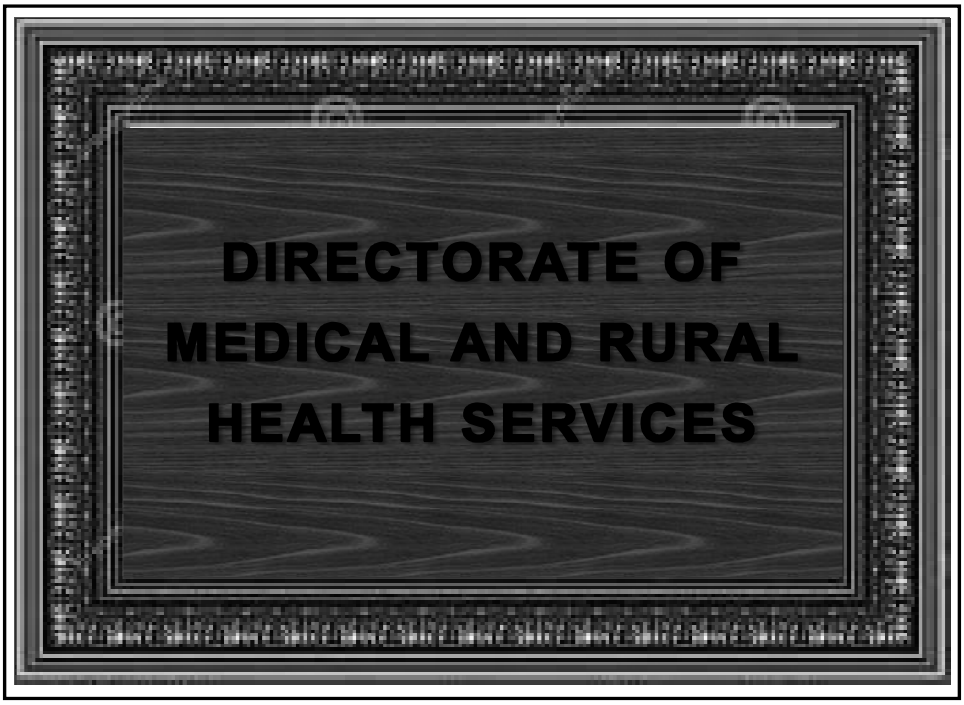
Name of the college	Name of the course	No. of seats permitted
Govt. Mohankumaramangalam Medical College, Salem	MD Anaesthesiology	4
	MD OG	3
KAP Viswanatham Government Medical College, Trichy	**MD Biochemistry**	**2**
Kanyakumari Medical College	MD Anaesthesiology	2
	MD General Medicine	3
Government Vellore Medical College	MD General Medicine	4
	MS General Surgery	2
Government Theni Medical College	MD OG	4
	MD Paediatrics	2
	Dental Surgery	
TN Govt. Dental College	MDS Oral Medicine & Radiology	5
TOTAL		**56**

MULTI SUPER SPECIALTY HOSPITAL, OMANDURAR

- Funds of Rs.26.93 crore sanctioned to PWD for conversion of Block-A.
- Rs.76.04 crore sanctioned for medical equipments and furniture.
- One Director post sanctioned to look after the modification works.
- 83 Medical Officer and 232 Para Medical posts sanctioned.
- Rs.123.30 crore sanctioned to PWD for conversion of Block-B as Medical College.

MULTI SUPER SPECIALTY HOSPITAL, OMANDURAR PENDING CORE ISSUES

- Filling up of Director post.
- H.R. Policy and financial sanction for Medical and Non-Medical posts.
- Financial sanction for outsourcing.
- G.O. issued for Block-B construction yet to be started.
- Financial and administrative sanction for Block B.
- PWD (Civil and Electrical) modification works expected to be completed by November, 2013.
- Orders placed for Rs.45 crore equipments yet be installed expected date 30.11.2013. For rest of the equipment tender process in progress.
- G.O. issued for construction of Radiation oncology block pending AERB approval.



IMPLEMENTATION OF IMPORTANT ACTS

Pre-conception and Pre-Natal Diagnostic (Prohibition of Sex Selection) Act, 1994 (PNDT).

- DM&RHS – Chairman of the State Level Advisory Committee
- District Collector – District Appropriate Authority (to Designate Joint Director of Health Services as District Appropriate Authority under consideration).
- Total Scan Centres Registered – 4978
- Case filed against Scan Centres - 72

IMPLEMENTATION OF IMPORTANT ACTS

Transplantation of Human Organ Act-1994

- DM&RHS – State Appropriate Authority
- Three Authorization Committee Constituted for approval of Oran Transplantation.
- 72 Hospitals Registered for performing renal, heart, liver, lungs and corneal transplantations.
- Cadavar

Cadaver Transplantation Programme

- Tamil Nadu ranks top in implementation.
- All the procedures are streamlined.
- 38 hospitals involved in the programme.

Performance

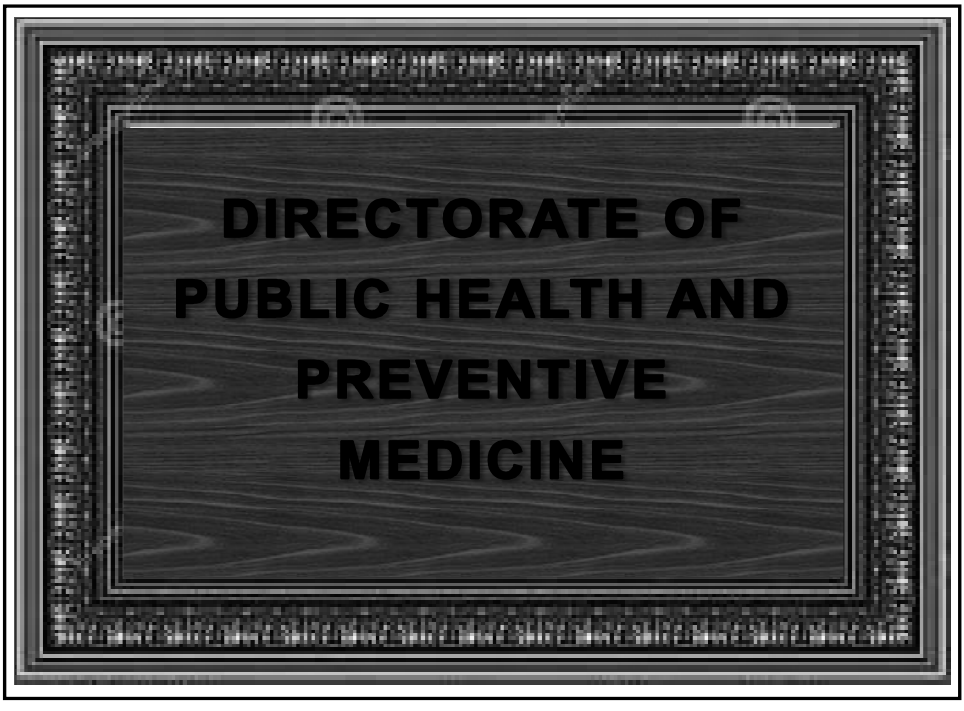
- From October 2008 to 07.10.2013, there were 410 donors .

Major Organs Harvested - 1216

- Heart – 64
- Lungs – 26
- Liver – 371
- Kidney – 755

District Mental Health Programme

- Under implementation in 16 districts



DR. MUTHULAKSHMI REDDY MATERNITY BENEFIT SCHEME

- Dr. Muthulakshmi Reddy Maternity Benefit Scheme (MRMBS) is implemented with an objective of providing assistance to poor pregnant women for improving the access to nutritional food and for compensating the wage losses
- Cash assistance of Rs 12,000 under this scheme is disbursed in three installments to poor pregnant women directly by ECS from treasury to beneficiary bank account.

PERFORMANCE REPORT

Year	Amount Allotted (Rs. in Crore)	Amount Disbursed (Rs. in Crore)	No. of Beneficiaries
2006 - 2007	100	100.00	2,41,095
2007 - 2008	300	296.64	6,79,831
2008 - 2009	350	349.26	5,79,821
2009 - 2010	360	358.60	5,99,126
2010 - 2011	360	347.51	5,81,790
2011 - 2012	660	515.11	6,73,093
2012 – 2013	720	639.54	6,70,313
2013- 2014 (up to 31-10-13)	720	359.54	3,72,387

IMMUNIZATION PROGRAMME

- Annually about 12 lakh pregnant women and 11 lakh infants are targeted and immunized as per national schedule
- Wednesday is designated immunisation day
- Outreach sessions conducted as per fixed place and fixed day policy
- Weekly around 10,000 immunisation sessions are conducted.
- Annually around 5.2 lakhs immunisation sessions are conducted.

PENTAVALENT VACCINE

- Govt. of India have selected 2 States in the Country – Tamil Nadu and Kerala for introduction of Pentavalent vaccines.
- Pentavalent vaccine – DPT+Hep-B+Hib.
- Pentavalent vaccine has been introduced in all districts from 21st Dec. 2011 onwards

PROGRAMME IMPACT

- For the past 30 years, the State had so far immunized about more than 3.5 crore children with different vaccines.
- No polio case for the past 9 years. Last polio case was reported from Tenkasi, Tirunelveli district during February 2004.
- Neo natal Tetanus Eliminated.
- The Incidence of Diphtheria, Pertussis is almost Nil.
- Measles cases are reported around 2000 cases per annum as compared to 15,000 cases reported every year during 80s.

MENSTRUAL HYGIENE PROGRAMME

Hon'ble Chief Minister Inaugurated the Scheme on 27.03.2012

BENEFICIARIES

Adolescent Girls	40,98,785
10-19 years in rural areas	32,79,028
Postnatal Mothers who deliver in Government Institutions	7, 25,771
Women Prisoners	700
Women inpatients of Mental health Institute, Chennai	525

DISTRIBUTION GUIDELINES

Rural Adolescent Girls

- 18 packs of Sanitary napkins (6 Pads per Pack) in a year
- @ 3 packs per two months
- Both School Going & Non school Going

For Post-Natal Mothers

- 7 packs Each
- @6 pads per pack

Women Prisioners

- 18 pack in a year
- @ 6 pads per pack

BUDGET ALLOTMENT

Year	Allotment (in crores)
2011-12	44.2
2012-13	55.0
2013-14	53.8

HOSPITAL ON WHEELS

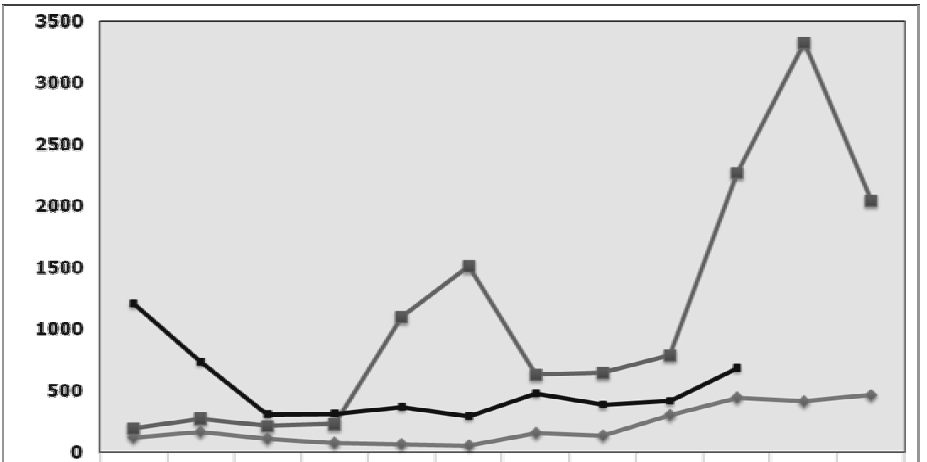
- 385 Mobile Medical Units upgraded as Hospital on Wheels at a cost of Rs.40 crore.
- Team consists of a Doctor, a Staff Nurse and a Lab. Technician.
- 255 vehicles fabricated and sent to field.
- Purchase of 100 new vehicles through TNMSC completed and sent to Bharidhabath and Jaipur for fabrication.

INCIDENCE OF VBDC – 2011 - 2013

Sl. No	Name of the Disease		2011		2012		2013 (1.1.13 to 27.10.13)	
			Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Dengue		2501	9	13204	66	5181*	0
2	Malaria		22171	0	18869	0	12317	0
3	Chikungunya		327	-	514	-	626	-
4	AES/JE	AES	762	29	954	72	52	6
		JE	27	4	33	5	21	0
5	Leptospirosis		3616	0	3587	1	1799	0
6	Scrubtyphus		563	0	783	1	465	0

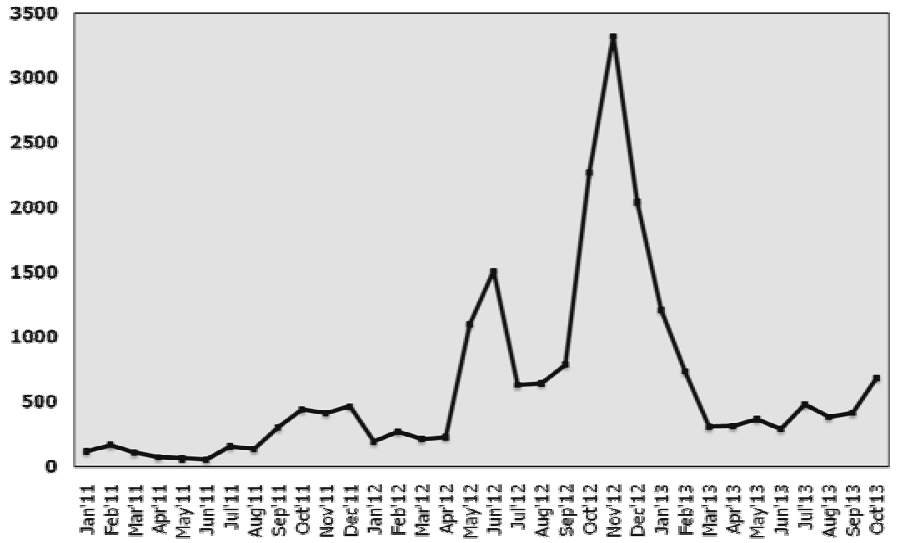
*** Upto 30.10.2013**

MONTH-WISE DENGUE CASES - 2011 TO 2013 (1.1.13 TO 30.10.13)

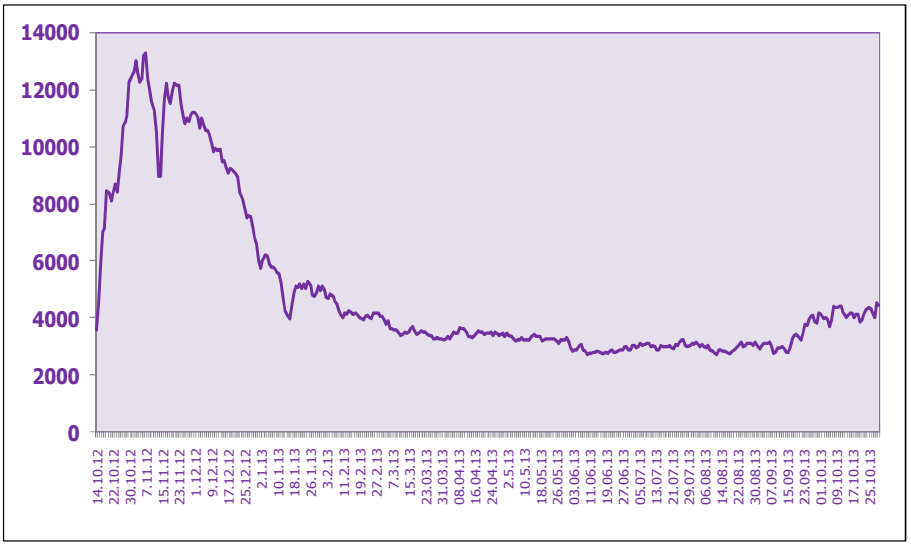


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2011	119	167	109	74	66	55	157	135	301	441	413	464
2012	193	270	213	228	1097	1509	631	643	787	2269	3324	2040
2013	1208	735	306	313	367	291	478	384	415	684		

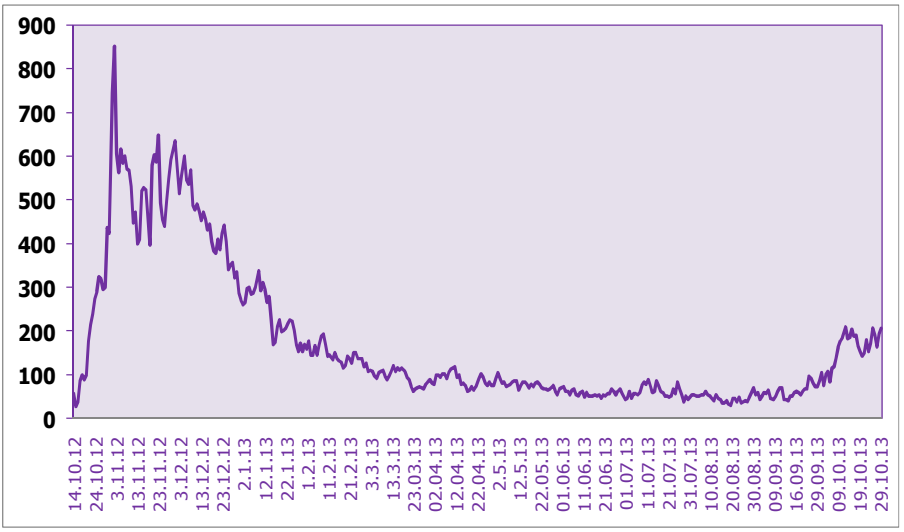
MONTHWISE DENGUE CASES - 2011 TO 2013 (1.1.13 TO 30.10.13)



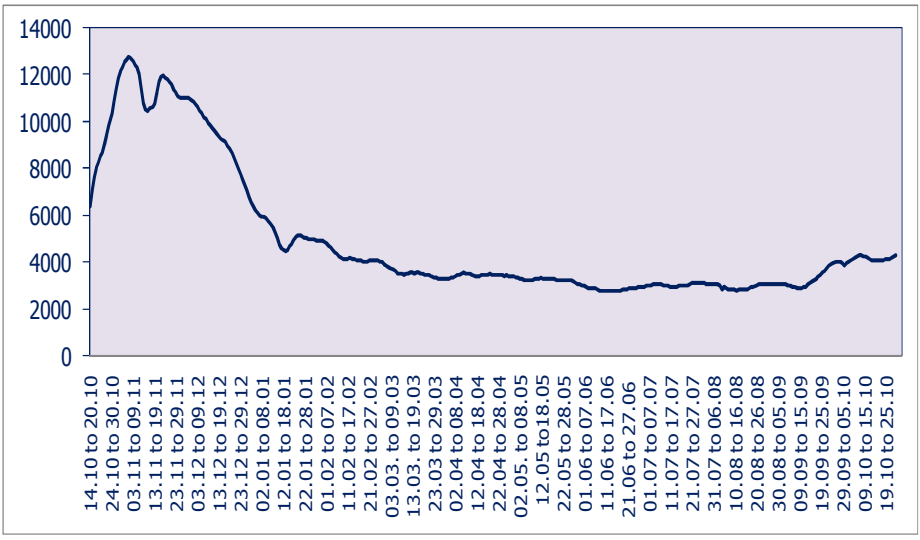
ANALYSIS OF TOTAL IP (IN PATIENT) FEVER CASES IN GOVT. & PVT. HOSPITALS (14.10.12 TO 30.10.13)



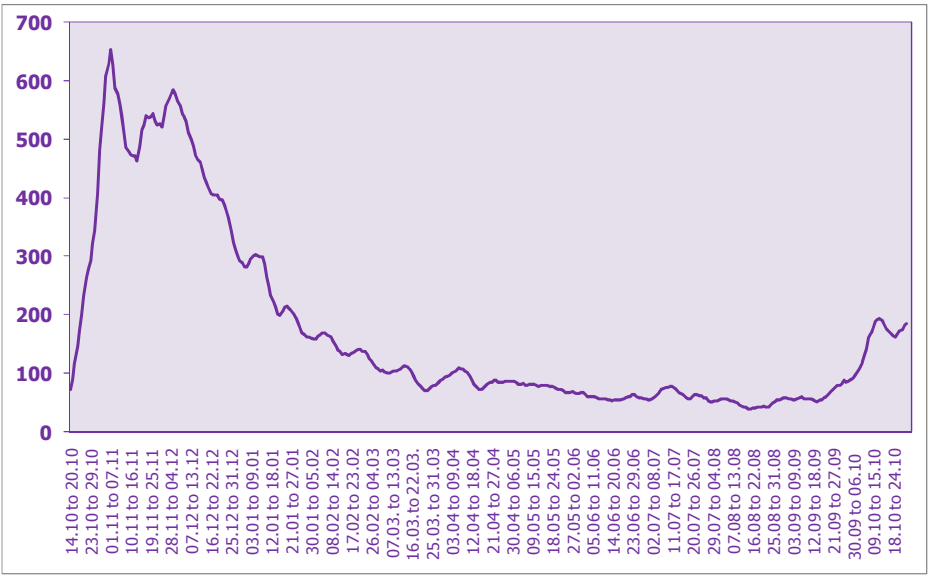
ANALYSIS OF TOTAL DENGUE ELISA POSITIVE CASES AMONG TOTAL IP IN HOSPITALS (14.10.12 TO 30.10.13)



WEEKLY MOVING AVERAGE OF TOTAL IP FEVER CASES IN HOSPITAL FROM 14.10.12 TO 30.10.13



WEEKLY MOVING AVERAGE OF DENGUE ELISA POSITIVE CASES AMONG TOTAL IP IN HOSPITAL FROM 14.10.12 TO 30.10.13



DENGUE

Year	2011	2012	2013* (1/1/2013 to 30/10/2013)
Total number of samples tested	14,015	72,734	24,316
Number of positive cases	2,501	13,204	5,181
Percentage of Positivity	17.8	18.5	21.31
Number of deaths	9	66	0

*One tenth of diagnostic centres are in Tamil Nadu and due to greater awareness people tend to get them tested for Dengue unlike other states where it might pass off as undifferentiated viral fever

STOCK POSITION OF INSECTICIDE / EQUIPMENTS FOR VBDC AS ON 20.10.13

Temephos	9,395 ltrs.
Pyrethrum	12,045 ltrs.
Fogging Machine	1,380 nos.

*Adequate stock available

MASS CLEANING CAMPAIGN

- Considering the last years experience, the Government may order taking up a mass cleaning campaign with special focus on prevention of rain water collection in tyres and other materials.
- Periodical campaign to clean the water tanks every 15 days may be done.
- Campaign may be done by Corporations, Municipalities,Town Panchayats and Village Panchayats using their maintenance funds.
- PWD may take up cleaning of the buildings under their control

HON'BLE CM's INSTRUCTIONS

for providing Siddha Medicines for Dengue fever in TN
Number of patients treated upto 15th October 2013.

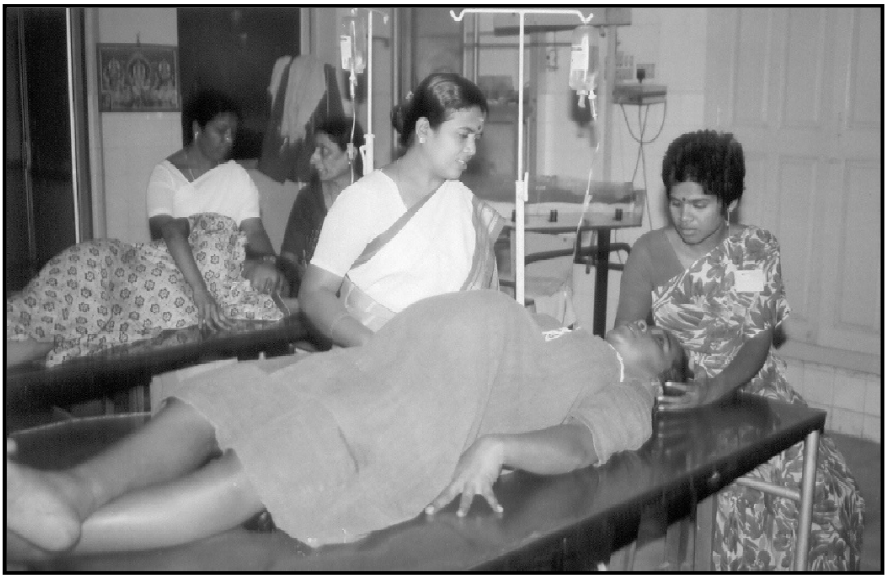
Patients treated at	Papaya leaf juice	Malai vembu leaf juice	Nila vembu leaf juice	Total
ISM out-patient wards as a preventive measure	64,975	55,086	46,78,495	47,98,556
Allopathy inpatient ward	13,149	7,612	3,09,057	3,29,818
ISM Special Camps as a preventive measure	13,678	11,420	6,08,113	6,33,211
TOTAL	**91,802**	**74,118**	**55,95,665**	**57,61,585**

A H1N1 INFLUENZA - Reported as on 31/10/2013

Total samples tested so far – 1925; Positive cases as on date – 0; Positive cases up to date: 30; Death as on date: 0
Upto date death : 4

Sl. No.	Name of the Govt. Hospitals / Pvt. Hospitals	Total positive cases admitted	No .of persons treated & discharged	No of Deaths	No.of cases under treatment in Hospital / House quarantine		Suspected cases in the Hospital
					Hospital Quarantine Ward	House Quarantine	
1	Communicable Diseases Hospital	1	1	0	0	0	0
2	Madras Medical College Hospital	1	1	0	0	0	0
3	ICH - Egmore	0	0	0	0	0	0
4	IOG - Egmore	0	0	0	0	0	0
5	Stanley Hospital	0	0	0	0	0	0
6	Kilpauk Medical College Hospital	0	0	0	0	0	0
7	Coimbatore Medical College Hospital	3	2	1	0	0	0
8	Salem - M.C.Hospital	0	0	0	0	0	0
9	Trichy - M.C.Hospital	0	0	0	0	0	0
10	Trichy - Private	0	0	0	0	0	0
11	Madurai - M.C.Hospital	0	0	0	0	0	0
12	Kanniyakumari - M.C.Hospital	0	0	0	0	0	0
13	Tirunelveli - M.C.Hospital	0	0	0	0	0	0
14	Sri Ramachandra Hospital, Porur	4	4	0	0	0	0
15	C.M.C,Hospital,Vellore	11	9	2	0	0	0
16	Chengalpattu Medical college Hospital	0	0	0	0	0	0
17	Private Hospital -Coimbatore	5	5	0	0	0	0
18	Private Hospital - Thanjavur	0	0	0	0	0	0
19	Private Hospital-Nagercoil	0	0	0	0	0	0
20	Other Private Hospitals(Madurai.Thiruvarur- Appollo Spl,Salem,Karur,Erode,Madurai	1	1	0	0	0	0
21	Thanjavur Medical College hospital	0	0	0	0	0	0
22	Private Hospitals Chennai	0	0	0	0	0	0
23	Jipmer Hospital Pondy	0	0	0	0	0	0
24	Other Government Hospitals	2	2	0	0	0	0
25	Apollo Chennai	2	1	1	0	0	0
26	Govt. Medical College Hospital, Dharmapuri	0	0	0	0	0	0
27	Private hospital Madurai	0	0	0	0	0	0
	TOTAL	30	26	4	0	0	0

MATERNAL HEALTH
BIRTH COMPANION PROGRAMME



MATERNAL DEATH AUDIT AT FACILITY LEVEL

Maternal Death Audit is conducted through Video Conferencing on every 4th Thursday

Maternal Death audit is conducted at the facility level

IMPLEMENTING PROGRAMMES

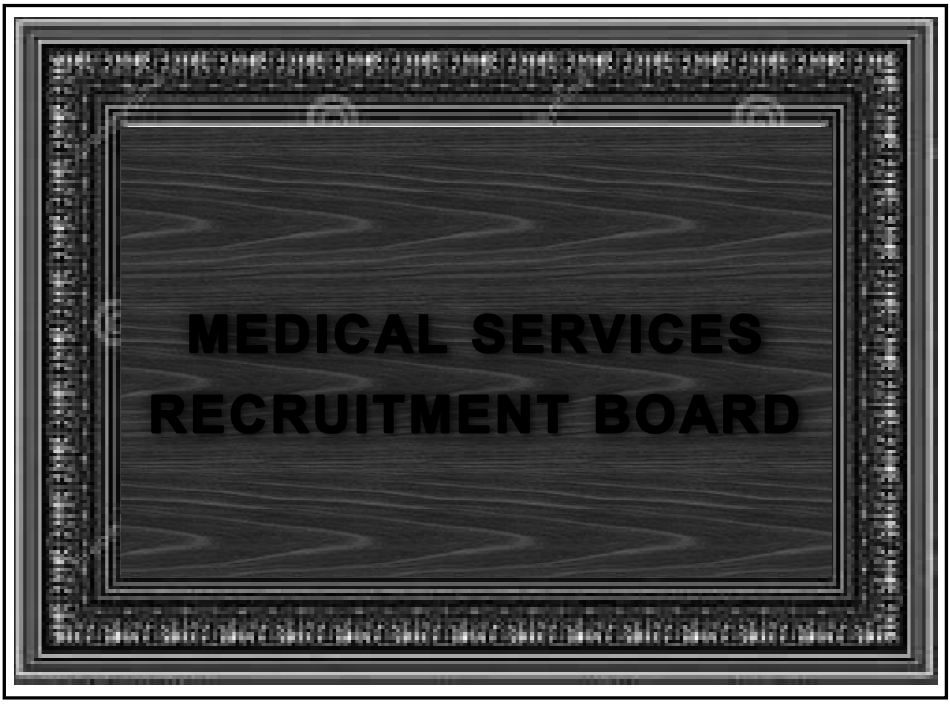
- Permanent Family Welfare Methods - Vasectomy, Tubectomy and Laparoscopic Sertilisation.
- Temporary Methods – Copper-'T' insertion, Oral Pills and Condoms
- Medical Termination of Pregnancy (MTP)
- Emergency Contraception

FAMILY WELFARE PERFORMANCE UPTO SEPTEMBER 2013 (2013-14)

Methods	Annual ELD	Prop. ELD	Achive-ment	%
Sterilization	4,00,000	2,00,000	1,66,794	83.4
IUCD	4,33,000	2,16,500	1,80,374	83.3
CC Users	1,80,000	1,80,000	93,507	51.9

SPACING METHOD & M.T.P. PERFORMANCE 2012-13 & 2013-14 (UPTO SEPTEMBER)

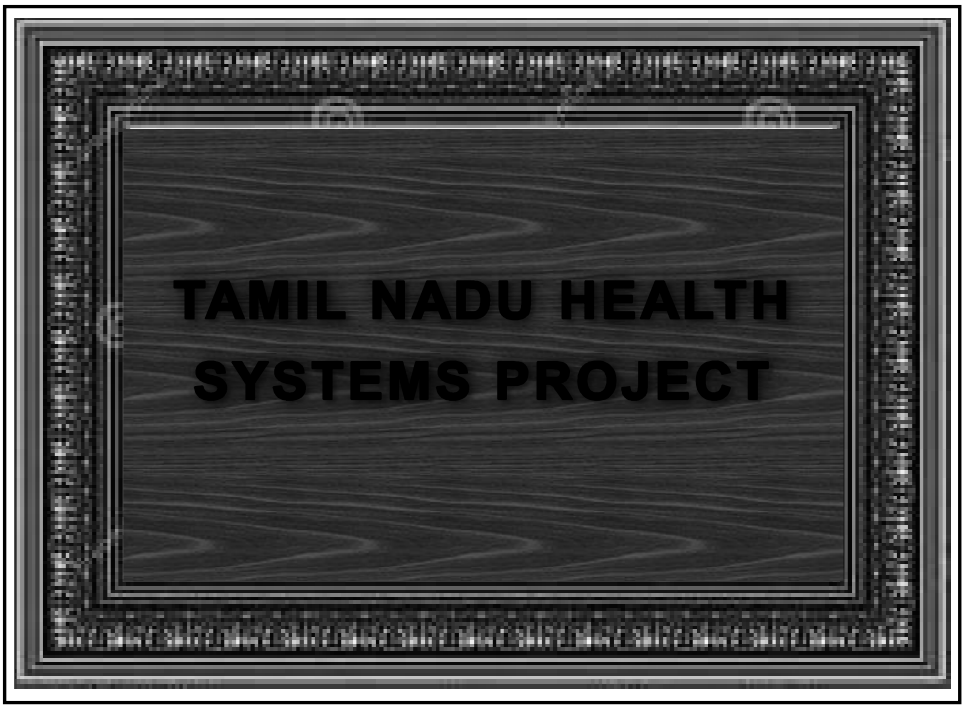
Method	**2012-13**	**2013-14**	**Increase / Decrease**	**% of Inc. / Dec.**
IUCD	163921	180374	16453	10.0
OP Users	29744	11653	-18091	-60.8
CC Users	99902	93507	-6395	-6.4
M.T.P.	28762	30576	1817	6.3



MEDICAL SERVICES RECRUITMENT BOARD

- Established in January 2012 to recruit candidates for all para medical posts and Doctors.
- First of its kind in India.
- Candidates so far selected

Asst. Surgeons (General and Speciality)	2120
Asst. Surgeons (Dental)	54
Pharmacists	344
Radiographers	197
Physiotherapists	18
ECG Technicians	29
Fitter Grade-II	60



PROJECT PROFILE

- Project period (Phase I) - Jan 2005 – Sep 2010
- Project period (Phase II) - Oct 2010 – Sep 2013
- Now being extended - Oct 2013 – Sep 2014
- Project Cost (Phase I) - Rs.597.15 Crores
  (Phase II) - Rs.627.72 Crores

Extension at No additional cost

- Funding Agency : Shared between GoTN & World Bank

FINANCIAL PERFORMANCES

Additional Financing

World Bank loan amount – Rs 564.95 Crores

State share amount – Rs 62.77 Crores

Total – Rs.627.72 Crores

Expenditure upto 30.04.2013 – Rs 364.83 Crores

Expenditure Projections

On 30.09.2013-Rs.471.77 Crores

On 30.09.2014-Rs.627.72 Crores

We have obtained World Bank and GOI extension for the programme till 30-9-2014

CEmONC PROGRAMME

- Establishment of 24 hours Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services in 125 hospitals
- TNHSP has provided
  - Buildings
  - Equipment
  - Specialist Doctors
  - Staff Nurses
  - Training
- Monitoring by reports, inspections and video conference

CEmONC PROGRAMME

Fully Functional CEmONC Centers with round the clock availability of specialists and services

(i) 20 Hospitals attached to medical colleges

(ii) 61 Secondary care hospitals

EmONC Centres :

44 Secondary care Hospitals

- Efforts are taken to post more specialist doctors to EmONC hospitals

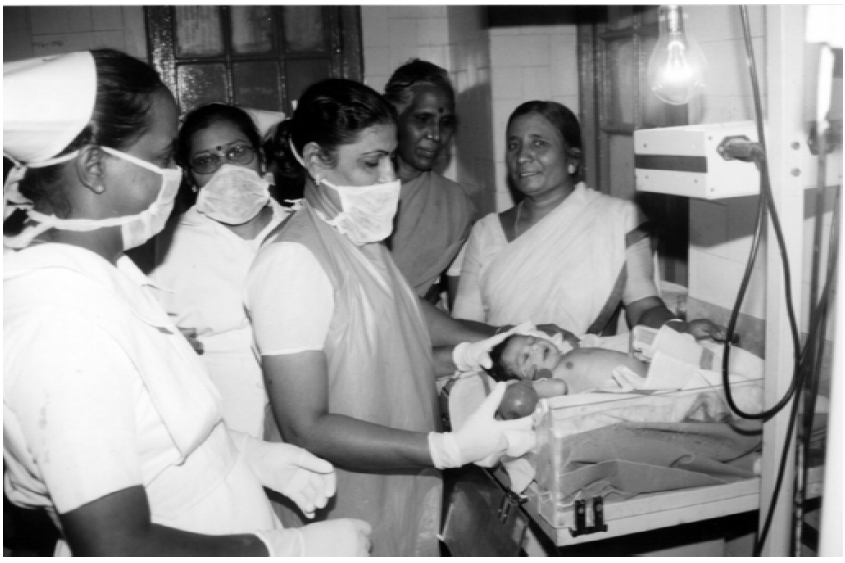
CEmONC PROGRAMME

Activities	2004-05 (Base Year)	2007-08	2009-10	2011-12	2012-13
Maternity Admissions	1,78,815	1,76,071	1,64,389	1,79,663	1,96,189
Complicated Maternal Admissions	30,707	93,140	1,00,119	1,08,216	1,25,171
Neonatal Admissions	70,595	1,17,172	1,11,765	1,13,588	1,27,932
Complicated Neonatal Admissions	11,593	21,914	26,676	36,484	41,152

CEmONC PROGRAMME

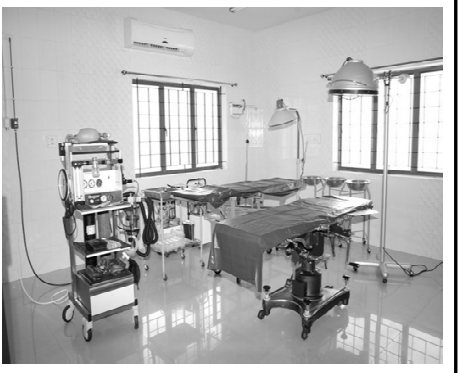
Details	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Deliveries	1,16,065	1,39,115	1,29,335	1,32,545	1,30,630	1,41,132	1,57,693
Caesareans	27,807	38,590	42,494	50,121	53,039	62,233	73,504
Night Caesareans	6,974	9,242	9,536	11,406	11,921	15,173	18,763

COMPREHENSIVE EMERGENCY OBSTETRIC AND NEONATAL CARE SERVICES

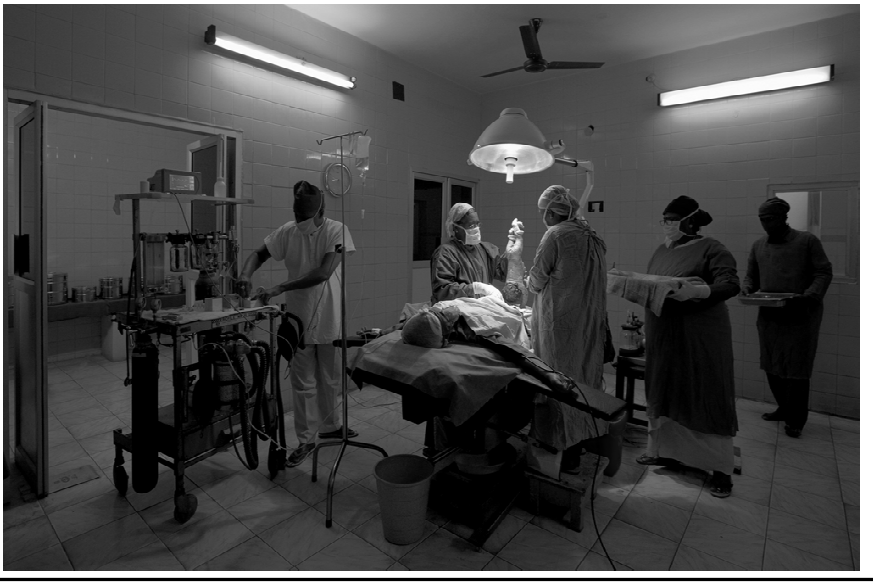


INFRASTRUCTURE UPGRADATION

163 First Referral Units and CEmONC centers provided with essential equipments for maternal and child care including central oxygen supply .



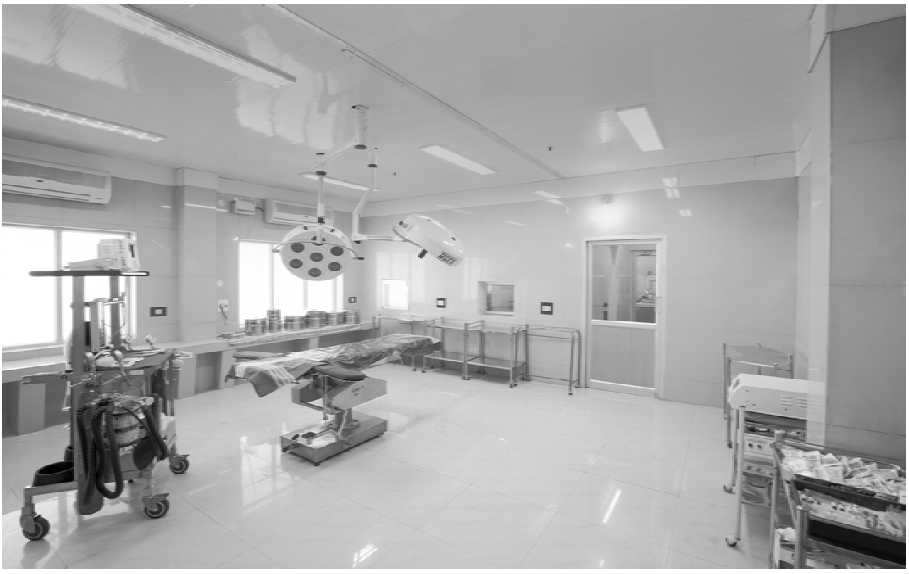
CAESAREAN OPERATION IN PROGRESS, PERIYAKULAM GH



TRIBAL OUTREACH SERVICES

114 DELIVERY POINTS IN SECONDARY CARE INSTITUTIONS ARE UPGRADED TO NEW BORN STABILIZATION UNIT (NBSU)

OPERATION THEATRE, PADMANABHAPURAM GH



NON COMMUNICABLE DISEASES

Strategy adopted are

1. Awareness Creation on risk factors leading to CVDs and Cancers through
   - School based
   - Work place based
   - Community based activities
2. Clinic based activities : All persons above 30 years of age coming to hospitals are screened for hypertension and diabetes. Women above 30 years are screened for cervical cancer and breast cancer also.

COLLABORATION WITH NRHM

- Under the 'Pengal Nala Thittam' of the State government through NRHM and Directorate of Public Health, screening camps are held since April 2013 to detect cervical and Breast cancer.
- In co-ordination with NRHM and Directorate of Public Health & PM, it is ensured that screened positive cases are brought into the NCD registration in the respective PHCs.

POSTING OF FEMALE NCD STAFF NURSES

- Government have sanctioned 2432 female NCD Staff Nurses for the hospitals and PHCs for implementation of NCD programme .
- 1092 Nurses already recruited on contract available with the department for 16 phase-I districts
- 1212 nurses needed for Phase-II districts could not be recruited due to legal constraints
- Government issued orders to outsource these nurses and 1212 have been outsourced since March 2013

IEC PROGRAMME

- Massive IEC Programme launched for NCD to bring in behavior change in the community
- TV spots
- Jingles in FM Radio
- Posters

Resulting in people coming to hospitals and PHCs for check up of their Hypertension and diabetes status and women in addition for screening for Cervical and Breast cancer

NCD PERFORMANCE

NCD Programme	JULY'12 TO SEPT'13
Number of Hypertension Screened	79,82,260
Number of Hypertension Detected	6,88,884
Number of Diabetes Screened	49,03,082
Number of Diabetes Detected	2,22,663
Number of Ca Cx Screened	21,77,584
Number of VIA/VILI Positive	81,835
Number of Ca Br Screened	31,69,128
Number of CBE Positive	33,893

108 EMERGENCY MANAGEMENT SERVICES

- MOU signed with EMRI in May 2008. *Further extension given for 5 more years from May'13*.
- Ramped up to a level of 385 by March 2010 and 629 by March 2013.
- All districts covered with an average population cover of 1.15 lakhs.
- Inter Facility transfers were offered as part of EMS for the first time since Oct 2010.
- Neo-Natal services launched in June 2011, for the first time in the country as part of public EMS.
- Expenditure for the year 2012-13 is Rs. 71.14 Cr

'108' PERFORMANCE

Monthly Average Performance						
	2009-10	2010-11	2011-12	2012-13	2013-14	Sep'13
Number of Districts 108 Services Operating	32	32	32	32	32	32
Total Vehicles on road	436	415	436	629	629	629
Total number of calls received in Emergency Response Centre (ERC)	62,07,681	87,50,618	79,03,217	70,10,577	33,62,192	5,10,623
Total Number of Emergency Calls	5,77,502	9,38,976	8,02,002	7,98,885	5,72,366	97,031
Total Number of Medical Emergencies calls	5,59,924	9,25,653	7,83,511	7,62,784	5,56,592	95,327
i) Availed	3,39,021	5,10,542	5,00,356	6,34,364	3,92,874	67,024
Availed cases/ambulance/day	2.41	3.44	3.14	3.25	3.41	3.55
RTA (Vehicular Trauma)	88,145	1,24,907	1,30,226	1,47,290	89,785	14,729
Pregnancy	93,613	1,28,476	1,39,068	1,60,160	1,01,170	18,264
Others	1,57,263	2,57,159	2,31,062	3,26,914	2,01,919	34,031
ii) Un availed	30,775	40,150	38,676	47,842	22,349	2,367
iii) Vehicle Busy	19,433	98,308	76,647	53,255	10,878	1,401
Police Dispatches	17,179	13,117	18,490	17,597	7,448	992
Fire Dispatches	NA	NA	NA	18,504	8,326	712

'108' WORK IN PROGRESS

- New Building under construction in DMS Complex admeasuring about 72,000 Sq ft.(Cost Rs 12.37 Cr).
  - – Basement completed. Ground + 2 floors.
  - – Completion expected by March 2014.
- 78 Four Wheel drive vehicles planned for hilly & tribal areas. To be deployed by March 2014. Fabrication under progress.
- Expanding patient drop back under JSSK
- 29 Neonatal ambulance – To be deployed by November end.
- 00 BLS – Fabrication Tender opened.
- AVLT device Supply expected by December 2013
- Emergency Care Centre (ECC) – Tambaram GH commenced & Padiyanallur PHC to commence by November end

FREE MORTUARY VAN SERVICES

- Transportation of dead bodies from Government hospitals to burial ground or residence at free of cost Implemented through Indian Red Cross Society, Tamil Nadu Branch.
- Central Response Centre No : 55377
- Total No. of vehicles : 38
- Achievement

from 2011 to September 2013:100384

MORTUARY VAN

MORTUARY VAN INTERIOR

CMCHIS PERFORMANCE
(11.01.2012 to 30.10.2013)

PRE-AUTHORISATION		CLAIMS	
NO	**AMOUNT (Rs. in crore)**	**NO**	**AMOUNT (Rs. in crore)**
5,05,135	1093.80	4,72,659	946.54

ABSTRACT OF MEGA HEALTH CAMPs

No. of Mega Camps	No. Of Hospitals Participated Mega Camp	Referred	Not Referred	Total Screened
704	2620	25200	245,443	270740

SMART CARD DISTRIBUTION

1st PHASE OF CARD PRINTING	NUMBER
No. of cards printed & despatched	1,07,84,627
No. of cards distributed	11,07,52,920
No. of Acknowledgement received	1,07,52,920

2ND PHASE OF CARD PRINTING FOR REMAINING 26 LAKHS NUMBER	NUMBER
NO. OF CARDS PRINTED	23,05,711
NO. OF CARDS RECEIVED BY SDC	21,99,864
NO. OF CARDS DISTRIBUTED BY SDC	21,46,978

CHIEF MINISTER'S COMPREHENSIVE HEALTH INSURANCE SCHEME PERIOD FROM 11-01-2012 CUMULATIVE PREAUTH STATUS REPORT TILL 30.10.2013

S. NO	SPECIALITY	NO. OF PREAUTH. SOUGHT FOR	APPROVED	CANCELLED	DENIED	NEED MORE INFO	PROCESS	APPROVED (%)
1	Cardiology	11509	10346	740	298	118	7	**89.89**
2	Cardiothoracic Surgeries	31373	28069	3047	190	64	3	**89.47**
3	Chest Surgery	83	67	10	4	2	0	**80.72**
4	Dermatology	742	665	48	21	8	0	**89.62**
5	Diagnostics	13	7	5	1	0	0	**53.85**
6	Endocrinology	120	96	15	6	3	0	**80.00**
7	ENT	55043	52006	1954	841	239	3	**94.48**
8	Follow up procedures	470	311	95	44	19	1	**66.17**
9	Gastroenterology	3500	2996	354	93	55	2	**85.60**
10	General Medicine	9962	8976	623	200	158	5	**90.10**

S. NO	SPECIALITY	NO. OF PREAUTH. SOUGHT FOR	APPROVED	CANCELLED	DENIED	NEED MORE INFO	PROCESS	APPROVED (%)
11	General Surgery	33113	29333	2472	976	328	4	**88.58**
12	Genitourinary Surgery	40568	36556	2962	898	147	5	**90.11**
13	Gynaecology & Obstetric Surgery	30005	26536	2293	978	193	5	**88.44**
14	Hepatology	10558	9947	295	263	39	14	**94.21**
15	Interventional radiology	1902	1524	238	82	57	1	**80.13**
16	Medical Oncology	79339	73335	3804	1880	301	19	**92.43**
17	Neonatology	22459	21025	951	225	251	7	**93.62**
18	Nephrology	55372	53014	1681	548	122	7	**95.74**
19	Neurology	11518	9892	1003	355	265	3	**85.88**
20	Neurosurgery	16567	14485	1612	356	110	4	**87.43**

S. NO	SPECIALITY	NO. OF PREAUTH. SOUGHT FOR	APPROVED	CANCELLED	DENIED	NEED MORE INFO	PROCESS	APPROVED (%)
21	Ophthalmology Surgeries	32890	28563	2712	1521	78	16	**86.84**
22	Orthopedic Trauma	22643	19146	2246	1048	189	14	**84.56**
23	Paediatric Intensive Care	10293	8921	848	320	201	3	**86.67**
24	Paediatric Surgeries	3202	2695	308	135	64	0	**84.17**
25	Paediatrics	2326	1961	223	81	61	0	**84.31**
26	Plastic Surgery	11709	10291	853	443	119	3	**87.89**
27	Poly Trauma	1840	1439	169	197	33	2	**78.21**
28	Pulmonlogy	2233	1937	199	50	47	0	**86.74**
29	Radiation oncology	22821	20900	1419	402	97	3	**91.58**
30	Replacement	12405	10371	1226	780	28	0	**83.60**

S.NO	SPECIALITY	NO. OF PREAUTH. SOUGHT FOR	APPROVED	CANCELLED	DENIED	NEED MORE INFO	PROCESS	APPROVED (%)
31	Rheumatology	759	675	63	9	12	0	**88.93**
32	Surgical Gastro Enterology	3214	2633	435	106	39	1	**81.92**
33	Surgical Oncology	14020	11413	1602	845	157	3	**81.41**
34	Transplantation	56	43	5	3	5	0	**76.79**
35	Vascular Surgeries	5620	4961	450	157	49	3	**88.27**
Grand Total		**560247**	**505135**	**36960**	**14356**	**3658**	**138**	**90.16**

TRANSPLANTATION/HIGH END PROCEDURES - DATA

Procedure	Total Attended	Approved	Preauthorisation Applied	Preauthorisation Approved	Approved Amount (Rs. in lakhs)	Claims Submitted
COCHLEAR IMPLANT	677	595	456	456	677.11	381
RENAL TRANSPLANT	250	200	113	113	162.85	94
LIVER TRANSPLANT	22	16	3	3	4.50	1
BONE MARROW	28	13	5	5	7.26	2
STEM CELLS TRANSPLANT	12	7	5	5	7.45	4
TOTAL	989	831	582	582	859.17	482

PERFORMANCE OF GOVERNMENT HOSPITALS UP TO 30.09.2013

PRE-AUTHORISATION		CLAIMS	
No.	Amount (Rs. in crore)	No.	Amount (Rs. in crore)
1,28,608	**265.01**	**1,16,529**	**237.16**

EXPENDITURE MADE	**Rs. 88.75 crore**
Incentives Distributed(15%)	**Rs. 19.35 crore**
Total no. of beds created in ward 500	**2,726**

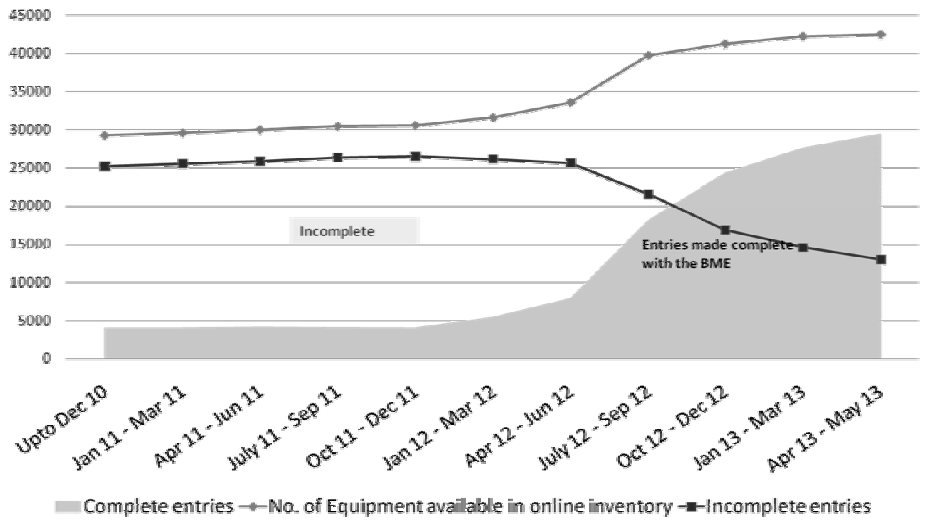
STRENGTHENING OF EQUIPMENT MAINTENANCE IN GOVERNMENT HOSPITALS

A. INVENTORY UPDATION:

- ✓ All medical equipment supplied to the Government medical Institutions have been categorized into
  - A category : value more than 50 lakhs (10 items)
  - B1 category : value more than 25 lakhs and less than 50 lakhs (08 items)
  - B2 category : value less than 25 lakhs (58 items)
  - C category: less value equipment which can be repaired locally.
- ✓ Electronic inventory created in all the 3 directorates (DPH&PM, DMRHS and DME) and the same has been uploaded and being updated as and when new supplies reaches the hospitals.*(by pharmacists with hands on training by BME)*
- ✓ The current status of **complete** equipment inventory is as follows:

S. No	Directorate	Master data	Updated as on 15.11.12	Updated as on 30.04.13
1	DMRHS	874	40008	41011
2	DPH&PM	874	19027	20804
3	DME	187	22320	25235

EQUIPMENT INVENTORY STATUS FOR DM&RHS INSTITUTIONS



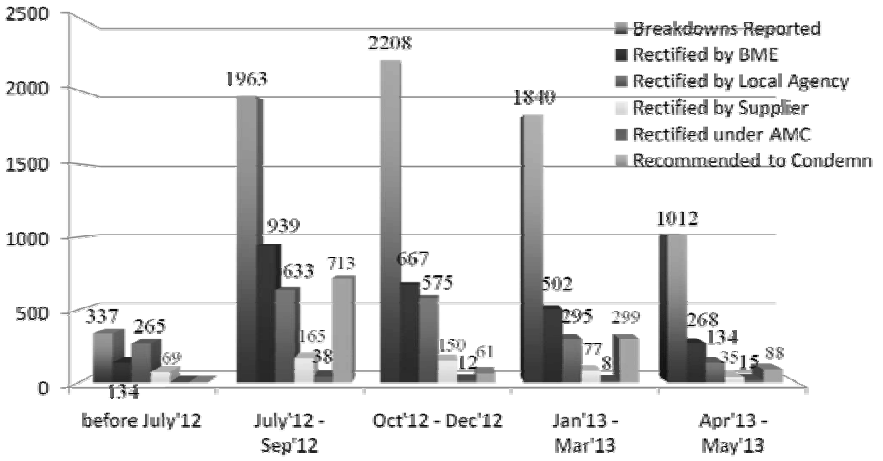
EQUIPMENT BREAK DOWN AND ITS MAINTENANCE

- ✓ 39 Biomedical engineers in addition to the 10 existing, were appointed on May 2012.
- ✓ Central Help desk with numbers 9445030801 (for NICU) and 94450 30802 has been established in TNHSP for the maintenance of the major and essential hospital equipment.
- ✓ Based on the details available in the updated electronic inventory, the Central Help Desk is now facilitating the equipment maintenance across the primary and secondary care facilities in the state there by optimizing the utilization of resources and implementing efficiency.
- ✓ EKAM foundation hired for NICU ; since 24 July 2012; 1341 equipment serviced in 32 NICU centers till date.
- ✓ Now, Annual Maintenance Contract has been executed with M/s. Wipro GE for the 84 nos of USG machines which are in working condition on 15.05.13 and for the balance 47 nos USG machines, which are under break down, the AMC would be executed after rectification of the same, for which orders will be issued soon.
- ✓ Execution of AMC with other major suppliers is in pipeline as mentioned below.,

  1. M/s.Madras Surgicals for 1356 equipment across the state for 20 type of equipment.
  2. M/s. Miti Electronics for 64 equipment across the state for 2 type of equipment.
  3. M/s. Bluestar for 3 equipment across the state for freezer rack

contd

✓ Equipment breakdown reported (exclusive NICU) and its current status is as follows:



TAMIL NADU MEDICAL SERVICES CORPORATION

- Tamil Nadu Medical Services Corporation Ltd.
  ISO 9001:2008 Certified Company, Established in 1994 under the Companies Act
- Procurement & Logistics System for drugs, surgical accessories
- Procure 304 essential drugs, 169 surgical and Suture items, 345 Speciality drugs and 5 Heamophilic drugs
- Funds allotment for drugs Rs.220 crore
- Also procure medical equipments and other accessories, Operates and maintains MRI and CT Scanners
- There are 25 Drug Warehouses

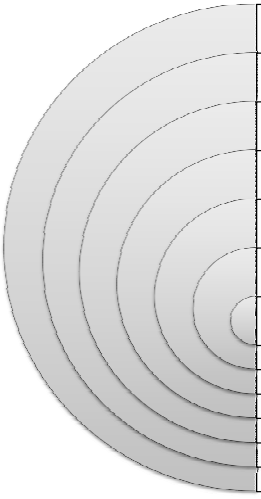
KEY OBJECTIVES

- Centralized procurement of generic drugs
- Essential Drug List of WHO from manufacturers who follow Good Manufacturing Practices.
- Efficient distribution through decentralisation at district drug warehouses
- Simplified indenting facilities for all the health institutions through drug pass book system.
- Ensuring quality drugs procurement
- Authorized capital - Rs. 10.00 crores
  Paid-up capital - Rs. 4.04 crores

Primary Objective

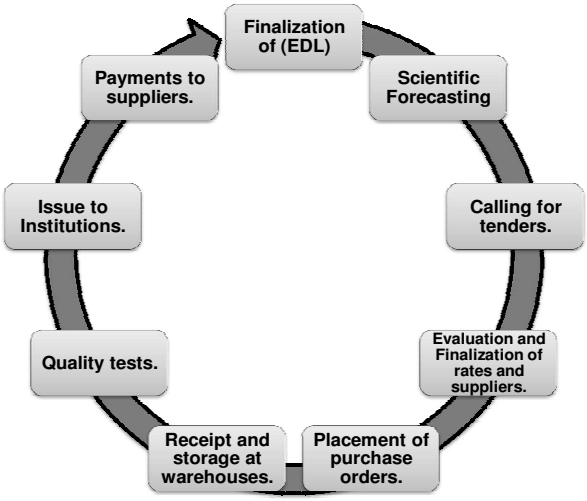
To arrange to deliver on time High Quality Drugs, Medicines, Surgical and Suture items to about 12,000 Government Medical Institutions including Veterinary Institutions.

Plan of Action



Rationalize the drug list.
Quantify requirement - State and District-wise.
Specify dosage size, primary and secondary packaging standards
Procure through national open tender.
Create adequate storage facility.
Create EFFECTIVE communication system within the organization
Create an EFFECTIVE distribution system in every district.

Stages of Procurement Process (Drugs)



Tender Process

In accordance with Tamil Nadu Transparency in Tenders Act, 1998 and rules 2000.

Notice inviting tenders published in news papers, designated websites, Trade journals, letters to drug controllers and Pharma Associations etc.,

Downloading of tender documents from the website.

Tenders to be submitted as two cover system, “Cover – A (technical bid) & “Cover – B”(Price bid).

Tender Process…

- Evaluation of technical bids
- Inspection of manufacturing units for Drugs
- Short-listing bidders for price bid opening
- Negotiation with L-1 bidders
- Approve by Board
- Matching of L-1 rate by other willing bidders for ordering during exigency

Modern Drug Warehouse

Anna Nagar, Chennai

Thiruvannamalai

Automated Material Handling System …

Anna Nagar, Chennai - Warehouse

Quality Tests

Quality with no Compromise

Samples from Warehouses within 3 days

⇩

Eliminating Common Batch at HO

⇩

Supplier identification Removed and Separate code given

⇩

Sent to empanelled LABS

⇩

Receipt of Results

⇩

If failed, samples are sent to Government Analystfor reconfirmation.

If Failed Return to Supplier

If Passed Distributed to Institutions

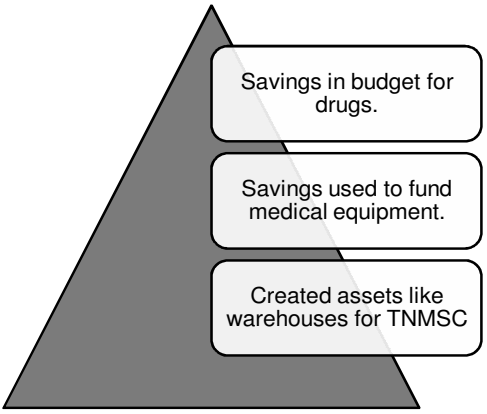
Issue to Institutions

- Through Pass book system on value basis.
- Indent by the concerned Medical Stores officers.
- Two pass books maintained per institution, one with the Institution and another with warehouse.
- Values debited on drawls on the values allocated by the heads of the Departments.
- Additional allocation required for additional drawls.
- Monitored by Inward Indent/Issue form, Outward Goods Register. Link to medical college hospitals' central stores to monitor stock position at hospital for advance action.
- Procurement of drugs by all medical institutions from the respective warehouses at specified, predetermined frequency.
- Delivery to Medical College Hospitals by TNMSC's transport arrangement. For Others fuel cost reimbursed

Strengths of TNMSC

- Total transparency of operations
- No drug shortage
- Quality ensured
- Overall price stability
- Savings in budget.
- Substantial improvement in availability of quality drugs at the grass-root level
- Reduction in average price paid for drugs up to 50 percent in case of certain drugs
- Increase operational efficiency of the system
- Increased cost effectiveness

Savings in Budget



Awards and Appreciation …

Winner of "best e-Governance initiative award"

Winner of "Rajiv Gandhi Quality Award"

Published in WHO "MONITOR"

Acclaim by World Bank - How to beat in-efficiencies in drugs procurement, and there by improve rural health service delivery: the TNMSC

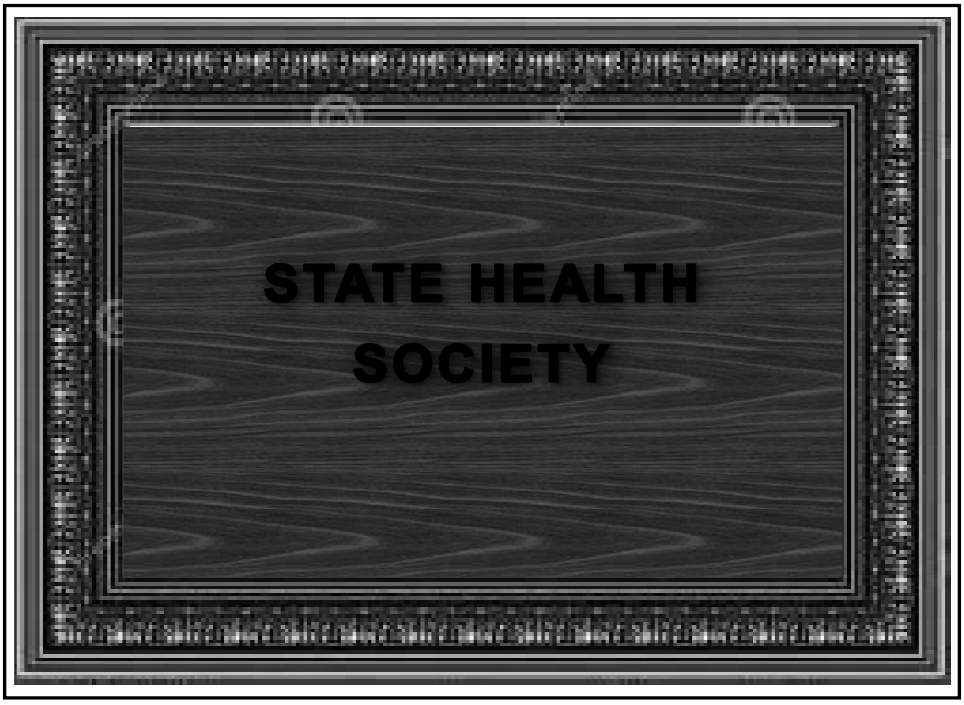
Source: World Bank (2004)

STOCK POSITION

Sl. No.	Description	Value
1	Drugs and Medicines	72,09,62,344.00
2	Special Surgical items	13,79,05,852.00
3	Surgical Items	4,58,03,502.00
4	Suture items	4,82,74,635.00
5	Speciality Drugs	3,31,58,658.00
6	Heamophilic Drugs	78,67,810.00
7	ICDS Drugs	73,07,086.00
8	RCH Drugs	4,33,24,170.00
9	TNHSP Drugs	1,56,17,254.00
	TOTAL VALUE	**106,02,21,310.00**

OUTSOURCING

- Tenders are under finalization in TNMSC for outsourcing of sanitary workers and security personnel in 31 medical institutions of DME and 48 medical institutions of DMS
- Orders will be issued shortly



NATIONAL RURAL HEALTH MISSION

- Government of India launched the Mission in April 2005.
- Funding sharing pattern was 85:15 between Government of India and State Government.
- Extended the Project in the 12th Plan period for 5 years.
- Current funding sharing pattern is 75:25

IMPORTANT PROGRAMMES

- 24x7 hour delivery care services in all PHCs.
- Janani Suraksha Yojana
- Janani Sishu Suraksha Karyakaram
- Strengthening of RCH and Maternity Service
- Providing feeding and dietary charges for ante-natal mothers.
- Hiring of Obstetricians and Anaethetist for emergency obstetric care.
- Establishment of Blood Storage Centres in upgraded PHCs.
- Establishment of Neo-Natal Intensive Care Units (NICU) and Sick Neo-Natal Intensive Care Units (SNCU)

IMPORTANT PROGRAMMES

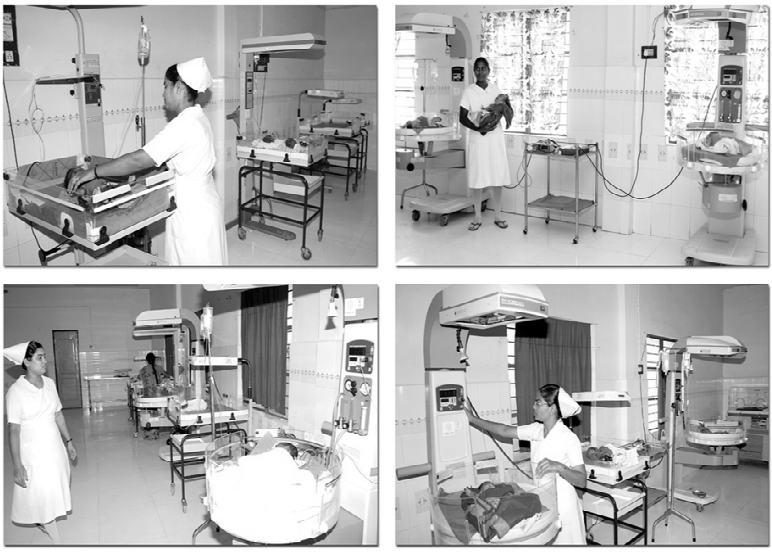
- Aneamia Control Programme
- Modified School Health Programme
- Establishment of New PHC and Upgradation of PHCs.
- Repairs and Renovation of the existing PHCs and HSCs.
- Appointment of ASHA
- Patient Welfare Society
- Village Health Water Sanitation and Nutrition Committee.
- Mainstreaming of AYUSH.
- Provision of Dental Services in rural areas.
- Annual Maintenance Grants and Untied Grants to Health Facilities

NATIONAL URBAN HEALTH MISSION

- Govt. of India launched the National Urban Health Mission on 1st May 2013 to take care of the primary health care needs of the urban poor.
- Centre-State sharing 75:25
- Except for Chennai Corporation, Health Department responsible for implementation
- For Chennai Meha City, NUHM implementation through local body
- Provisional resource envelope for Tamil Nadu to be received from Govt. of India
- Sensitization workshop organised on 14th June for Urban Local Bodies

- Already established 135 Urban PHCs brought under DPH control.
- Formation of Urban Health Cell in the State PMU, inclusion of addition members in State Health Mission, Governing Body, Executive Committee, formation of City Urban Health Society, City Project Management Unit etc. is under progress.
- Project Implementation Plan (PIP) sent to Government of India for approval.

NEONATAL ICU



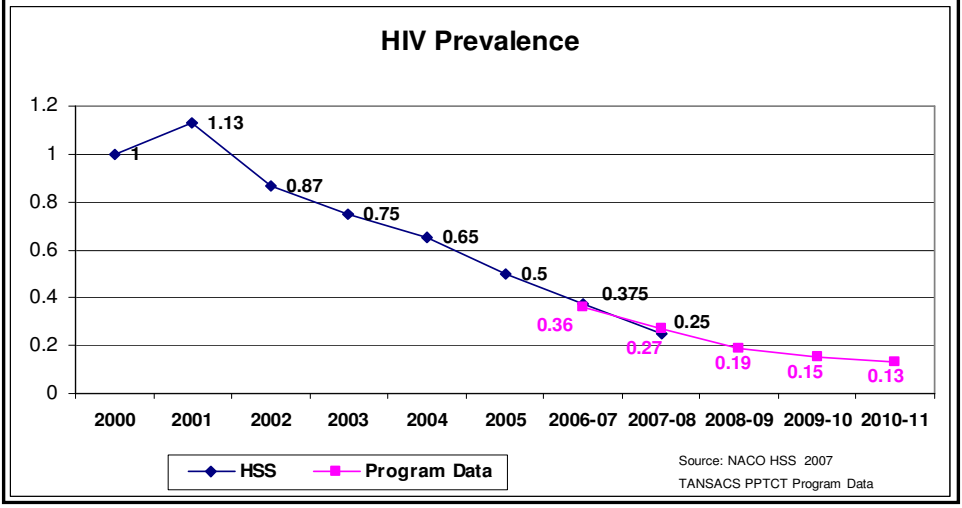
NEONATAL INTENSIVE CARE UNIT

NEWBORN INTENSIVE CARE UNITS (NICU)

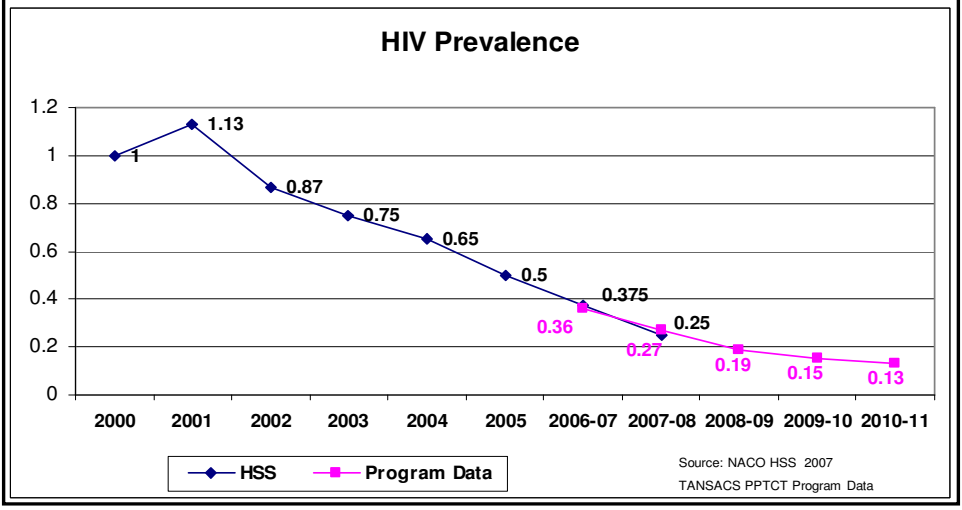
24 HOUR BLOOD BANK

TAMIL NADU STATE AIDS CONTROL SOCIETY

HIV Prevalence among Ante Natal Clinic Attendees



HIV Prevalence among Ante Natal Clinic Attendees - Sentinel Surveillance (2000-2007)
Percentage of AN Mother Detected HIV Positive (PPTCT Program Data 2006-2011)



Basic Service Division
Integrated Counseling and Testing Centers

- Single dose PPTCT programme replaced by TLE regimen in March 2013.
- New TLE regimen reduces mother to child HIV transmission from 10% to less than 5%.

PREVENTION OF INFECTION

- Interventions for Specific Groups (Targeted Intervention) FSW-16 , MIGRANT-7, MSM-11, TG-2, Composite-44, Truckers-5, TOTAL-86

- Programs for General population
  - Integrated Counselling and Testing Centres (ICTCs)
  - Prevention of Parent to Child Transmission (PPTCT)
  - Sexually Transmitted Infections (STIs)
  - HIV – TB Collaboration

- Blood Safety & Quality Assurance
- Information, Education and Communication (IEC)

Integrated Counseling and Testing Centers (ICTCs)

Stand Alone	Public Private Partnership	Facility Integrated	Total
795	76	600	1471

Counseling - Target (2013-14)	Achievement (Upto Sept.13)	Total HIV Positive (Upto Sept.13)	General Population Positive (Upto Sept.13)	ANC Positive (Upto Sept.13)
25 Lakhs	13.67 Lakhs	8388	8060	328

- **1471 Counseling and testing services provided to 13.67 lakh people (April – Sept. 2013)**
- **Additional PHCs are already covered**
- **NRHM supports 402 PHCs level ICTCs**
- **Branding of ICTCs**
- **Strong linkages with TI and LWS projects**
- **There is a need for enhancing the response of the private sector – 124 identified.**

Blood Safety

Total Blood Banks	278
Govt. Blood Banks	85
Govt. undertaking BBs	09
Private blood banks	184
Govt. Blood Component Separation Units	15
Govt. Blood Storage Centres	196
Mobile Blood unit	3
Blood transportation van	17

Blood donation area

- **Specific focus on Voluntary blood donation and camps**
- **Celebrity involvement for encouraging blood donation**
- **Voluntary blood collection**
  - **Govt. Blood Banks – 99%**
  - **Private Blood Banks – 95%**

Special Initiatives

- Orphan and Vulnerable Children (OVC) Trust for HIV infected and Affected Children
- Free Legal-aid clinics
- Red Ribbon Clubs for Colleges
- Life Skill Education Programme (LSEP) in Govt. and Govt. Aided Schools
- Post Graduate Diploma in HIV Epidemiology course.
- Free Bus pass for ART patients (2 travel/month)
- Monthly Monetary benefit Scheme for Farmers infected with HIV on ART through “Uzhavar Paathukappu thittam” .
- PLHIV included as Target Beneficiary under “Pudhu Vazhvu Thittam”
- PLHIV given preference under “Pasumai Veedu Thittam”.

Getting to Zero

FOOD SAFETY AND DRUG CONTROL ADMINISTRATION

COMMISSIONARATE OF FOOD SAFETY IN TAMIL NADU

- The Food Safety and Standard Act 2006 Central Act (34 of 2006) is being implemented in Tamil Nadu State with effect from 05.08.2011
- Designated Officers appointed for 32 Revenue Districts.
- 584 Food Safety Officers appointed (385 for rural + 199 for urban).
- Six Food Analysis Laboratories functioning.

147

FSSA-FBOs REGISTRATION AND LICENSING STATUS UPTO 30.04.2013

	Govt. Institutions	Private FBOs	Total
Registration	42176	177211	219387
License	3055	29782	32837

148

SAMPLES RECEIVED AND ANALYSED FROM 05.08.2011 TO 30.04.2013

Category	Received	Analysed	Safe	Unsafe
Milk	403	401	363	38
Mineral Water/Packaged Drinking Water	470	469	225	244
Beverages	110	107	71	36
Fruit & Vegetable Products	38	38	25	13
Oil	90	87	23	51
Others	723	709	446	263

WATER SAMPLES ANALYSED AS PER GREEN TRIBUNAL ORDERS

No. of samples analysed	Safe	Unsafe
805	663	142

RIPENING OF FRUITS USING CARBIDE - DESTROYED

30 Tonnes of mangoes ripened using carbide stone/gas seized and destroyed in the current mango season.

BAN ON GUTKHA AND PAN MASALA

As per the announcements of Hon'ble Chief Minister

- Gazette notification issued on 23.05.2013.

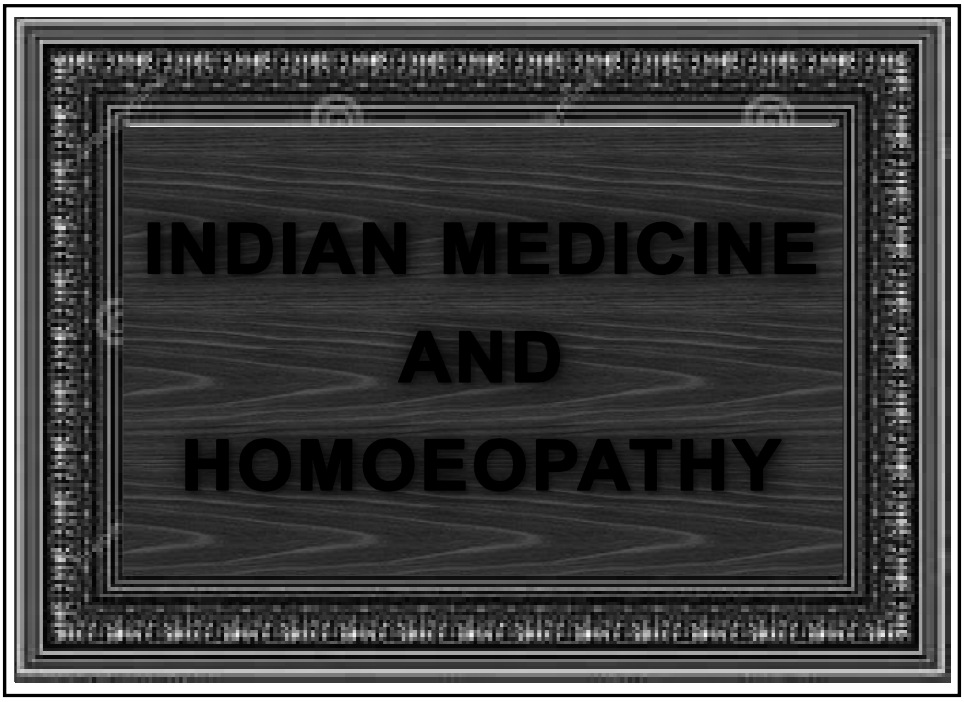
  "Prohibiting manufacture, storage, distribution, sale of Gutkha and Pan masala and any other food products containing tobacco or nicotine as ingredients."

- A committee formed under the chairmanship of District Collector involving Revenue, Commercial Tax, Police, Transport etc., to oversee the implementation.

- So far 57620 shops inspected; 196 Tones of Gutkha and Pan masala; Seized products value Rs.2.46 crore

FUNCTIONS OF THE DEPARTMENT

- Enforces the following Acts for regulating the manufacture, distribution and sale of drugs and cosmetics.
  - ✓ Drugs and Cosmetics Act, 1940 and Rules, 1945.
  - ✓ Drugs Prices Control Order, 1995
  - ✓ Drugs and Magic Remedies (Objectionable Advertisement) Act 1954
- Drug Controller is the licensing authority for manufacture and sale of allopathy and Homeopathy medicines and cosmetics.
- He is also licensing authority for blood banks in the State along with Central Approving Authority.
- There is model Drug Testing Laboratory for testing of samples drawn by the Drug Inspectors.



NUMBER OF GOVERNMENT AND PRIVATE MEDICAL COLLEGES OF ISM

Sl. No.	Medical System	No. of colleges	
		Govt.	Private
1	Siddha	2	5
2	Ayurveda	1	3
3	Unani	1	--
4	Homeopathy	1	8
5	Yoga & Naturopathy	1	4
Total		**6**	**20**

NUMBER OF SEATS AVAILABLE IN THE GOVERNMENT COLLEGES AND THE PRIVATE COLLEGES.

Sl. No.	Discipline	Details of Seats available for admission				
		Government Colleges		Private Colleges		Total
		UG	PG	UG	PG	
1.	Siddha	150	94	200	--	444
2.	Ayurveda	50	--	160	--	210
3.	Homoeopathy	50	--	400	24	474
4.	Yoga & Naturopathy	20	--	200	--	220
5.	Unani	26	--	--	--	26
Total		**296**	**94**	**960**	**24**	**1374**

NUMBER OF SEATS SANCTIONED FOR DIPLOMA COURSE IN INTEGRATED PHARMACY AND FOR NURSING THERAPY

Sl. No.	Name of the Institution	Number of seats		Total
		Diploma in Integrated Pharmacy	Diploma in Nursing Therapy	
1.	Arignar Anna Government Hospital of Indian Medicine, Chennai	50	50	100
2.	Government Siddha Medical College, Palayamkottai, Tirunelveli	50	50	100
Total		**100**	**100**	**200**

INSTITUTIONS UNDER ISM

System	Total
Siddha	1,047
Ayurvedha	100
Unani	65
Homoeopathy	107
Yoga and Naturopathy	56
Total	**1,375**

ISM WINGS LOCATED IN

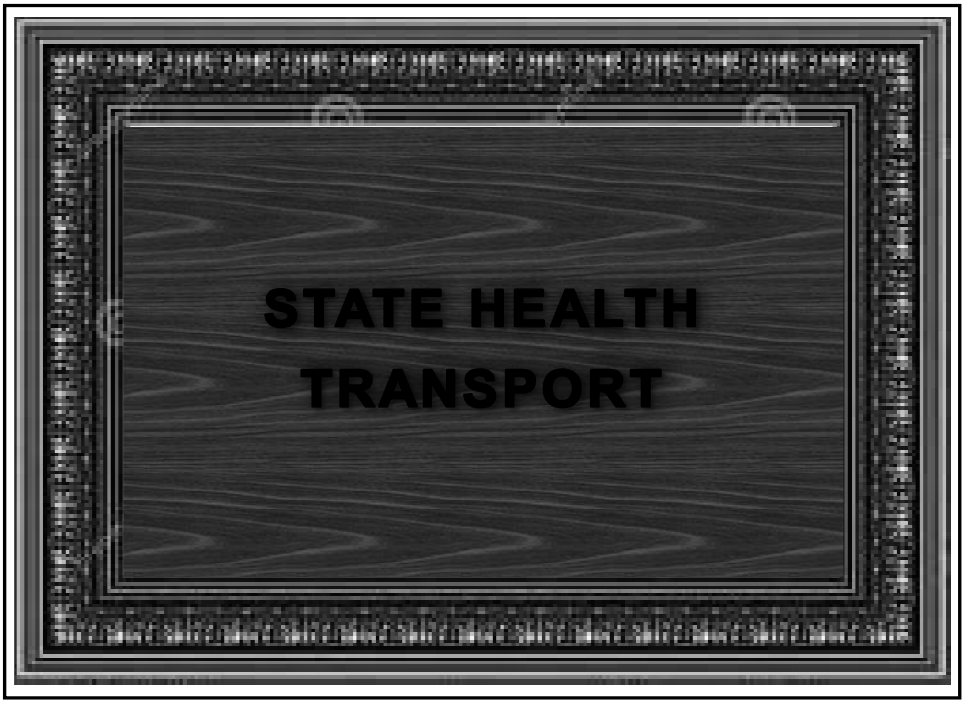
- District Headquarters Hospitals – 30
- Taluk and Non-taluk Hospitals – 231
- Primary Health Centres – 954 (475 wings under NRHM)

ISM MEDICINES

- State licensing authority appointed under Drugs and Cosmetic Act for issue of licenses exclusively for Siddha, Ayurvedha and Unani Drugs.
- District Siddha Medical Officer are the Drug Inspectors.
- Drug Testing Laboratories established for quality control of ISM medicine.

TAMPCOL

- Established in the year 1983.
- Currently manufacturing 92 ISM medicines – 58 Siddha Medicines, 26 Ayurveha and 8 Unani.



- Department formed exclusively for maintenance of the vehicles under the control of the Health Department.
- Maintenance 2739 vehicles of various Directors under the control of Health Department.
- Seven Regional Workshops and 29 Mobile Workshops established to attend the repair works.

PROPOSALS PENDING WITH GOVERNMENT OF INDIA

- National Institute of Ageing at a cost of Rs.142.60 crore
- Advance Nursing Institute
- Metro Blood Bank at Chennai
- Central Vaccination Institute at Chengalpattu in 100 acres being handled by Industries department

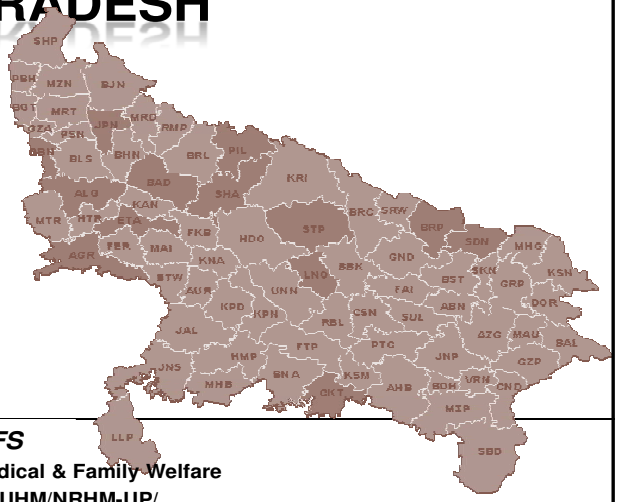
OTHER IMPORTANT ISSUES

- NEET exams – State has its own pattern, GOI has proposed to review the judgement against NEET
- DD Medical College- MCI has permitted legal batch (2010-11) for relocation in Government Medical Colleges–2011-12 and 2012-13 has not been recognized by MCI and State has offerred to accommodate them in courses other than Medicine and Dental- Students and DD medical College has approached High Court
- 350th year of start of Modern Hospital in Chennai – Function to be organised

Thank you

Annexure-VII

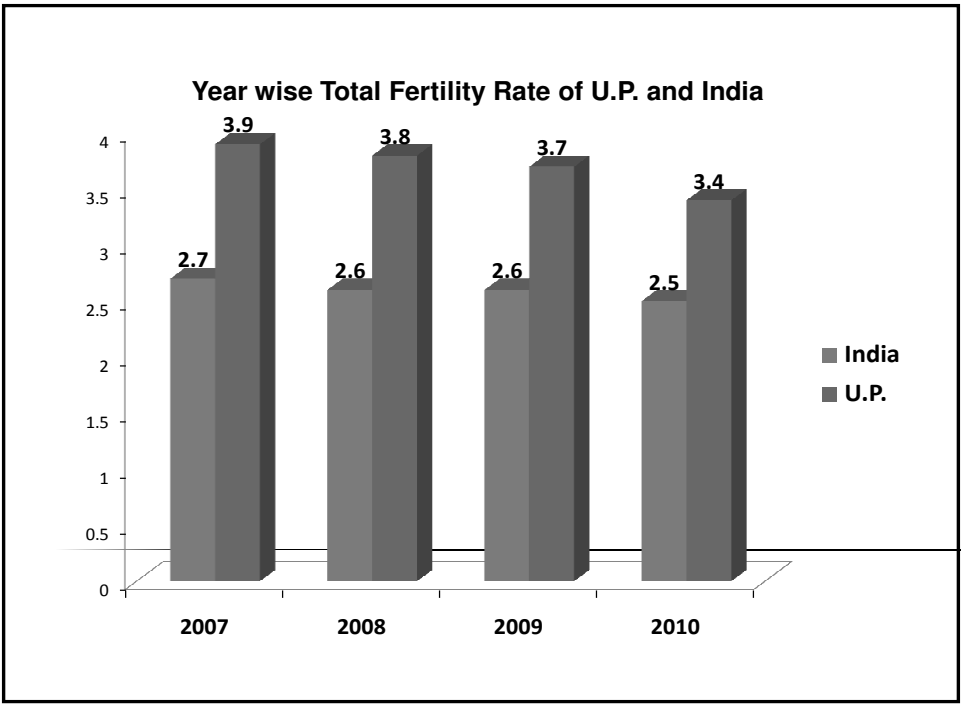
REVITALIZING HEALTH CARE IN UTTAR PRADESH

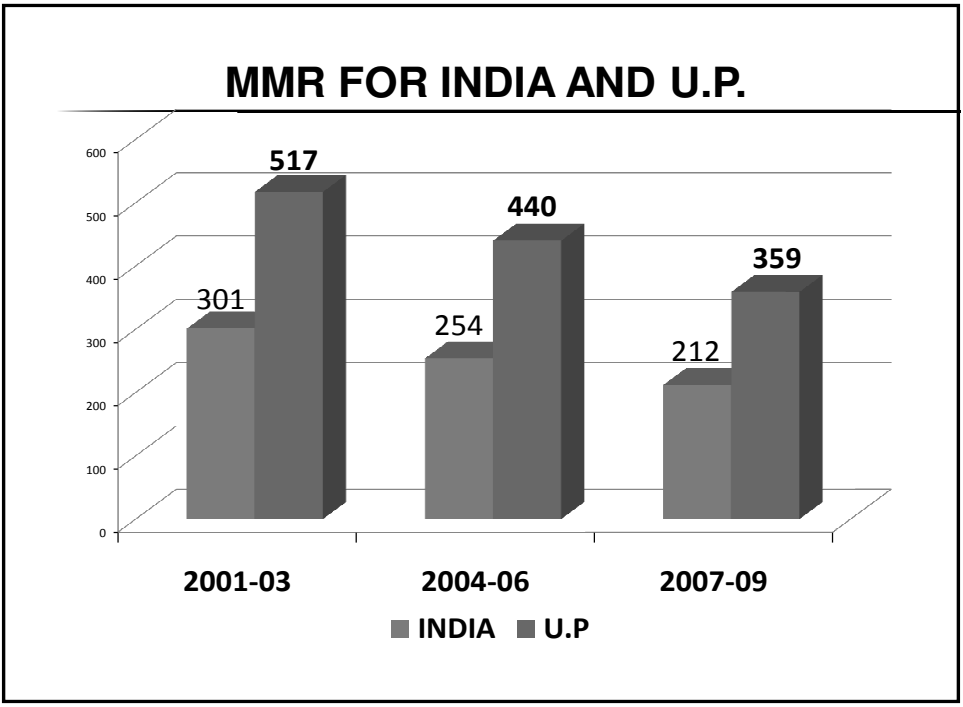


Dr.Shashank Vikram, IFS
Special Secretary, Health, Medical & Family Welfare
Additional Mission Director,NUHM/NRHM-UP/
Additional Executive Director, SIFPSA

CHALLENGES AND CONCERNS

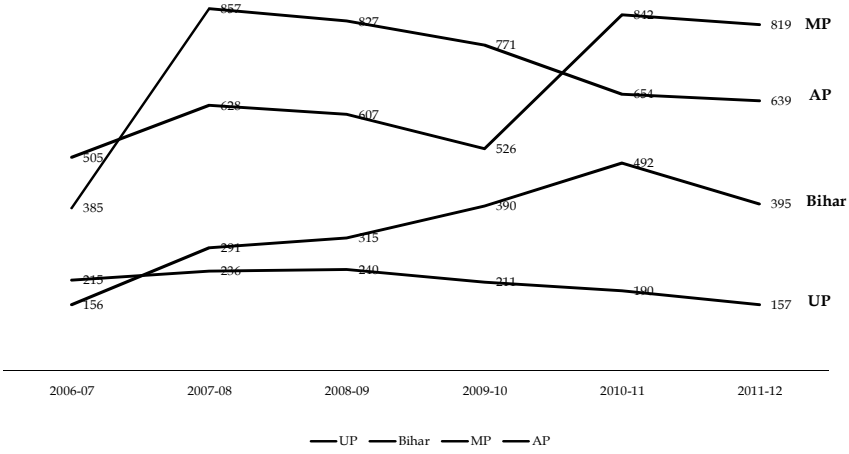
- High Population — **20 Crore** ***(5th Largest country in terms of Popn)***
- Low Female Literacy rate — **59 %**
- 18 Divisions and 75 Districts (*requires huge techno-managerial on-going competence)*
- ANM is working on an average 8000 Population *(IPHS for Popn of 5000 one ANM)*
- Shortage of Human Resource *(highly skilled Gynecologist & Pediatricians)*
- Sub optimal functioning of NBCC & Delivery points
- Insufficient Functional FRU — **174/820** ***(21%)***
- Insufficient SNCU — **26/75** ***(34.7%)***
- Early initiation of Breast feeding — **33 %** ***(AHS2011)***
- Exclusive Breast Feeding — **17-7%** ***(AHS2011)***


Year wise Total Fertility Rate of U.P. and India
4
3.5
3
2.5
2
1.5
1
0.5
0
3.9
3.8
3.7
3.4
2.7
2.6
2.6
2.5
2007
2008
2009
2010
India
U.P.


MMR FOR INDIA AND U.P.
600
500
400
300
200
100
0
517
440
359
301
254
212
2001-03
2004-06
2007-09
INDIA
U.P

Family Planning

Number of sterilization per 100,000 population performed in last 6 years



HEALTH INFRASTRUCTRUE & HR

(OF THE STATE GOVT.)

STATE PROFILE

Sl.	Indicators	No.
1.	Total Population (census 2011)	19.96 Crores
2.	Total Rural Population	15.52 Crores
3.	Total Urban Population	4.44 Crores
4.	Districts	75
5.	Tehsils	312
6.	Blocks	822
7.	Total Towns/ Cities	915
8.	Gram Panchayat	51914
9.	Villages	107480

HEALTH INFRASTRUCTURE

Sl.	Name of Health Facility	No. of functioning Health Facility
1.	Subcentres	20521
2.	Primary Health Centres	3692
3.	Community Health Centres	773
4.	Urban Health Posts (Govt.)	134
5.	District Hospitals	1 57(104 DH/CH and 53 DWH)
6.	Medical Colleges	11 (9 Govt. and 2 centrally aid)
7.	New State Govt. Medical Colleges	9
8.	AYUSH Medical Colleges	17
9.	Nursing Training colleges	12 Govt. and 168 Pvt.
10.	Super Specialty Govt. Hosp	3

HEALTH ADMINISTRATION

- Principal Secretary
- State level:
  - **Directorate of Medical health**
    - Director General , Directors, Additional Directors and Joint Directors
  - **Directorate of Family Welfare**
    - Director General , Directors, Additional Directors and Joint Directors
  - **State Programme Management Unit , National Health Mission**
    - Mission Director, Additional Mission Director (NRHM) Additional Mission Director (NUHM), General Managers and other support staff
- At Divisional level: Additional Directors and Joint Directors
- At District level:
  - Chief Medical Officer, Additional CMOs, Chief Medical Superintendents of District Hospitals

HUMAN RESOURCE AT HEALTH FACILITIES

Sl.	Cadre	Sanctioned posts	In position
1	Medical Officers	14785	10260
2	Staff Nurses	5795	5148
3	Pharmacists	5409	3933
4	Chief Pharmacists	1385	1308
5	Lab Technician	2286	1836
6	ANMs	23578	21166
7	BHW (Male)	8857	2566
8.	Other paramedical Staff	10646	8089
9.	X rays Technician	818	531
10.	Dark Room Assistants	467	112
11.	Physiotherapists	41	13

SHORTFALLS AND POSITIVE ACHIEVEMENTS

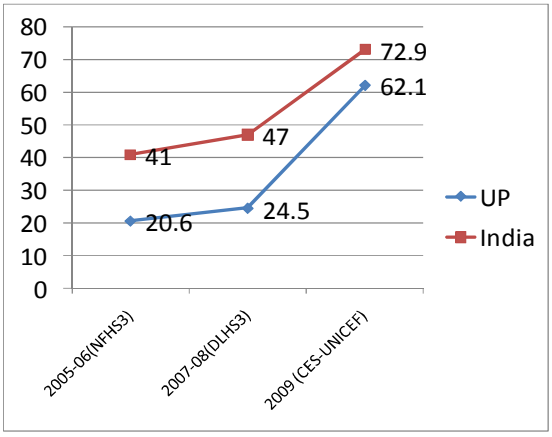
- State has fallen short of achieving the 2011 markers for critical issues such as reducing TFR, increasing age at marriage, complete immunization, TT coverage, increasing the average age of the mother at first birth
- There have been achievements in proposed figures of MMR, IMR, ANC and Institutional Deliveries.

Goals for 2012-2017

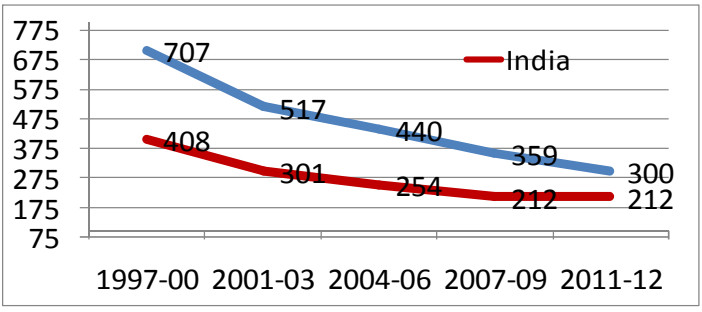
Indicators	Current Status as per available data	Cumulative target for next five years	2012 -13	2013 -14	2014 -15	2015 -16	2016 -17
Maternal Mortality Ratio (MMR)	359 (SRS- 2009)	200	310	280	250	225	200
Infant Mortality Rate (IMR)	57 (SRS -2011)	32	56	51	45	38	32
Total Fertility Rate (TFR)	3.7 (SRS -2009)	2.8	3.6	3.5	3.4	3.1	2.8
Complete Immunization	40.9% (CES - 2009)	90%	50%	60%	70%	80%	90%
Contraceptive Prevalence Rate (CPR)	43.6% (NFHS- III)	53%	45%	47%	49%	51%	53%
Institutional Delivery	62.1% (CES – 2009)	85%	65%	70%	75%	80%	85%

INSTITUTIONAL DELIVERIES

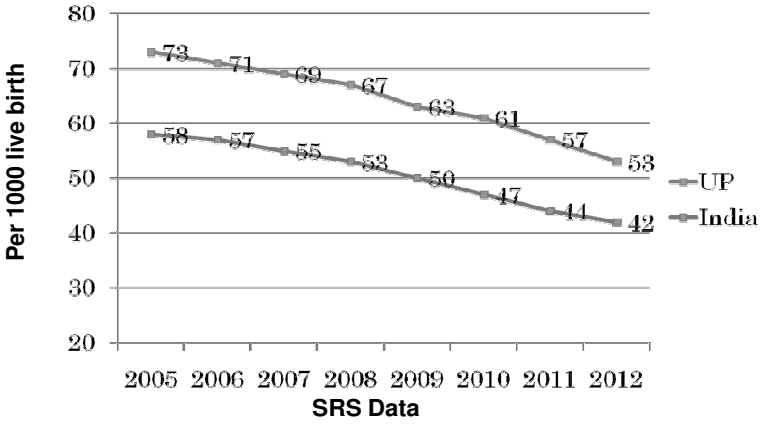
BIG JUMPS FROM A SMALL BASE



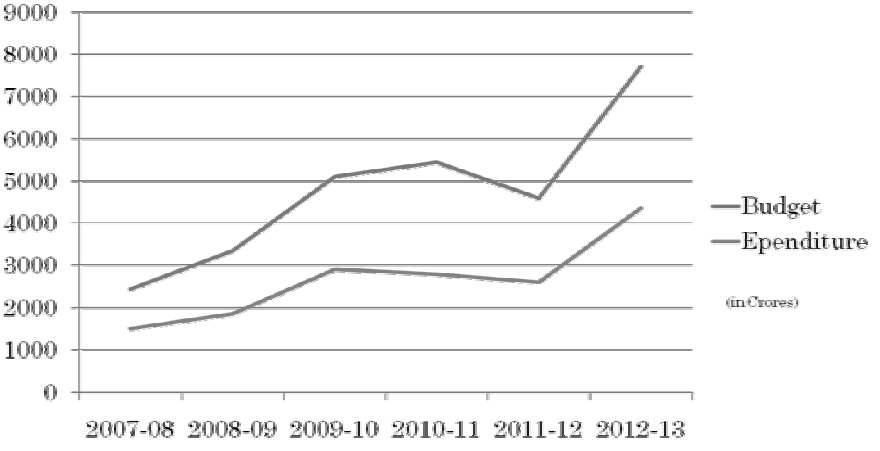
COMPARATIVE TRENDS IN MMR



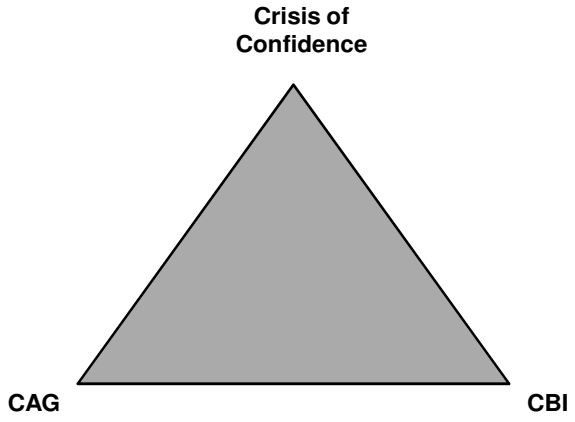
COMPARATIVE TRENDS IN IMR



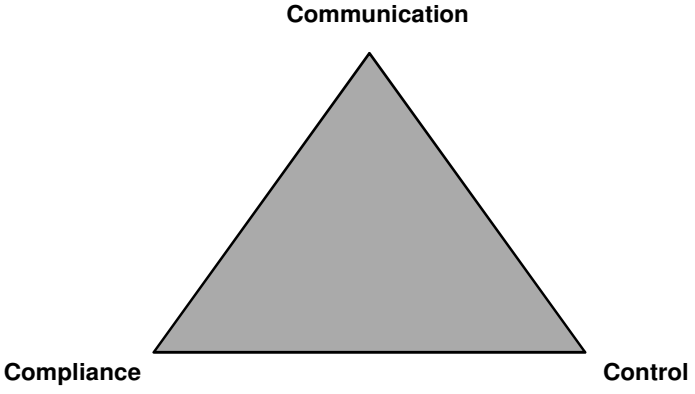
FINANCIAL TRENDS



CONDITIONS AT THE END OF PHASE 1



STRATEGY - ADOPTION OF 3 CS



STRATEGIES

Compliance	Control	Communication
1. SHM,GB and EC meetings being held 2. Audits and financial compliance 3. SPMU and DPMU augmentation	1. Supportive supervision system operationalized – field visits in 10 districts per month 2. Regular feedback to Districts and Blocks 3. Facility-wise reviews in DHS based on HMIS & MCTS data 4. Community-based monitoring	1. Regular meetings, conferences and reviews with DGs, SPOs, SPMU GMs 2. Regional workshops 3. A brand-focused RMNCH+A campaign launched 4. CUGs to be given to all ANMs, ASHAs and MOICs

FOCAL AREAS CONTINUUM OF CARE

- Intensification of delivery of the JSY and JSSK schemes
- A brand-focused state-wide RMNCH+A BCC campaign-'Hausla' launched
- Introduction of '102' ambulance service
- Enforcing MCTS and linking it to ASHA payments
- 207 FRUs in the year 2013-14
- Process for Quality Assurance system in health services delivery system in UP initiated

FOCAL AREAS NEWBORN CARE

2013-14 is the Year of Intensification of Newborn Care

Activity/ Meaurable Outputs	Target 2012-13	Current Status	Planning up to 2017
SNCUs	27	26	75
New Born care Corners	830	810	3500
Stabilization units in FRUs	165	125	300
Nutrition Rehabilitation Centres	26	24	75

FOCAL AREAS COMMUNITY-BASED MONITORING

"Chalo Gaon ki Oar"

Education and awareness promotion:

- Community awareness on health entitlements
- Training of VHSNC and RKS
- Display of Citizen's charter and service guarantees
- Sehat Sandeshvahini – Mobile video vans

Monitoring and information sharing:

- Collection of information and sharing of report cards, community experiences of health services, progress against village health plans
- Active multi stakeholder Monitoring and Planning Committees at PHC, Block and District levels

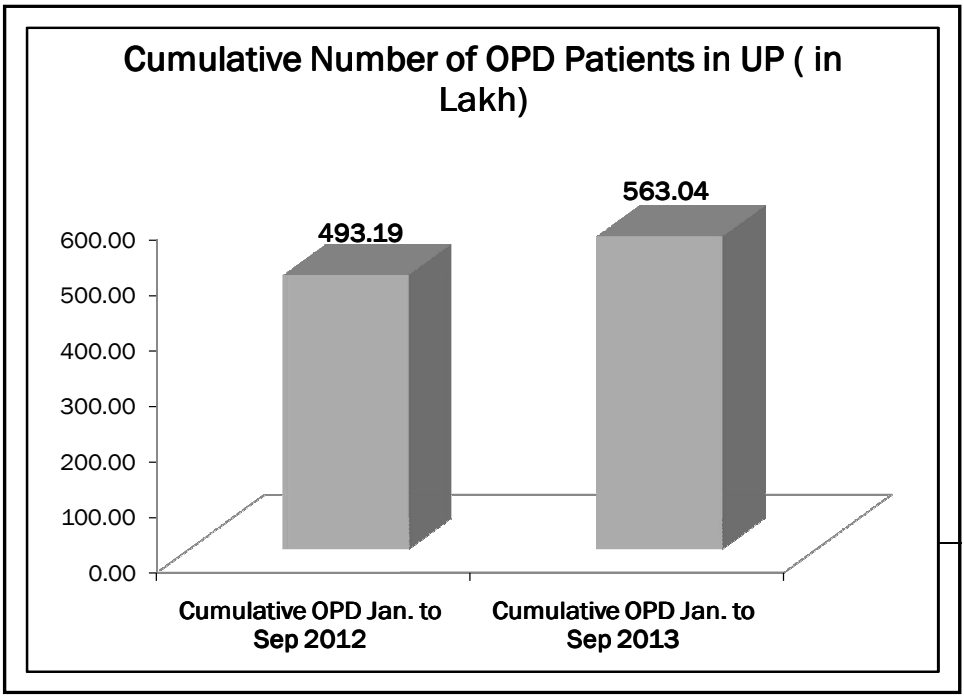
Public dialogue:

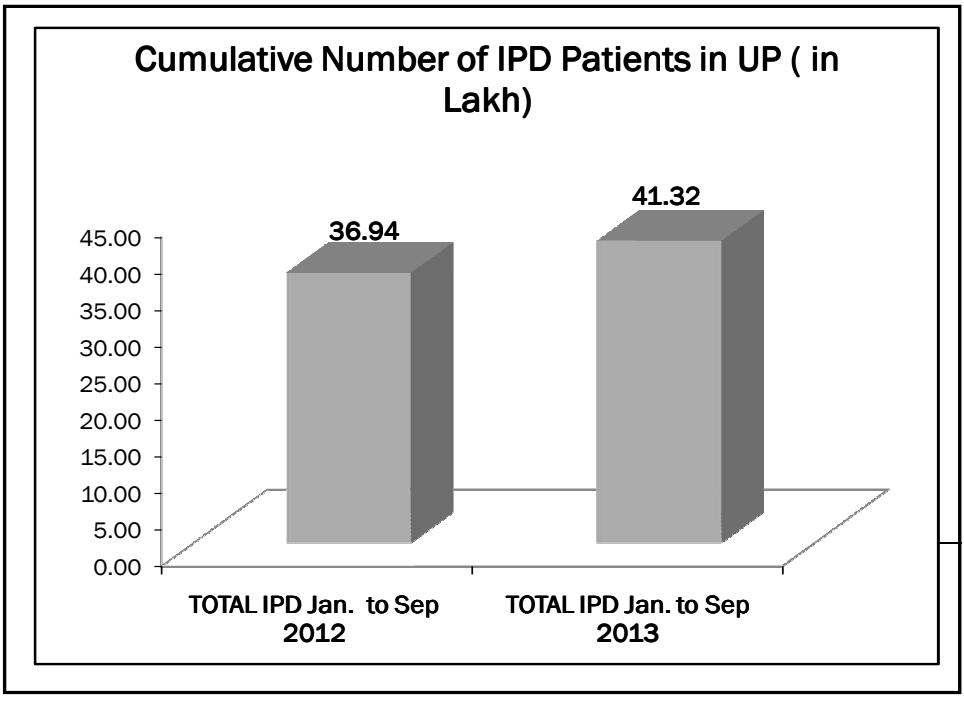
- Periodic public dialogue (Jan Samvad) - Engagement with providers based on community evidence

FOCAL AREAS MONITORING AND EVALUATION

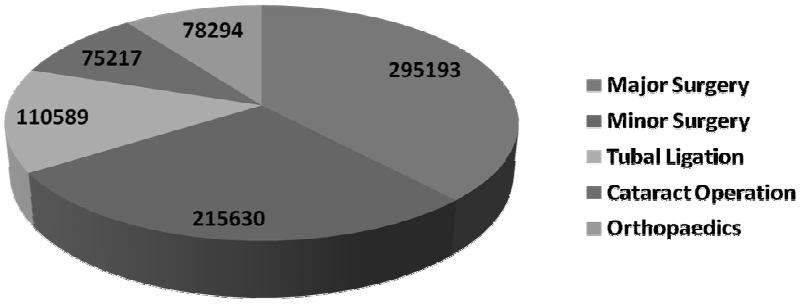
- Regular review meetings and video conferencing with sub-state level authorities and officials, covering entire state
  - Monthly meetings with ADs and Divisional PM
  - Meetings with CMOs, CMSs, ACMOs, DIOs, DPMs, DCMs and DAMs every 2 months
  - 2 video conferences with CMOS, CMSs, Ads, Div. PMs and DPMs every month
- Quarterly State Review Mission to be conducted on the pattern of Common Review Mission from the year 2013-14
- Supportive Supervision: Regular mandatory field visit routines prepared for state, divisional, district and block level officers
  - 10 districts being visited every month
- In 2011, a web-based beneficiary tracking system was launched to induce sense of transparency in the JSY programme
  - + http://www.jsyup.org contains district, block, facility-wise beneficiary details
- Data of HMIS and MCTS being used for review purposes

KEY ACHIEVEMENTS IN UP

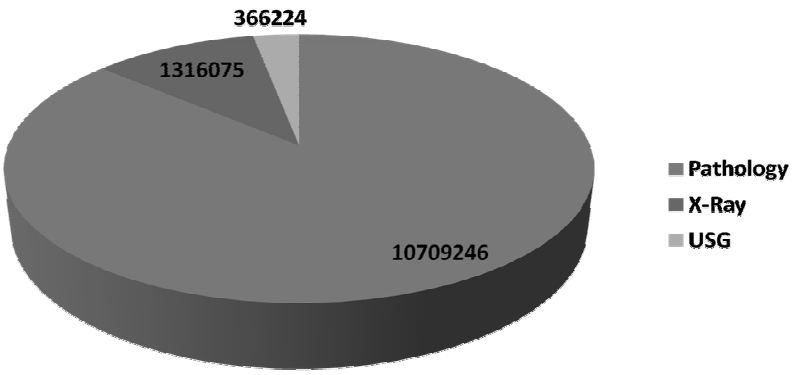

Cumulative Number of OPD Patients in UP (in Lakh)
600.00
500.00
400.00
300.00
200.00
100.00
0.00
493.19
563.04
Cumulative OPD Jan. to Sep 2012
Cumulative OPD Jan. to Sep 2013


Cumulative Number of IPD Patients in UP (in Lakh)
45.00
40.00
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
36.94
41.32
TOTAL IPD Jan. to Sep 2012
TOTAL IPD Jan. to Sep 2013

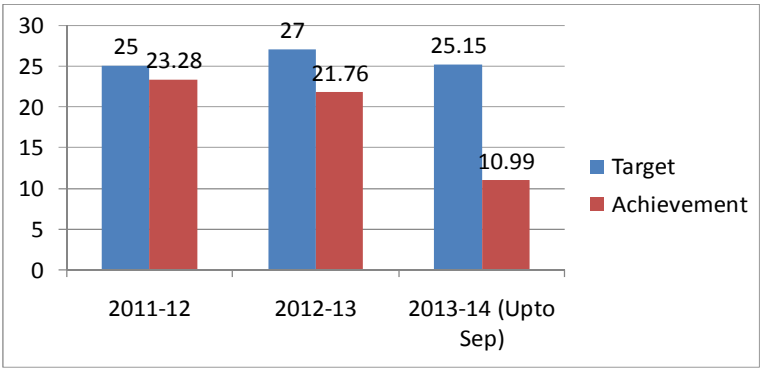
SURGERY PERFORMANCE IN UP (JAN-SEP'2013)



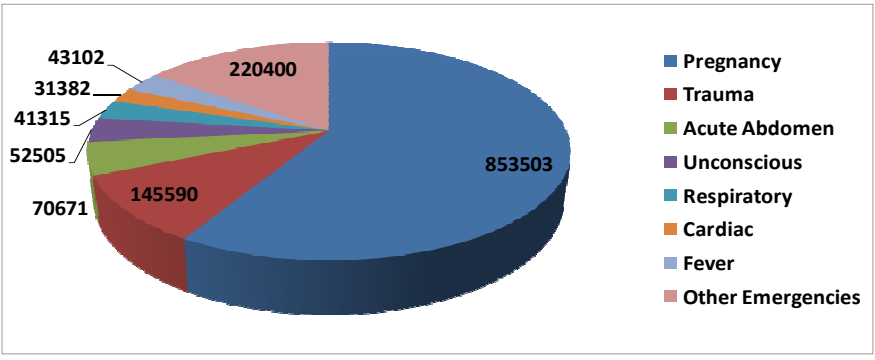
PATHOLOGY, X-RAY , USG PERFORMANCE IN UP (JAN-SEP'2013)



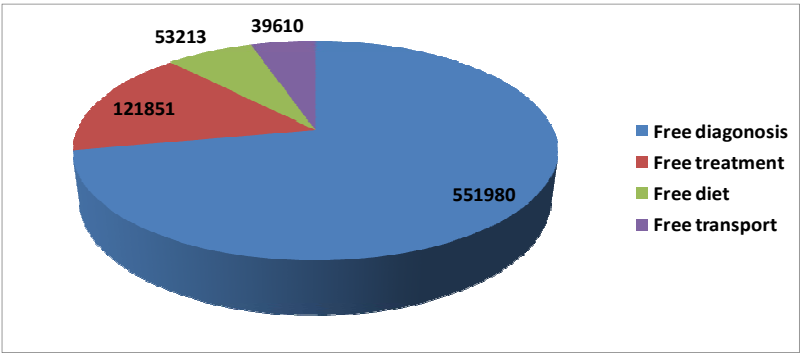
JANANI SURAKSHA YOJNA
(BENEFICIARIES IN LAKH)



EMERGENCY MEDICAL TRANSPORT SERVICE (108) (UPTO 31.10.2013)



JANANI SHISHU SURAKSHA KARYAKRAM (JSSK) (UPTO SEP-2013)



RASHTRIYA BAL SWASTHYA KARYAKRAM

FEBRUARY TO SEPTEMBER 2013-14 (8 MONTHS)

S.N.	Activities	Target	Progress
1	Implementation of Programme	75 District	*73
2	Recruitment of Medical Teams	1640	1476
3	No. of Schools Covered	3,34,000	2,40,000
4	Health Examination of children, distribution of IFA/ Deworming tablets	2,09,48,000	94,57,000
5	No of Referred Children (about 2%)	4,18,000	7,34,000
6	No of treated Children(At the spot & referred)	20,90,000	16,08,000

*3 Distt.– Rampur and Raibareli have not started the programme.

MAJOR ACHIEVEMENTS

- Remarkable increase in OPD (2 times-from 357 lacs in 2006 to 642 lacs in 2011) and indoor attendance (5 times-from 11 lacs in 2006 to 51.7 lacs in 2011) of female hospital/CHCs and PHCs.
- The institutional deliveries in UP have increased from 20.6% (NFHS-III 2005-06) to 62.1% as per Coverage Evaluation Survey 2009, conducted by UNICEF.
- Janani Suraksha Yojna and Janani Shishu Suraksha Karyakram are being implemented all over the State
- 988 Ambulances (108) are providing Emergency Transport Medical Services and 972 UP ambulances are providing transport and drop back facility to PW and newborn . In year 13-14 ,total 1000 ambulances will be made operational under this scheme

NEW INITIATIVES

- State-wide campaign on 'Hausla' an IEC/BCC campaign to promote awareness on health programmes, health related issues and entitlements
- State-wide campaign 'Sehat Sandehvahini' to create awareness on health issues and entitlements
- Establishment of 24x7 helpline integrated with 'Hello Doctor' scheme
- Establishment of new health posts in urban slum areas of selected cities

- Establishment of Quality Assurance cell at all levels to ensure services as per IPHS
- Launch of 102 Ambulance service in the state
- Plans to distribute sim cards/mobile phones to all FLWs
- ICT based initiatives like mAcademy and mobile kunji
- State PIP of NUHM has been sent to GoI in that total 131 cities have been taken under NUHM , in these cities total 638 U-PHCs will be established covering 3.14 Crores urban population.

- Proposed construction of one 200 bedded referral maternal and child health hospital, 49 MCH wings of 100 bed, 12 MCH wings of 50 beds at CHC, 78 MCH wings of 30 beds at CHC, 15 CHC & 28 PHC
- These new constructions will add 7940 beds in the state and are expected to be completed by March 2015.

COMMITMENT FOR HEALTH AND FAMILY WELFARE

Through largest public health programme i.e. NRHM and upcoming NUHM by

- Addressing equity
- Ensuring quality
- Integration into the continuum of care

THANK YOU

THE UN COMMON UNDERSTANDING ON A HUMAN RIGHTS BASED APPROACH

Goal	Process	Outcome
All programmes of development, cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments	Human rights standards and principle guide all development cooperation and programming in all sectors and phases of the programming process	Development cooperation contributes to the development of the capacities of 'duty-bearers' to meet their obligations and /or of 'rights-holders' to claim their rights

KEY ASPECTS OF THE RIGHT TO HEALTH

1. The right to health is an inclusive right

The determinants of health are

- Safe drinking water and adequate sanitation
- Safe food
- Adequate nutrition and housing
- Healthy working and environmental conditions
- Health-related education and information
- Gender equality

KEY ASPECTS OF THE RIGHT TO HEALTH (CONTD...)

2. The right to health contains freedoms

These freedoms include

- the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization and
- To be free from torture and other cruel, inhuman or degrading treatment or punishment

Key Aspects of the right to health (Contd...)

3. The right to health contains entitlements

These entitlements include

- The right to a system of health protection providing equality of opportunity to every one to enjoy the highest attainable level of health
- The right to prevention, treatment and control of diseases
- Access to essential medicines
- Maternal, child and reproductive health
- Equal and timely access to basic health services
- The provision of health related education and information
- Participation of the population in health related decision making at the national and community level

KEY ASPECTS OF THE RIGHT TO HEALTH (CONTD...)

4. Health services, goods and facilities must be provided to all without any discrimination

   - Non discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health

KEY ASPECTS OF THE RIGHT TO HEALTH (CONTD...)

5. All services, goods and facilities must be available, accessible, acceptable and of good quality
   - Functioning public health and health care facilities, goods and services must be available in sufficient quantity within state
   - The facilities should be medically and culturally acceptable
   - The facilities must be accessible physically, financially and on the basis of non-discrimination
   - The facilities must have trained health professionals, scientifically approved and unexpired drugs ad hospital equipment, adequate sanitation and safe drinking water

SUMMARISED KEY ASPECTS OF THE RIGHT TO HEALTH

Parameter	Determinants
Availability	Functioning public health and health care facilities, goods, services and programmes in sufficient quantity
Accessibility	Non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility
Acceptability	Respectful of medical ethics and culturally appropriate, sensitive to age and gender
Quality	Scientifically and medically appropriate

COMMON MISCONCEPTIONS ABOUT THE RIGHT TO HEALTH

- The right to health is NOT the same as the right to be healthy

  A common misconception is that the State has to guarantee us good health but good health is influenced by several factors that are outside the direct control of the State such as an individual's biological make-up and socio-economic conditions

COMMON MISCONCEPTIONS ABOUT THE RIGHT TO HEALTH

- The right to health is NOT only a programmatic goal to be attained in the long run

  The fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on State arise from it. In fact, State must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without any delay.

THREE TYPES OF STATE OBLIGATIONS

Parameter	Details
Respect	Not to interfere directly or indirectly with the enjoyment of the right to health e.g. refrain from limiting access to health-care services or marketing unsafe drugs
Protect	Prevent third parties from interfering with the right to health e.g. ensure that private companies/government provide safe environmental conditions for their employees and surrounding communities
Fulfill	Adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health

COMMON MISCONCEPTIONS ABOUT THE RIGHT TO HEALTH

- The right to health is NOT only a programmatic goal to be attained in the long run

  The fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on State arise from it. In fact, State must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without any delay.

COMMON MISCONCEPTIONS ABOUT THE RIGHT TO HEALTH

- A country's difficult financial situation does NOT absolve it from having to take action to realize the right to health

  When considering the level of implementation of this right in any State, the availability of resources at that time and the development context are taken into account. No State can justify a failure to respect its obligations because of lack of resources. State must guarantee the right to health to the maximum of their available resources even if these are tight

HUMAN RIGHTS-BASED APPROACH (HRBA) TO HEALTH

- A human rights-based approach to health specifically aims at realizing the right to health and other health related human rights. Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights.

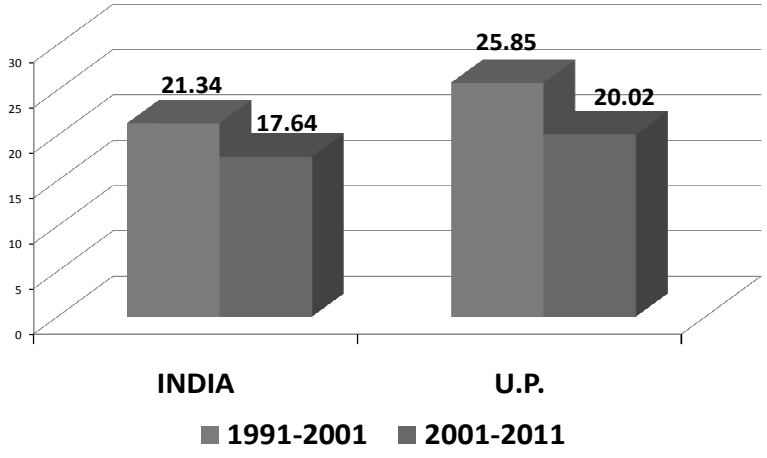
HUMAN RIGHTS-BASED APPROACH (HRBA) TO HEALTH (CONTD....)

- Elimination of all forms of discrimination is at the core of HRBA
- Gender mainstreaming is a key strategy to achieving gender equality and eliminating all forms of discrimination on the basis of sex

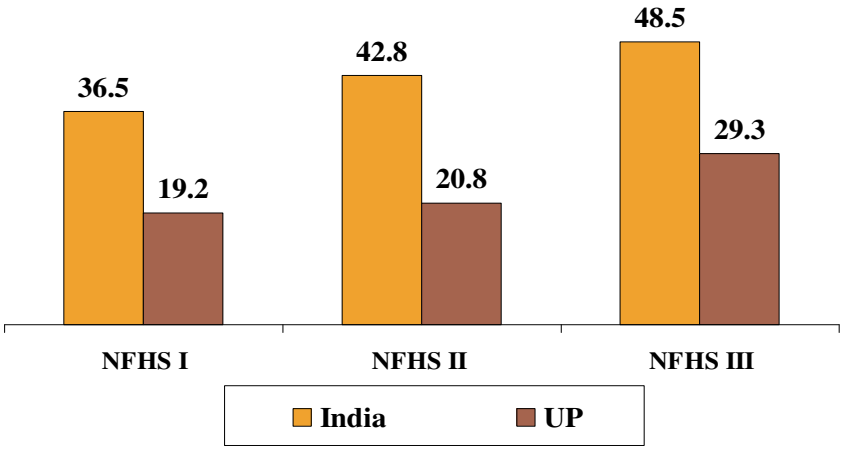
PROCESSES UNDER HRBA TO HEALTH

A human rights-based approach gives importance not only to outcomes, but also to the processes the processes.HR standards and principles – such as participation, equality and non-discrimination, and accountability are to be integrated into all stages of health programming process: assessment and analysis, priority setting, programme planning and design, implementation, and monitoring and evaluation

Comparative Decadal Growth Rate for India and U.P.



CONTRACEPTIVE PREVALENCE RATE INDIA VS UP



Source: NFHS III 2005-06

Annexure-VIII

Human Rights perspective on MCH

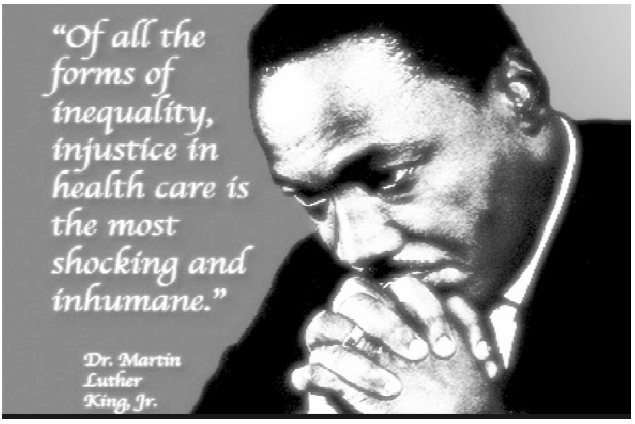
Prof Dileep Mavalankar
Director
Indian Institute of Public Health, Gandhinagar
Public Health Foundation of India and
Govt of Gujarat Initiative

1

The Battle of Solferino 1859, Henry Dunant, Geneva convention – 1863, Red Cross society

2

Inequality and Injustice



3

Global Human Right – Health Care

4

Human Rights violations is not only this

5

MCH / child birth – rights of two people – one “wounded internally and one very Vulnerable” !!

Health Rights of the poor, tribal and vulnerable

Maternal and Child mortality in India

- 50,000 maternal deaths per year – MMR 200
- 2 million child deaths – IMR of 44, CMR 57
- Most tragic because 80-90% preventable even with India's resources
- 99% are preventable with developed country resources

8

Taj Mahal, Maternal death and Midwifery in sweden:300 year history

MMR of India = 200

MMR of Sweden = 2

9

What does today's Mothers and children in India need ?? – a lot

- Not words and promises or Plans – but actions and delivery of care – not as a welfare but as a constitutional rights
- Scientifically correct quality care which is accessible and affordable / free
- With dignity and respect -

10

The critical step for mothers is Improving skilled care at birth and EmOC

- Are government PHC / CHC /FRU functional 24X7 with adequately and skilled staff ?
- Are they supervised ? Monitored ?
- Do they have adequate funds and flexibility ?
- Public Private partnership / contracting
- " I do not mind if the cat is back or white as long as it catches the mice" Deng Xiaoping

11

NRHM is a big plus + money and flexibility and some planning PIP

- What further is needed ??
- Long term policy – strategy, – plan, and implementation capacity needed.
- Human resource policy – ANM to fully qualified midwife, NN care provider and community health nurse – Nurse practitioners
- Task shifting: Training of MBBS docs to provide EMOC, Anesthesia, and skilled delivery & NN care
- Legal framework is missing or weak for task shifting.

12

Bottleneck is always at the top !!

Management & regulatory structure for MCH & public health

- National MCH directorate / bureau with about 60 professionals needed – currently 3+3 officers
- State level MCH directorates with 10-40 –professionals depending on size of the state -currently 3 – 6 officers
- District MCH bureau with 6-10 professionals including supervisory midwifery, nursing and public health officers – currently 1-2 officers
- Public health service and public health cadre – 3000 -6000 officers needed in the whole country
- National health Council – not medical council – broader representation of health interests “patients and citizens” , Civil society, and professionals / doctors.

13

Skilled care at PHC / CHC and FRU / SNCU level

- Training of doctors and appointment of fully qualified midwives at these levels.
- OBGYs or skilled MO for providing MCH services including managing EmOC and NN care
- Home visiting by midwives and ANMs – Home based maternal and newborn care.

14

Replace ANM with 3 year trained fully qualified midwife and separate community health nurse – nurse practitioners ANM is a World War II vintage concept

15

Reaching services to the most remote and difficult areas

- Special division of service providers – separate cadre or sub-cadre – specially recruited, differentially paid, highly supported with special privileges and highly respected – like commando battalions of army
- Special partnerships with NGO, Corporates, PSU, etc to provide high quality services in difficult areas

16

Progressive realization of rights; Monitor the progress using data

- Birth and death registration and analysis – set up needed system to get correct IMR MMR at district level over next 5 years – dissolve SRS
- UN process indicators for Maternal health / EmOC – access, use and quality measurements
- Measure management actions via MIS – HR, outputs …..
- Proper Demographic, epidemiological and HMIS units at taluka, district, state and central level with adequate staff, finances and powers

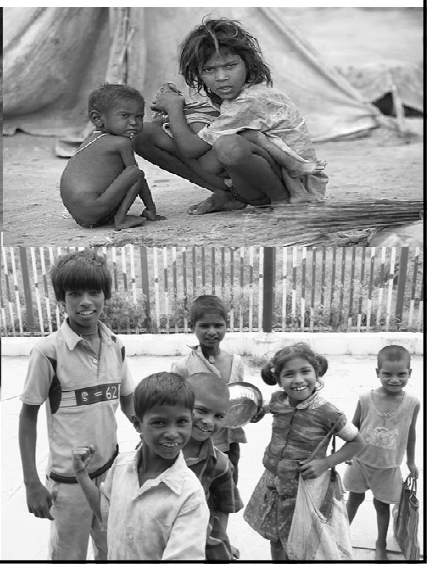
17

Service Guaranties and Grievance Redressal mechanisms

- Citizen's charter
- Taluka level and district level ombudspersons
- Support and Over view boards of the civil society
- Independent data monitoring and review boards at district level and state level

18

Rights vs Rights : Dog vs Children



Rights of the citizens vs staff

Thanks.

- We need to build a framework of laws, government institutions, academic institutions and civil society partners to ensure delivery of care to all women and children in India with equity, respect and dignity.

21

Annexure-IX

Application of Human Rights Based Approaches for Prevention of Maternal Mortality and Morbidity

Jashodhara Dasgupta,
Coordinator, SAHAYOG, Lucknow

Alternatively….

Realizing maternal health: Making rights real for *all* women in India

The context:

Sukhpuri, a remote village in Madhya Pradesh, central India:
the local health centre is 15 kilometres away – you can travel by a bullock-cart

The rights holder:
Baniya Bai, tribal woman aged 21, goes into labour on 11 Nov 2008

She reached a hospital well in time during labour, before night fall

There was a nurse and a paramedic at the primary health centre

She stayed overnight in the health centre during labour

So far so good….

Health services: Institutional delivery

The next morning….

She had to crawl out of the labour room during advanced labour

She gave birth on the street outside the hospital.

A local TBA helped her. Her father-in-law's loin cloth covered her body

The REASON:

The paramedic and nurse demanded that she pay them Rs. 100 (a bit less than USD2) as informal fees. Her family could not afford it. The staff asked her to leave at once.

The role of the Human Rights Defenders

- Madhuri Krishnaswamy, a health and human rights activist works in the region to empower the tribals for claiming their rights
- Madhuri helped Baniya Bai reach another hospital with the help of health officials
- Her organization held peaceful protests asking for action against the paramedic and nurse

Accountability and grievance redress

- The paramedic (who had demanded money from Baniya Bai) framed Madhuri in false cases, which the police took up with exemplary speed!

  16 May 2013
  Madhuri Krishnaswamy is arrested in court and imprisoned

21 May 2013 – Tribal women picketing in the district headquarters, calling for her release

India has made great improvements in MMR; even so…

- Maternal death or serious illness remains a very real possibility for millions of women across the country
- MMR reflects inequitable access to maternal care services and there is a pattern of deaths among the most vulnerable social groups such as the very poor, those without education, tribal women and those living in rural areas.
- Services today are not uniformly available, accessible, acceptable, and of high quality
- Robust accountability mechanisms are not in place

Maternal mortality in India an unacceptable violation of women's constitutional rights

- Right to life, the right to the highest attainable standard of health (including available, accessible, acceptable and high quality services) – Art 21
- Right to be free from cruel inhuman and degrading treatment
- Right to equality and non-discrimination Art 14, 15
- Women's reproductive rights, including the right to attain the highest attainable standard of sexual and reproductive health.

" No woman, more so a pregnant woman, should be denied facility or treatment at any stage irrespective of her social and economic background… this is where the inalienable right to health which is so inherent in the right to life gets enforced."

Indian Government is obligated to ensure maternal health services under constitutional rights to health and reproductive rights as well as under its international legal commitments, ref the UDHR, the CEDAW as well as the ICESCR)

Consolidated orders 2010: Laxmi Mandal v. Deen Dayal Harinagar Hospital and Ors (Delhi High Court, 2008) and *Jaitun v. Maternal Home Municipal Corporation of Delhi Jangpura and Ors* (Delhi High Court 2009),

State obligation: RtH is not optional (ICESCR Gen Com 14)

A right to health approach includes

- Respect: State must not itself interfere with the right
- Protect: State must protect interference from 3rd parties
- Fulfill: Must take legislative, administrative and other measures to realize the right
- Availability, Accessibility, Acceptability and

Quality of health care

The way forward: how can India implement a HRBA to prevention of MMM?

Technical Guidance

- Human Rights Council requested the Office of the High Commissioner for Human Rights to prepare a guidance for govts. -

  Technical Guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (HRC document A/HRC/21/22, hereinafter TG) presented in 2012 to the HRC

Principles

- A human rights-based approach is premised upon empowering women to claim their rights (as active agents who participate in decision-making, rather than seeing them as passive beneficiaries, or 'patients')
- Social determinants of women's health, including structural factors which perpetuate discrimination against women;
- Inclusion of marginalized and excluded groups, who suffer multiple forms of discrimination, and higher rates of maternal mortality and morbidity as a result

- Accountability must be built into strategies and plans (including systematic monitoring, review, grievance redress, remedial action etc)
- Health goods, services and information are available, accessible (including financially accessible), acceptable, and of good quality
- A just, as well as effective, health system – claims for sexual and reproductive health services and information are also understood as rights
- States are obliged to ensure that third parties do not interfere with the enjoyment of sexual and reproductive health rights.

Applying HRBA to the Policy Cycle

- A **national action plan** on Health from a human rights perspective, such as essential medicines and services, specific measures to address discrimination, and capacity building for duty bearers
- A **situational analysis**, carrying out an ex ante impact assessment, and devising the plan in consultation with & full participation of affected populations.
- Assessing whether the **maximum of available resources** is being allocated to the realization of the right to health, and on ensuring transparent and participatory budgetary processes.

Implementation of HRBA

- A ***diagnostic exercise*** that is required to understand what is happening to whom and where; why it is happening; who or what institution is responsible for such factors, and for addressing the problem; and how action should be taken
- Identifying **barriers to implementation** with meaningful participation of local affected populations and front line health workers, who understand and see actual problems in implementation

Accountability

- Effective **monitoring**, including the use of appropriate indicators, is critical to ensuring accountability.
- Availability of disaggregated data + more robust data collection for indicators like access to emergency obstetric care
- Several forms of review and oversight (legislative, departmental, finance & audit, judiciary and NHRC as well as citizen oversight through social audit, community-based monitoring, civil society engagement)
- Accountability mechanisms need **effective remedies** which have the potential to address structural causes behind the violation, and can lead to necessary legal and policy changes

Addressing maternal health as a human rights issue in India

Maternal mortality in India at its current level is an unacceptable violation of women's human rights including their right to life and the highest attainable standard of health.

I. A thorough review of the recommendations suggested by the former UN SR in his report of 2010.

II. Ensure compliance to the various orders passed by the judiciary as mentioned above.

III. The implementation of the OHCHR *Technical Guidance* (UN HRC 2012) in order to apply human rights based approaches for the prevention of maternal mortality and morbidity.

Thank you!

Annexure-X

Right to Maternal and Child Health Care

Strengthening Institutional Arrangements

Elements of a Rights based approach

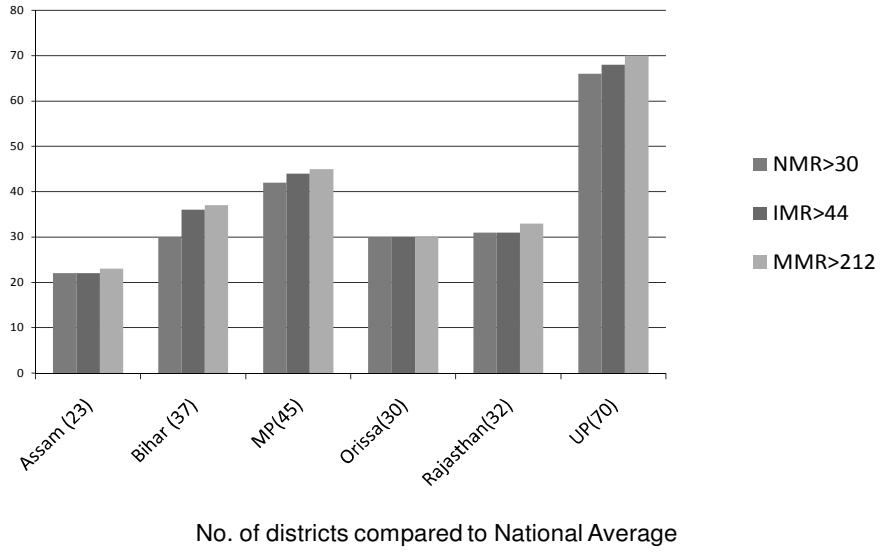
- Accessibility
- Availability
- Acceptability
- Quality
- Non-discrimination

Paternalism
vs
Rights

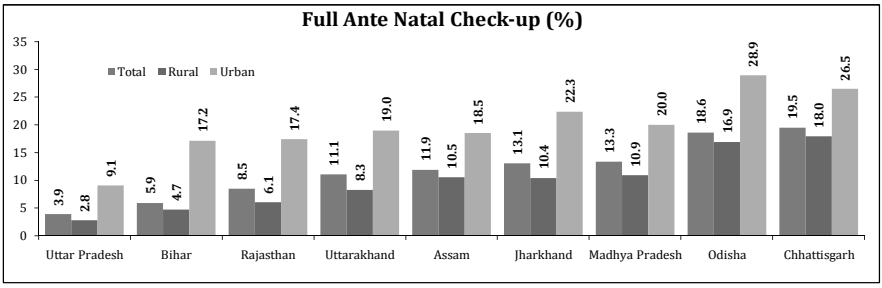
- Was there respect?
- Was there choice or alternatives?
- Were the options technically sound?
- Were the options explained ?
- Was there coercion or compulsion or denial?
- Was there any way to express discomfort and to be heard?

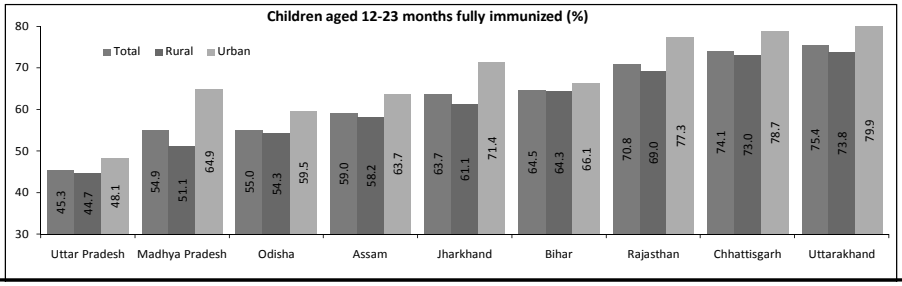
Eleventh Plan Monitorable Goals and Achievements

S. No.	Eleventh Plan Monitorable Target	Baseline Level	Recent Status
1	Reducing Maternal Mortality Ratio (MMR) to 100 per 100000 live births.	254 (SRS, 2004–06)	212 (SRS, 2007–09)
2	Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.	57 (SRS, 2006)	44 (SRS, 2011)
3	Reducing Total Fertility Rate (TFR) to 2.1.	2.8 (SRS, 2006)	2.5 (SRS, 2010)
4	Reducing malnutrition among children of age group 0–3 to half its level.	40.4 (NFHS, 2005–06)	No recent data available
5	Reducing anaemia among women and girls by 50%.	55.3 (NFHS, 2005–06)	No recent data available
6	Raising the sex ratio for age group 0–6 to 935	927 (Census, 2001)	914 (census, 2011)



MCH Service delivery





MCH Care: Some issues

- An overwhelming number of districts in the 6 high population – high focus states are below the national average for MCH outcomes
- Basic services for MCH care are not being provided adequately and uniformly in the states of highest priority even after five years
- Some services are being 'pushed' more than others
- Some areas are doing better even though the service delivery is 'weaker' than in other places
- The overall service package/ solution provided is the same for all places

MCH Care : Some Experiences

- Shanti Devi – New Delhi
- Fatima – New Delhi
- Snehalata Devi – Muzzafarnagar, UP
- Baniya Bai – Barwani, MP
- Vyapari Bai – Barwani, MP

These are just five women whose experiences of MH Care made it to the courts but there are millions of women with poor experiences of Maternal Health care

MCH Care the evolving story

- FP, the most important health programme is slowly replaced my RH and then MH
- MH with JSY and ID becomes the policy focus in NRHM especially after the MDG review in 2005
- JSY+ID+JSSK becomes a short cut for quality assured services with emergency obstetric care back up
- All support for home based delivery is withdrawn and ID at all costs assumes greater importance than ensuring EmOC/life saving care
- Reviews have not yet established the benefits of this approach but an optimistic approach continues
- This 'optimism' is hurting over 8 million women during delivery every year.

Results of an ID + JSY focus after 8 years

50% ID

+

- Some ANC
- Some EmOC
- Some PNC

+

- Poor QoC

50 % Home Birth

+

- Little or No ANC
- No EmOC
- No PNC

Reality of about 8 million women every year in India

A Human rights assessment of MCH care

- Respect – Policy articulation, budgetary allocation.
- Fulfill – The overall plan of ID + JSY + JSSK needs review. Better and more appropriate planning for serving underserved areas. Adopting better solutions considering available resources and limitations.
- Protect – No consideration of the 'negative' experiences/ consequences, lack of dignity, discrimination.
- Accountability – Notional, not substantive. No mechanisms/ provisions for complaints and redress
- Coercion – JSY ends up being doubly coercive through its incentivisation of both ID and the ASHA. Also a corrupting

Strengthening Institutional mechanisms

- State and district wise mapping of MCH service capacities - including infrastructure and HR
- Map peoples perceptions, practices and experiences related to MCH care – routine and emergency; include social determinants
- Develop state and district level MCH plans appropriate to situation while addressing the need for emergency/ live saving services. Use tailored plans using new technology (mobile/crowd sourcing) and innovative deployment of available resources
- Train all staff in 'soft skills' and client-centred approach
- RKS members need to trained in understanding and representing client interests in the planning and review forum.
- Develop state and district level robust accountability mechanism including community monitoring, complaint, redress mechanism including establishing a 'health ombudsman'
- NHRC and SHRC can develop a MCH care report card for states and districts and conduct periodic hearings on these report cards

Annexure-XI

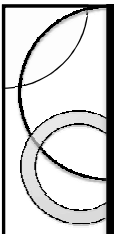
Maternal and Child Malnutrition: Need for Nutrition Education and Capacity Development

Rekha Sharma, ***M.Sc., PGDM, RD***
President, Indian Dietetic Association
Country representative and Director, International Confederation of Dietetic Associations
Director, Nutrition and Dietetics, Diabetes Foundation (India)
Former Chief Dietician, All India Institute of Medical Sciences, New Delhi

Maternal and child Malnutrition

Malnutrition affects:

- Survival
- Development
- Growth
- Health
- Productivity
- Economic Growth



Most Vulnerable Groups are . . .

- 0-6 year children
- Pregnant Women
- Lactating Mothers
- Adolescent Girls
- Aged

Burden of Malnutrition

- 47 % of India's children below the age of three years are malnourished (underweight) –UNICEF -08
- The World Bank puts the number at 60 million. This is out of a global estimate of 146 million.
- 47% of Indian children under five are categorized as moderately or severely malnourished UNICEF- 08
- 32 babies out of every 1000 born alive do not see their first birthday

Burden of malnutrition

- At least half of Indian infant deaths are related to malnutrition, often associated with infectious diseases.
- Malnutrition impedes motor, sensory, cognitive and social development, so malnourished children will be less likely to benefit from schooling, and will consequently have lower income as adults.

NHFS III

Burden of malnutrition

22.0%	Low Birth Weight Babies (for whom birth weight reported)
33.0%	Women with Chronic Energy Deficiencies
78.0%	Children (6-59 months) with anaemia
50- 57.0%	Women are anaemic

NFHS-III

Vitamin A deficiency & Iodine Deficiency Disorders continue to be public health problems

Infant and Maternal Mortality

Indicator	Previous data	Available data
Infant Mortality Rate	IMR was 80/1,000 live births by 1991	Reduced to 44 in 2011
Child mortality 0-4 years	was 26.2/1000	Reduced to 13.2/1000
Maternal Mortality Rate	was 437/1,00,000 1992-1993	Reduced to 212/1.00,000 2007-09

Ministry of Health and family welfare report2010

Nutritional Challenges

- UNICEF (2009) data shows infant mortality to be declining steadily, but is still 1726 thousand deaths for children below the age of 5 against 26787 thousand births .
- Despite the country's growing economy and an ambitious rural health initiative
- Over 100,000 women die from pregnancy-related causes each year – highest in the world

Nutritional Challenges

- While breastfeeding is nearly universal in India, less than half of children (46%) are fed only breast milk for the first 6 months, as recommended
- Only 23.4% of children are breastfed within one hour of birth and the prevalence is significantly lower among the non-educated mothers and in rural areas.
- Only 55.8% of children aged 6-9 months receive solid or semisolid food and breast milk - making complementary feeding a high-priority to be addressed
- The higher the education of the mother, the better the nutrition status of themselves and their child.

(NFHS-3)

Macro and Micronutrient deficiency

- Deficiency of vitamin minerals often occurs in conjunction with PEM
- One third of the World's people do not fulfill their physical and intellectual potential. because of unrecognized deficiencies of vitamins and minerals- Vitamin A, Iron, Iodine, folate etc.

The picture (UNICEF and MI VM global progress report)

Folate deficiency	Approximately 200,000 babies with severe birth defects and 1in 10 deaths from heart disease in adults – in India
Severe Iron deficiency	Causes loss of life more than 60,000 young women in pregnancy and child birth and loss of 2% GDP. This is high economic cost on virtually every developing nation---world bank

The Picture (UNICEF and MI VM global progress report)

Iodine deficiency	Estimated to have lowered the Intellectual capacity by 10-15 percentage points in India
Iron deficiency in 6-24 m olds	Mental development impaired by 40-60%
Vitamin A deficiency	Impaired the immune system leading to an estimated one million children not reaching their 5th birthday
Iodine deficiency in mothers	6.6 million babies being born mentally impaired every year in India

Programme recommendations:

- Supplementary feeding activities-with clear criteria set for quality assurance and accountability.
- Growth-monitoring activities need to be performed with greater regularity, -involving and educating the parents for monitoring
- Involving communities in the implementation and monitoring of programmes and anganwadi centers, to improve the quality of service delivery and increase accountability in the system
- Systems are good – require rigid implementation and coordination between different departments

Exclusive breastfeeding prevents child malnutrition

- 0-6 months is critical, 6-12 is next with weaning foods
- We allow child under nutrition to set in - with poor feeding (Breast feeding and complementary feeding)
- Neonatal infections, Diarrhea and pneumonia give 2/3rd mortality in 1st year
- According to WHO, other 2/3rd mortality is related to poor feeding practices

Way Forward

Prevention and cure for under nutrition in children

- There are ten proven, high-impact interventions, that can help in bringing, child under nutrition, figures down:
  1. Timely initiation of breastfeeding within one hour of birth.
  2. Exclusive breastfeeding in the first six months of life
  3. Timely introduction of complementary foods at six months
  4. Age-appropriate foods for children six months to two years

Way Forward

5. Safe and hygienic complementary feeding practices
6. Full immunization and bi-annual vitamin A supplementation with deworming
7. Appropriate feeding for children during and after illness
8. Therapeutic feeding for children with severe acute malnutrition
9. Adequate nutrition and anemia control for adolescent girls
10. Adequate nutrition and anemia control for pregnant and breastfeeding mothers

UNICEF

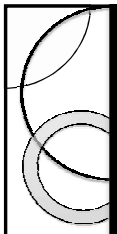
Way Forward

Prevention and cure for Anemia:

- Increasing the iron content of food through dietary intake
- Increasing the iron content of food through fortification
- Increasing iron intake through supplementation
- Reducing blood loss by treating for parasites
- Reducing blood loss from hemorrhage by improving birthing or abortion practices and post-abortion care

Nutrition Interventions to combat Micronutrient Malnutrtition

- Nutrition and health Education
- Dietary diversification
- Fortification
- Supplementation



Nutrition Education

- Breast feeding practices
- Weaning foods at proper age
- Easy recipes with supplementation
- Cereal + Pulse mixes
- Use of kitchen garden fresh fruits and leafy vegetables
- Use of millets , whole grains vs refined foods
- Hygiene and clean water

Nutrition Education – capacity building for mothers

- With locally trained women who go from house to house, advising mothers how to add supplementary foods available at home such as mashed GLV to be added to rice/chapatti and dal - from six months onwards, while maintaining breastfeeding as long as possible.
- The best way of conveying this is by simple message to meet the calorie and protein gap of a child under three.

DIETARY DIVERSIFICATION to combat Micronutrient Malnutrition

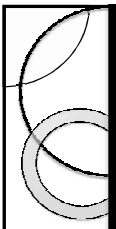
- Horticulture interventions: Promote the Nutritious crops by providing incentive to the farmers – fruits and vegetables
- Nutrition and Health Education to promote healthy eating patterns–long term sustainable intervention – behaviour change
- Promotion of correct Infant and Young child Feeding Norms
- Promotion of low cost locally available nutritious food–Educating them and by providing them recipes and demonstration of the recipes

Supplementation

- Recipes suitable for infants and children
- Recipes which can be prepared daily specifically for the infant
- Adult food modified to suit children's needs
- Protein-rich supplements that may be added to the family diets
- Low cost - ready-to-use infant weaning foods can be prepared
- Recipes suitable for preschool children
- Nutritious snacks for infants and preschool children

Nutrition Programmes

- Improving mothers' feeding and caring behaviour with emphasis on infant and young child feeding and maternal nutrition, during pregnancy and lactation.
- Improving household water and sanitation.
- Strengthening the referral to the health system, with emphasis on prevention and control of common child diseases including acute malnutrition.
- Providing micronutrients.
- Actual implementation follow ups.



Conclusion

- Burden of Malnutrition is huge, in spite of slow decline – both in mothers and children below 5 years
- Micronutrient deficiencies occur in conjunction with CED
- Anaemia is a challenge
- Nutrition Education of mothers and involving the families in Nutrition programmes could help
- Breast feeding and timely complementary feeding with education on low cost protein rich recipes from locally available foods .

Annexure-XII

Water, Sanitation and Hygiene

"THE FORGOTTEN FOUNDATIONS OF HEALTH"

Dr (Col) S K Thakur
MD, DM
Senior Consultant Gastroenterologist

Introduction

- What is hygiene
- What is sanitation
- What is health
- Why its necessary for food.

What is Hygiene

- The art and branch of science that deals in preserving good health is hygiene.
- It is derived from “hygieia” meaning goddess of health”

What is sanitation

- The word sanitation, derived from the latin word “Sanus” meaning “Sound and healthy”
- The knowledge as well as the acceptance and effective application of sanitary measures of good health.

What is health

- Health is a state of complete physical, mind and social well-being and not more than absence of disease or infirmity.

Magnitude of the problem

- Globally 2.4 million deaths (4.2 % of all deaths)can be prevented annually with appropriate hygiene and good reliable sanitation and drinking water (WHO 2008).

- Deaths mostly in children of developing countries from diarrhoea, malnutrition and diseases attributable to malnutrition.

- "BIG – THREE" attention seekers of the international public health community – HIV/AIDS, Tuberculosis, Malaria.
- Rarely, discussed alongside – "Diarrhoea" alone kills more young children each year that all three combined.
- Key to its control is Water, Sanitation and Hygiene (WASH).

Disease burden associated with deficient "WASH" - mostly preventable

1. Diarrhoea Diseases – 53% (90 % below 5 Yrs age, 73 % in only 15 Dev-countries)
2. Consequences of malnutrition – 29%
3. Malnutrition – 7%
4. Schistosomiasis – 2%
5. Trachoma – 2%
6. Filariasis – 4%
7. Intestinal worm infections – 3%

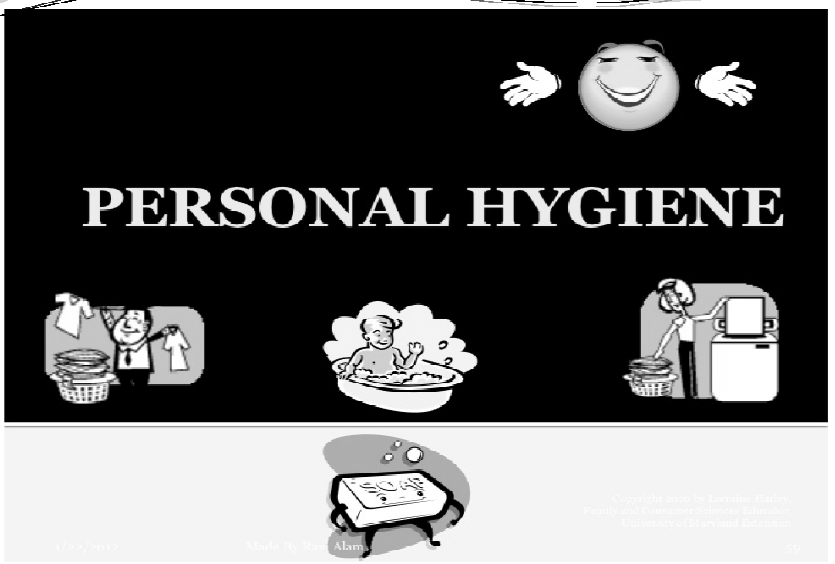
Water, Sanitation and Hygiene as a risk factor for disease transmission

- Transmission through ingestion of water- drinking/bathing.

(FECAL – ORAL OR WATER BORNE)

VIRAL	- Hepatitis A, E.
	- Diarrhoeas
BACTERIAL	- E. Coli, Cholera, Typhoid.
PROTOZOAL	- Amoebiasis, Giardiasis

- Transmission caused by lack of water linked to inadequate personal hygiene (water – washed).
  - Skin/ Eye infections- scabies, conjunctivitis, trachoma.



Personal Hygiene

- Personal Hygiene
- Hand washing is the single most important means of avoiding sickness and preventing the spread of disease.
- Also teach your children how to wash their hands properly

Hand Washing

A change in people's health behaviour.

"Dirty hands cause disease" – cognitive statement.

" Clean hands feel good" – emotional lever.

- Transmission caused by poor personal, domestic or agricultural hygiene.
  - Person – to – person transmission of fecal-oral pathogens.
  - Food – borne transmission of fecal-oral pathogens.
  - Use of contaminated water for irrigation or cleaning eg. Thyroid, cholera, hepatitis, worm infestations.

- Transmission through contact with water (bathing/ wading)
    - Schistosoma.
- Transmission through vectors proliferating in water reservoirs, stagnant water or certain agricultural practices:-
    - Insect vector diseases – Dengue, malaria, yellow fever.
    - Rodent – borne diseases – Leptospirosis.

Conclusion

1. A massive disease burden is associated with deficient water supply, sanitation and hygiene.
2. This is largely preventable with proven, cost effective interventions.
3. Water supply, sanitation and hygiene are development priorities and the international policy on drinking water and sanitation requires more attention.
4. Water supply, sanitation and hygiene continue to have health implications in the developed world.
5. The active involvement of health professionals in water supply, sanitation and hygiene is crucial to acclerating and consolidating progress for health.


WOMEN? THEY ARE TOO BUSY TO DISCUSS WATER!


ROTI
KAPADA
AUR
MAKAAN

Foundations of Health

- Water
- Sanitation
- Hygiene

THANK YOU

Annexure-XIII

Gram Vikas

Towards better Health with Safe water and Sanitation

Presented at "National Conference on Health care as a Human Right"

6th November 2013, New Delhi

Health Context

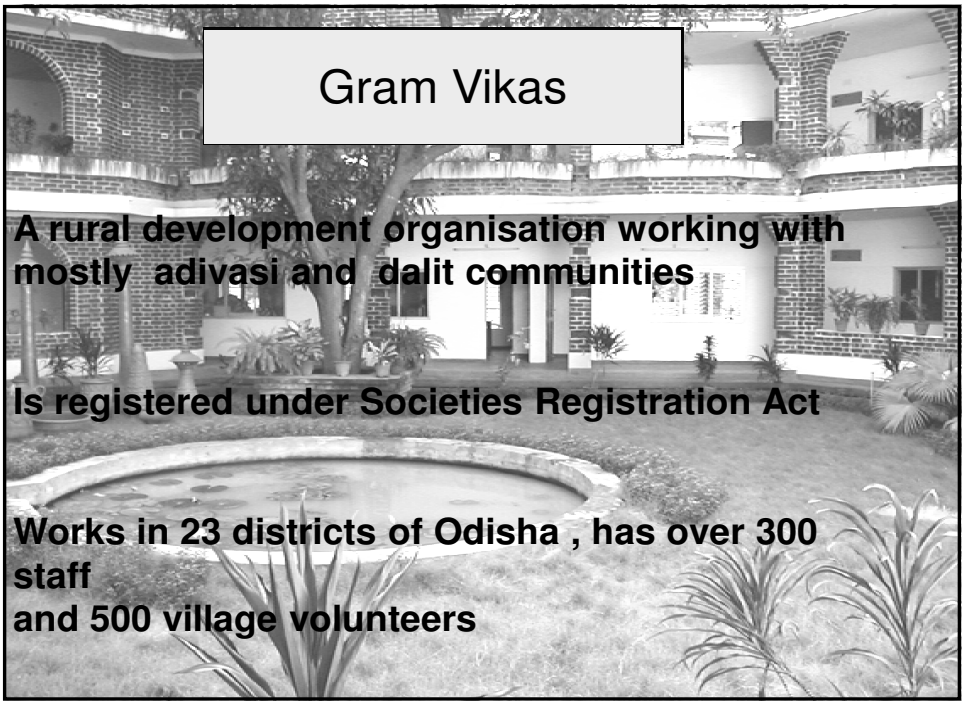
- Universal health as a human right
- MDG 4 and 5 – related to prevention of child death and maternal health remains a distant goal unless……

Health Context

- Enabling living conditions are provided to all sections of the society
- Proper housing
- Safe water
- Sanitation
- Transport and communication

Health Facts

- World bank estimates- annual economic impact of inadequate sanitation in India is 6.4% of GDP
- Diarroheal death of children under five in India was 12.6% of child death
- 80% of diseases - jaundice, typhoid, worm infections, scabies and reproductive tract infections are water borne
- Malnutrition and stunting- 48% children in India under five years age are stunted
- WHO reports say that 50% of health burden of malnutrition is attributable to environment- particular to poor water , sanitation and hygiene



Gram Vikas' Health Interventions

- Preventive , Promotive and Curative health
- Emphasis on malaria, diarrohea and tuberculosis prevention
- Reproductive and child health care interventions with an emphasis to build local trained health workers
- Enabling communities to access micro insurance policies and also health schemes of the Government – JSY, MAMTA, RSBY

Health Interventions

- Creating enabling living conditions
- With Focus on Water and Sanitation
- Odisha context
- 85% rural communities continue to practice open defecation
- Only 20% of the rural population have access to safe piped water facilities

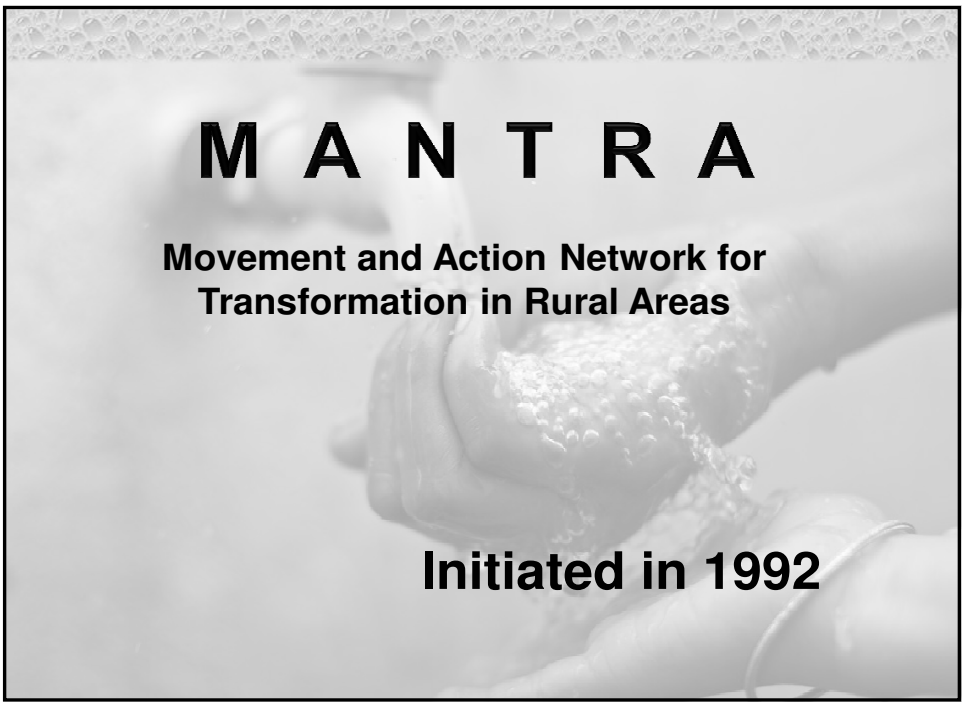
People consume unprotected water

This is the water, the villagers in Hundula village , Keonjhar use for drinking and cooking. No matter how much you boil a water like this, it will still be contaminated with germs and Chemicals. There is a government tube well also but it has not been functional for 2 years now and in spite of so many complaints, no action has been taken in this regard as of now.

There is opportunity cost of accessing drinking Water

In India, 60% of the girls who are not in schools are held responsible for sibling care and household chores.
Here are 10 yr old Damini and Kajal washing dishes from a nearby pump in the Goverdhan village, Keonjhar . A case of lost innocence.

40 % children under five years in Odisha are underweight.

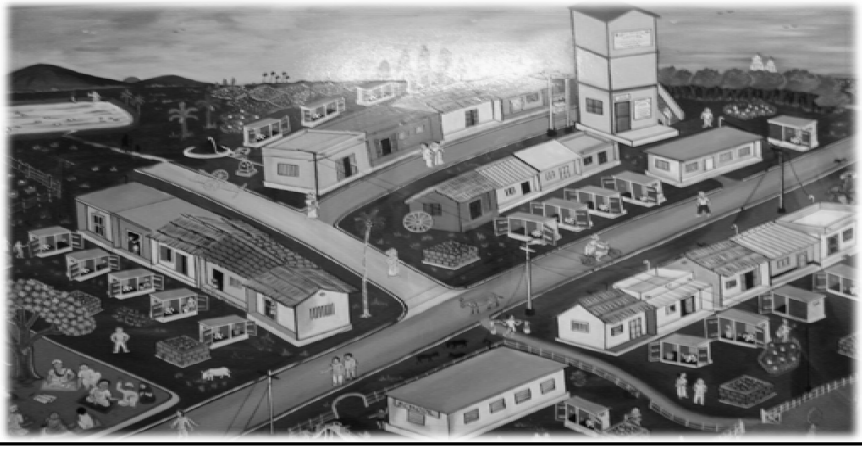


Gram Vikas' Approach

- Universal Access to Sanitation and Safe drinking water
- In India, toilets without water is not a workable solution
- Therefore both have to be seen as a comprehensive package

Gram Vikas' Approach

100% of all households have access to a private toilet and shower facility



Gram Vikas' Approach

Each household contributes 60% of the cost of sanitation infrastructure and the community contributes about 20 % of the cost of establishing piped water facility

Gram Vikas Approach

The Third Tap

Gram Vikas' Approach

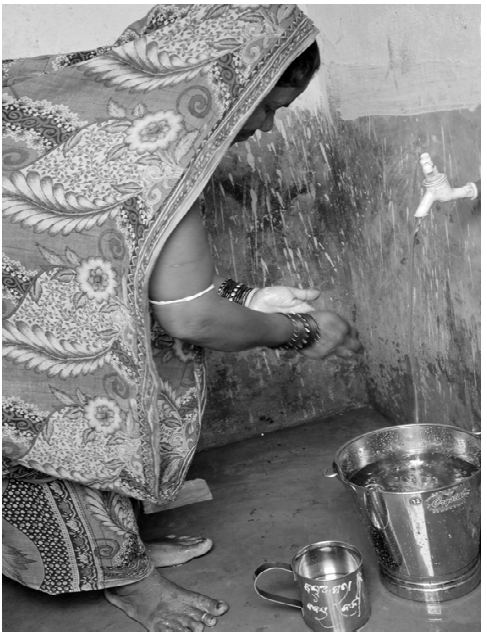
- Village level institutions and institutional mechansims are the building blocks for sustainability
- Each household is represented by an adult man and woman in the General body
- An executive committee with equal representation of men and women and proportionate representation across caste groups

Gram Vikas' Approach

- Village Corpus fund by contribution on an average of Rs. 1000 per family
- Maintenance fund established through household contribution and developing community assets

Gram Vikas' Approach

- Health and hygiene education with Village community members
- School children undergo hygiene orientation
- SHG members take responsibility for maintaining cleanliness of village and also maintenance of the sanitation facilities



Backyard gardens add to Food and nutrition security of households

RESULTS

85% reduction in incidence of water borne disease

Women relieved of the drudgery of fetching water

Toilet and bathing rooms constructed for 60763 households in 1043 villages

Toilets to new households: 405 units

Corpus fund of over Rs. 66 million

Government development funds of about Rs. 56 million accessed annually directly by villages

Over 90% immunisation of children

Building **dignity**, not just toilets!

Gram Vikas

An **equitable** and **sustainable** society where people live in **peace** and **dignity**

Annexure-XIV

Drinking water, sanitation and hygiene as human rights: Perspectives from the ground

Indira Khurana

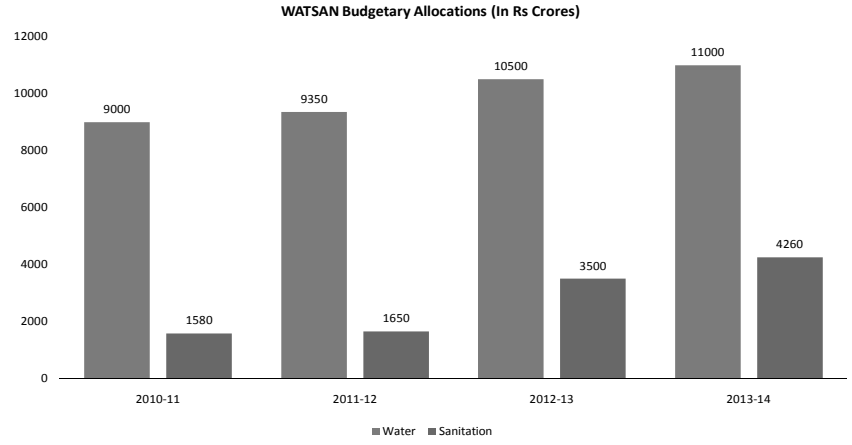
Importance of WASH

- Foundation of socioeconomic development
- Affects health: Cause of morbidity/mortality
- Causes stunting, and children with low IQ
- Affects education, exacerbates poverty
- Affront to dignity, especially of women, leading to poorer health, abuse and violence
- Menstrual hygiene, almost total neglect

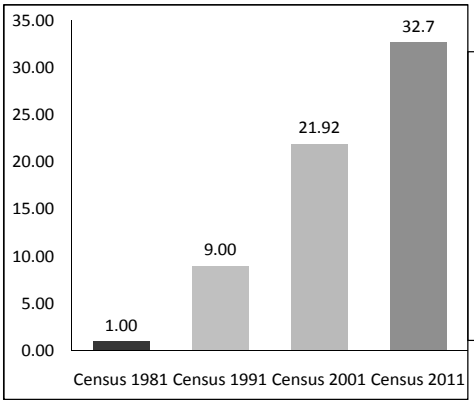
Rural WASH programmes

- Drinking water
  National Rural Drinking Water Programme
- Nirmal Bharat Abhiyan

Annual budgets

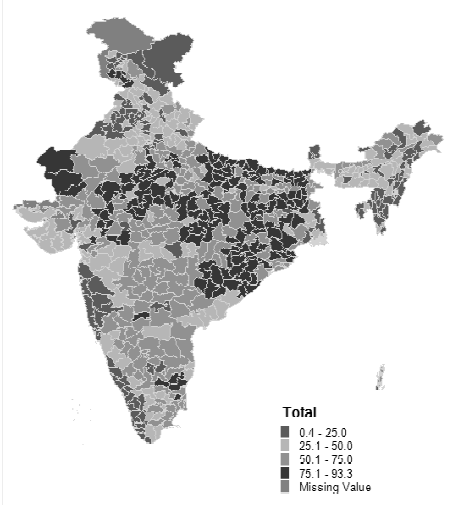


Rural Sanitation Coverage



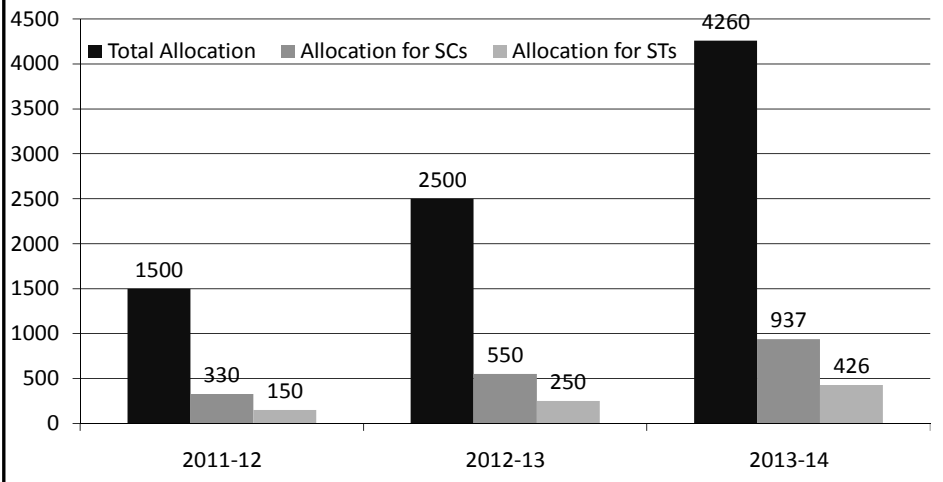
- JMP 2013 update: Nearly 620 million people country defecate in the open.
- This constitutes nearly 59.52% of those practicing open defecation in the entire world.

Rural sanitation coverage map



Percentage of rural population practising open defecation.

Allocation for general population, SCs and STs (In Rs crore)



What the figures speak

Sanitation

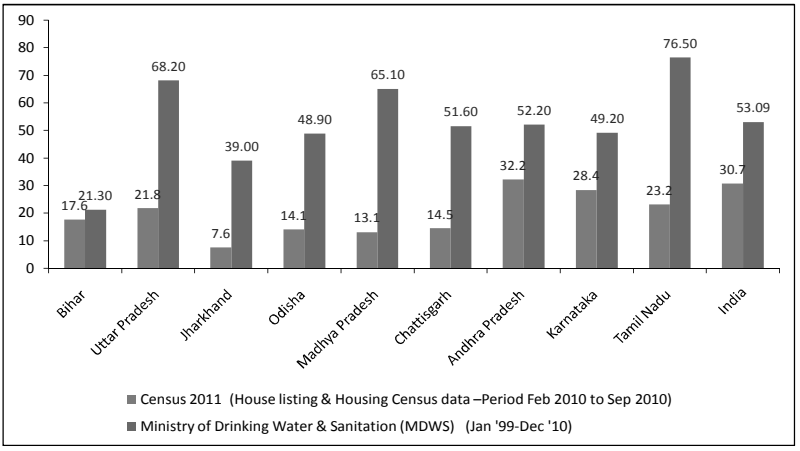
- An average of 25-30% difference in the two sets of data – Census and MDWS.

Water

- National drinking water coverage, unlike sanitation, is comparable across the 2 reports studied (i.e. Census 2011 & MDWS Data)

Why this discrepancy?

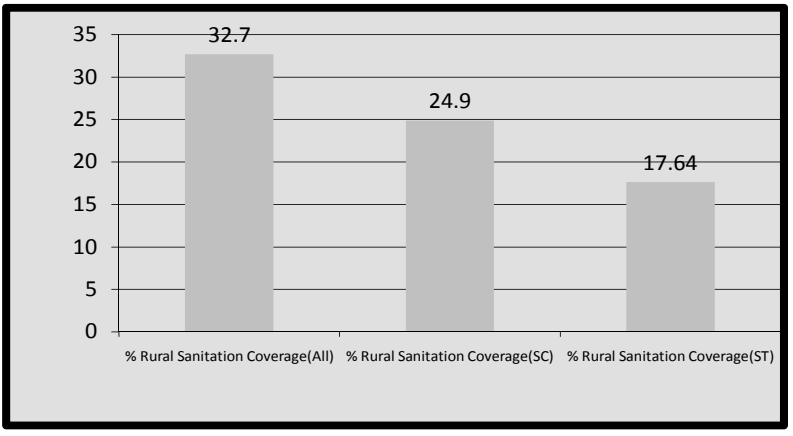
Census 2011 Vs MDWS Sanitation Rural Data Comparison for select states



Note: As per Census 2011 Delhi Sanitation Coverage is 76.3%

Challenge: Equity

- Differences in coverage and access by general population and SCs/STs



Story of Jharkhand

- Jharkhand's rural population76%, with substantial ST (26%) and SC (12%) population.
- High level of poverty, especially amongst STs, SCs.
- Jharkhand tops the list among Indian states with of homes having no toilet facilities: 77 %
- Allocations not released in timely manner
- Unfinished trainings and knowledge gaps persist in Jal Sahiyas, hampering their work

WASH facilities in PHCs

- Many PHCs do not have water available, toilets are non-existent, unsable or locked
- Centres where HIV/AIDS patients come for counseling and therapy often do not have access to safe drinking water/sanitation

Rationale for WASH rights

Enables:

- Prioritising and protection of budgets/ programmes
- Improved accountability and governance
- Genuine participation and access to information
- Priority for people without basic access – marginalised and vulnerable groups
- Affordability of services
- Legal mechanism for redressal of lack of access
- Recognition of responsibility of the right holder

GOI commitments: International

Signatory to

- Conventions such as CEDAW, Child rights, etc
- SACOSAN declarations (III, IV and V) which recognise sanitation as human rights
- UN General Assembly Resolution recognising drinking water and sanitation as human rights

Existing legal environment

- Not a fundamental/ legal right
- However various provisions – through which the right to drinking water and sanitation can be interpreted

  Best option currently available and used:

  Article 21: Right to Life

  Article 21: Right to Education
- Case law

Right to water: within national constitutions/ legislation

Algeria, Morocco, Eriteria, Ethiopia, Egypt, Kenya, Tanzania, Uganda, Mozambique, South Africa, Zambia Angola, Madasgascar, Congo, Gambia, Mauritania, Indonesia, Sri Lanka, Phillippines, Iran, Kazakhstan Nicaragua, Panama, Uruguay, Costa Rica Honduras Paraguay, Peru, Venezuela, Bolivia, Columbia, Ecuador, Dom inican Republic, Guatemala, Chile, Brazil, United Kingdom, the Netherlands, Belgium, France and Slovania.

Sanitation as a RIGHT

	Sanitation in Constitution	Sanitation in an Act
Bolivia		Yes
Columbia	Yes	
Ecuador	Yes	Yes
Guatemela	Yes	
Kenya		Yes
Maldives		Yes
South Africa	Yes	
Uruguay		Yes

Way forward

- NHRC to take *suo moto* cognisance of violation of WASH rights;
- Set up a group within the framework of NHRC to monitor access/violation. Focus should be on the most marginalised with special plans and budgets
- Engage with the SHRCs to monitor progress/violations
- NHRC to ask states to develop time bound action plans for complete coverage

Way forward

- Move towards drinking water and sanitation as legal rights in a progressive, time bound manner
- Appropriate allocation of human and/financial resources for WASH programmes
- Ensure that all health care facilities and institutions have adequate and safe WASH

Annexure-XV

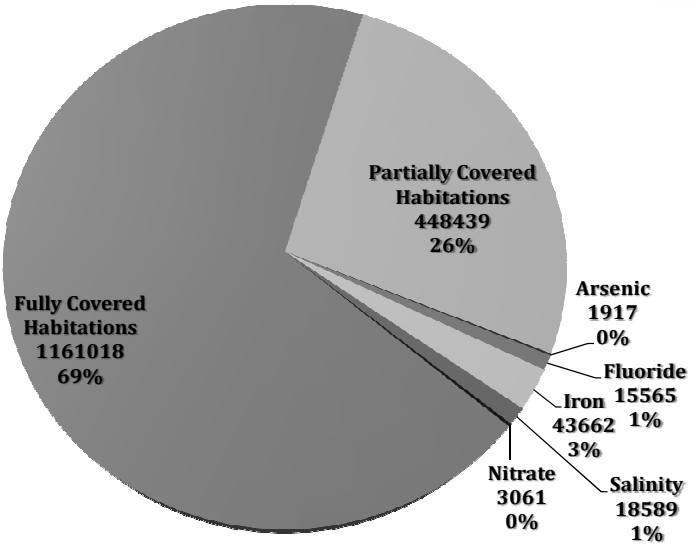
" Policies and Programmes of Government of India on Water and Sanitation"

Satyabrata Sahu
Joint Secretary,
Ministry of Drinking Water and Sanitation
Government of India

National Rural Drinking Water Programme (NRDWP)

- **Goal**
  - To provide every rural person with adequate safe water for drinking, cooking and other domestic basic needs on a sustainable basis. This basic requirement should meet minimum water quality standards and be readily and conveniently accessible at all times and in all situations.
- **Vision**
  - Safe and adequate drinking water for all, at all times, in rural India.

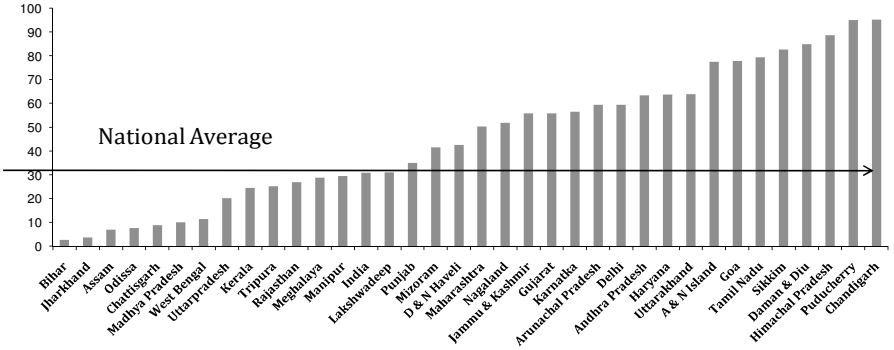
Status of Habitations as on 01.04.2013



% of Households having tap connection (both household taps and public taps)

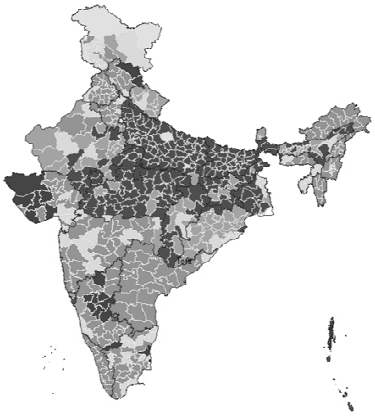
As per Census 2011

% of Households having tap connections (both household taps and public taps)



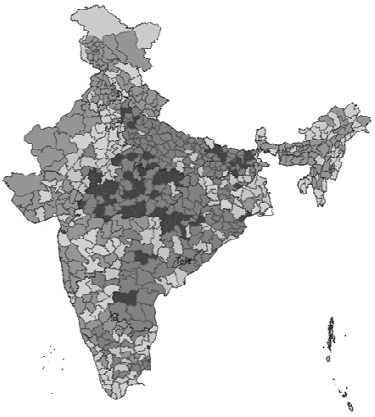
Major sources of Water Supply in Districts

Piped Water Supply



Rural Population
- 0.1 - 25.0
- 25.1 - 50.0
- 50.1 - 75.0
- 75.1 - 99.0
- 99.0 - 100.0
- Missing Value

HAND PUMP

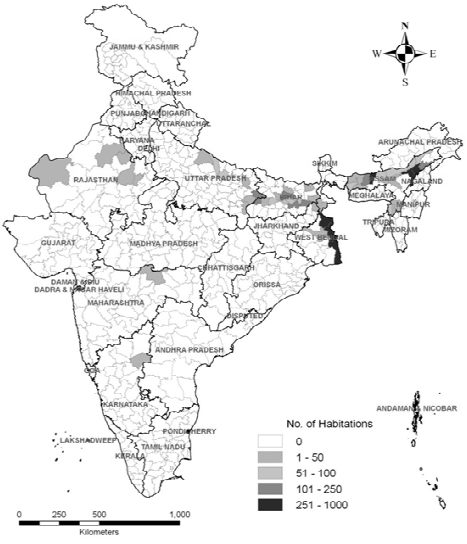


Rural Population
- 99.0 - 100.0
- 75.1 - 99.0
- 50.1 - 75.0
- 25.1 - 50.0
- 0.1 - 25.0
- Not Available

As per IMIS data

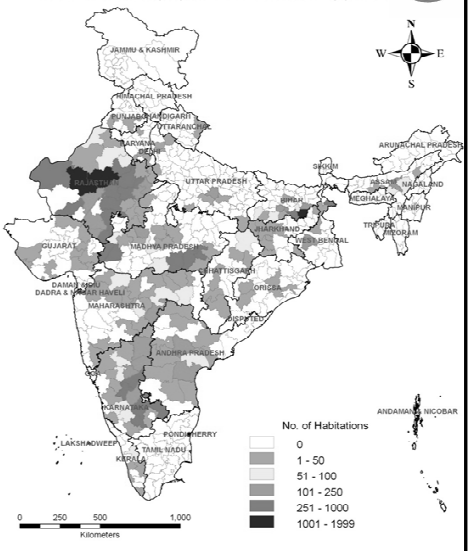
Quality affected districts

INDIA - HABITATIONS AFFECTED WITH ARSENIC



Arsenic contamination shown in Rajasthan and Maharashtra is incorrect

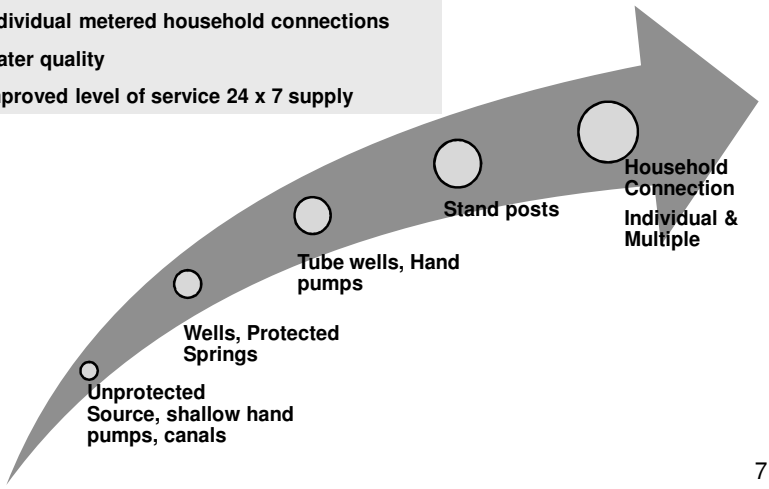
INDIA - HABITATIONS AFFECTED WITH FLUORIDE



Rising expectations moving up the ladder

Emphasis on

- **Individual metered household connections**
- **Water quality**
- **Improved level of service 24 x 7 supply**



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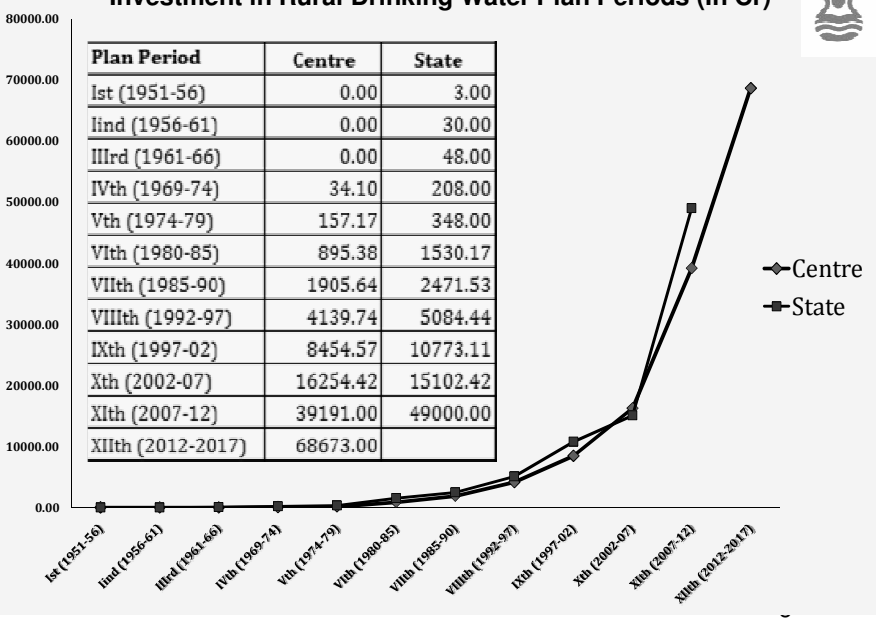
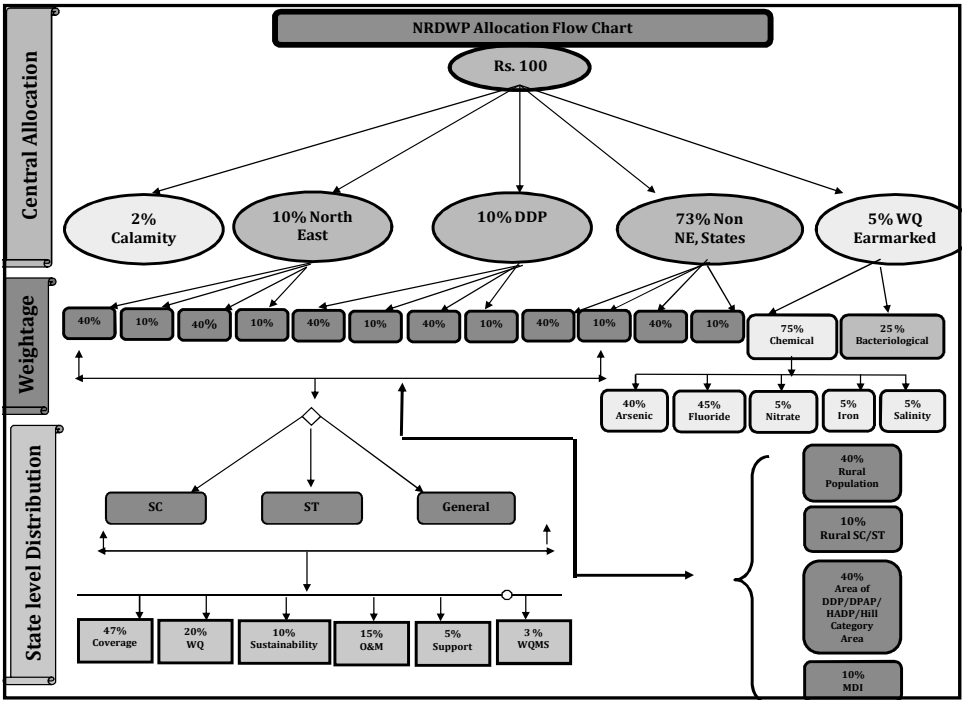
Investment in Rural Drinking Water Plan Periods (In Cr)

Plan Period	Centre	State
Ist (1951-56)	0.00	3.00
IInd (1956-61)	0.00	30.00
IIIrd (1961-66)	0.00	48.00
IVth (1969-74)	34.10	208.00
Vth (1974-79)	157.17	348.00
VIth (1980-85)	895.38	1530.17
VIIth (1985-90)	1905.64	2471.53
VIIIth (1992-97)	4139.74	5084.44
IXth (1997-02)	8454.57	10773.11
Xth (2002-07)	16254.42	15102.42
XIth (2007-12)	39191.00	49000.00
XIIth (2012-2017)	68673.00	





Goals and Timelines for drinking water supply - Strategic Plan 2012-2022

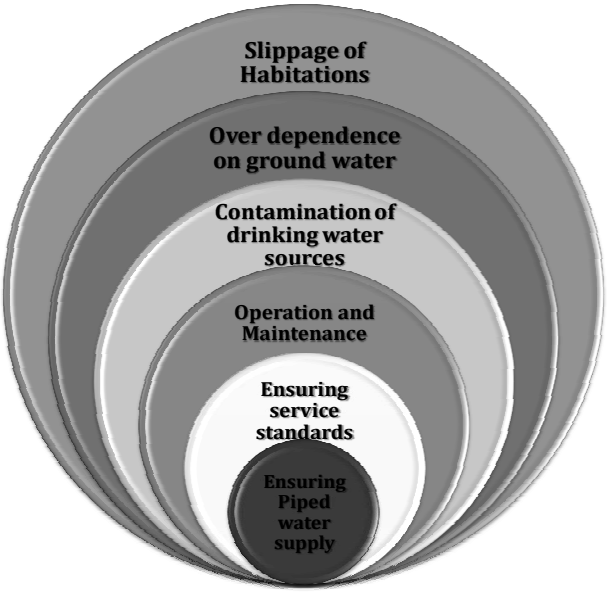
By 2017

- Ensure that at least 55% of rural households are provided with piped water supply; at least 35% of rural households have piped water supply with a household connection;
- Ensure that all households, schools and anganwadis in rural India have access to and use adequate quantity of safe drinking water.
- Provide enabling support and environment for Panchayati Raj Institutions and local communities to manage at least 60% of rural drinking water sources and systems

By 2022

- Ensure that at least 90% of rural households are provided with piped water supply; at least 80% of rural households have piped water supply with a household connection;
- Provide enabling support and environment for all Panchayati Raj Institutions and local communities to manage 100% of rural drinking water sources and systems.

Issues/challenges



Paradigm Shifts

- Preference from habitations to households
- Ensuring drinking water security using basic minimum requirement.
- Adoption of 24 X 7 approach.
- Maintain potability and reliability of drinking water quality standards both at the production as well as at the consumption points .
- Focus on personal hygiene, and proper storage at the house hold level.
- Ensuring quality of water, (BIS) IS: 10500
- Water safety plan links the identification of a water quality problem
- Health based target needs to be established for using groundwater,
- Transfer of Water supply schemes to PRIs

New Developments and Initiatives to tackle challenges

- In XIIth Five year plan period, proposed to increase service level of drinking water supply in rural areas from 40 lpcd to at least 55 lpcd focused on piped water supply
- Conjoint approach of rural drinking water supply with rural sanitation for providing piped water supply to open defecation free GP's on priority.
- 5% Water Quality earmarked fund in NRDWP for States with Water Quality affected habitations and with JE/AES affected high priority districts.
- From 2011-12, 3% of NRDWP allocation is now to be spent exclusively on Water quality Monitoring and Surveillance at the grass root level as well as through laboratories
- World Bank assistance of $500mn for funding of Rural Drinking Water Supply and Sanitation Schemes.
- National Clean Energy Fund for Solar Powered Dual pump based piped water supply schemes in 10,000 habitations in Integrated Action Plan districts

New Developments and Initiatives

- Pilot projects in 15 water-stressed blocks in 10 States to prepare water security plans in a participatory manner using practices like Water Budgeting.
- International Centre for Water Quality in Kolkata is being set up.
- To ensure sustainability of schemes, allocation for Operation and Maintenance from State NRDWP allocations has been increased from 10% to 15%.
- 10% NRDWP funds to be spent on promoting Sustainability of sources.
- A Management Devolution Index has been introduced to incentivize devolution of operation and management of rural water supply schemes to PRIs.
- Preparation of Hydro-geomorphological maps to enable the States to locate sources for drilling of tubewells/borewells and suitable sites for water conservation and recharge structures.

Nirmal Bharat Abhiyan

NBA envisages covering the entire community for saturated outcomes with a view to create Nirmal Gram Panchayats with following priorities

- Provision of Individual Household Latrine (IHHL) for both BPL and identified APL households within a Gram Panchayat
- Gram Panchayats with coverage of Rural Water Supply
- Provision of adequate sanitation facilities separately for boys and girls in Government Schools and Anganwadis in Government buildings within these GPs
- Solid and Liquid Waste Management (SLWM) for proposed and existing Nirmal Grams.
- Extensive capacity building of these stakeholders like PRIs, VWSCs and field functionaries for sustainable sanitation.
- Appropriate convergence with MNREGS for coverage with IHHL.

Provision made under Nirmal Bharat Abhiyan launched in April, 2012

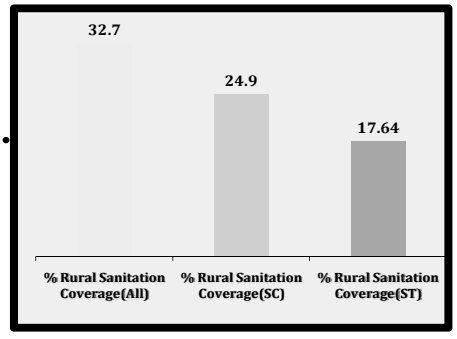
- Higher financial assistance provided to the tune of construction cost of toilets up to Rs 10,000 (GOI-3200 + State-1400 + Beneficiary – 900 + MNREGA - 4500.
- All households under SC and ST categories irrespective to their wealth quintile are eligible for the incentive.
- Incentives extend to other categories like women-headed households , small and marginal farmers, people with disability and landless labour.
- Construction of community toilets so that SCs and STs are able to get necessary benefit from their construction along with other landless people, commuter.
- From 2011-12, 22% and 10% of the total allocation is earmarked for SCs and ST population under NBA.
- Hygiene education in convergence with other Ministry.

Provisions continued….

- Child friendly toilets for children.
- Ramps for easy access of physically disabled.
- Additional assistance Rs. 500 for people in remote and hilly areas.
- A Standard Operating Procedures (SOP) for rural drinking water supply and sanitation while responding to natural disasters with clear-cut responsibility and action plan required to furnish water, sanitation and hygiene requirement.
- All targeted beneficiaries are provided incentives for conversion of insanitary latrines into sanitary latrines. No bucket/dry latrines permitted. This is to prohibit complete manual scavenging.

Access to sanitation by marginalized communities

Access to latrines	Total no. of Households	Total no. of HHs with toilet facility	% HHs having access to toilet
Access to latrine among total rural HHs	16,78,26,730	5,48,29,231	32.7
Access to Latrines among SC HHs	3,29,19,665	81,95,489	24.90
Access to Latrines among ST HHs	2,01,42,434	35,53,840	17.64



Monitoring mechanisms & Way Forward

- Online monitoring system has been introduced to strengthen monitoring mechanism and transparency.
- State Governments are urged to report the physical and financial progress online on monthly basis and update the panchayat wise data on annual basis.
- The progress achieved in construction of Individual household latrines under NBA for SCs and STs is being monitored.
- Improvements have been made in website and in the online monitoring system for capturing of achievement data for toilets constructed in APL SCs/STs households and Women headed households.
- For the 12th Plan, total Rs. 37,159 crore have been allocated for rural sanitation, Out of which Rs. 8175 crore and Rs. 3,715 crore are for SCs and STs.
- To bring necessary attitudinal change amongst the service providers.
- Various vulnerable groups are to included in the planning and implementation processes so that the needs of all are addressed
- The NBA guidelines can be adapted to suit local requirements.

Annexure-XVI

"Management of Occupational Health and Safety through Use of Technology & Capacity Building"

Dr.Shakti Samant Waghe,
Director (Medical),
Central labour Institute, Mumbai.

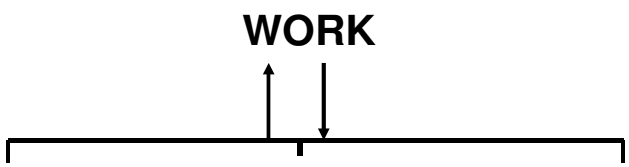
Definition

ILO & WHO, define occupational health as the promotion & maintenance of the highest degree of physical, mental & social well-being of workers in all occupations.

Thus occupational health is
TOTAL HEALTH OF ALL AT WORK.

Two way relationship between work & health.

WORK
HEALTH ⇄



SCHEDULE III
[Section 89,90]

LIST OF NOTIFIABLE DISEASES

1) Lead poisoning including poisoning by any preparation or compound of lead or their sequelae.
2) Lead – tetra – ethyl poisoning .
3) Phosphorus poisoning or its sequelae
4) Mercury poisoning or its sequelae
5) Manganese poisoning or its sequelae
6) Arsenic poisoning or its sequelae
7) Poisoning by nitrous fumes
8) Carbon bisulphide poisoning
9) Benzene poisoning , including poisoning by any of its homologues, their nitro or amide derivatives or its sequelae
10) Chrome ulceration or its sequelae

11) Anthrax.
12) Silicosis
13) Poisoning by halogens or halogen derivatives of the hydrocarbons of the aliphatic series.
14) Pathological manifestations due to –
    (a) radium or other radioactive substances ;
    (b) X – rays
15) Primary epitheliomatous cancer of the skin
16) Toxic anemia
17) Toxic jaundice due to poisonous substances.
18) Oil acne or dermatitis due to mineral oils and compounds containing mineral oil base.
19) Byssionosis.

20) Asbestosis.

21) Occupational or contact dermatitis caused by direct contact with chemicals and paints .
These are of two types , that is, primary irritants and allergic sensitizers.

22) Noise induced hearing loss (exposures to high noise levels).

23) Beryllium poisoning.

24) Carbon monoxide .

25) Coal miner's pneumoconiosis.

26) Phosgene poisoning.

27) Occupational cancer.

28) Isocyanates poisoning.

29) Toxic nephritis.

Occupational diseases occur as a result of exposure to:

- Physical
- Chemical
- Biological
- Or psychosocial factors in the work place.

Hazardous Factor	Adverse Health effect or other outcomes
1. Mechanical risk factor	1. Occupational accidents & injuries
2. Physiological strain & heavy physical work	2. Musculoskeletal disorder, Strain Injury, Low – back pain
3. Ergonomics factor	3. Strain injuries, Mental stress, Lowered Productivity and quality of work
4. Physical Factors e.g. noise, & vibration	4. NIHL, Traumatic Vasospastic disease
5. Chemical hazards	5. Intoxications, fibroses, cancers, allergies nervous system injuries.
6. Biological factors	6. Infection, allergies
7. Psychological strain	7. Psychic stress, work dissatisfaction, burnout, depression
8. Psychosocial aspect of work	8. Conflict, lowered productivity, lowered quality of work, mental stress

Differences Between Occupational & Work – related Diseases

Work –related Diseases	Occupational Diseases
• Occurs largely in the community.	• Occurs mainly among working population.
• "Multifactorial" in origin.	• Cause specific.
• Exposure at work Place may be a factor.	• Exposure at workplace is essential.
• May be notifiable & compensable.	• Notifiable & Compensable

CORRELATION BETWEEN ENVIRONMENTAL EXPOSURE & HEALTH STATUS

*** Nature of substance of exposure**
*** Intensity or severity of exposure**
*** Length of exposure; &**
*** Personal susceptibility**

METABOLISM AND EXCRETION

- Once absorbed into the body, this toxic effect of the agent is regulated by the metabolic an excretory processes.
- Metabolism in the body can either enhance the toxicity, or reduce it, by detoxification or storage in a relatively inert form.
- The main avenues of excretion are the urinary and the intestinal tracts as well as the lungs.
- The skin and its appendages and the salivary glands are also considered as excretory organs.

ACUTE AND CHRONIC EFFECTS

- ACUTE - by large doses of poisonous substances
- CHRONIC - is the result of repeated or continuous small doses in an industrial environment, the conditions causing chronic poisoning are more significant than those causing acute poisoning.

Other responses which are more typically chronic in nature include damage to lungs, to blood, nervous system, liver, kidneys, bones, skin, etc

A few examples are:-

(i) inhalation of dust containing silica, arsine, and lead may produce silicosis and changes in blood.

Organophosphates destroy the enzyme, cholinesterase which is present in the red blood cells.

(ii) carbon disulphide and some of the halogenated hydrocarbons have a cumulative effect upon the nervous system. Chronic mercury and manganese poisonings usually involve in nervous system,

(iii) injury to liver and kidney may be caused by carbon tetrachloride

(iv) chronic poisoning from yellow phosphorus and fluorine may cause serious damage to bone structure. Cancer frequently develops in bones in which radium is deposited;

(v) skin affliction in the form of dermatitis may be attributed to the skin absorption of tetraethyl lead epoxy resins, cutting oils, etc. Skin cancer may be caused by long continued contact will certain constituents of coal tar and shale oil,

(vi) bladder-tumors may be caused when chemical carcinogens, such as betanapthylamine and benzidine are inhaled over a considerable time. Radioactive substances also produce tumors.

PREVENTION OF OCCUPATIONAL DISEASES
Two approaches

1) Elimination of control of the casual agent in the work place.
2) Surveillance of the health of the worker.
   - Primary prevention → elimination of the exposure to harmful agents or its reduction to a level considered as innocuous, for various reasons, mostly technical, sometime of economical nature.
   - Secondary prevention → early detection of occupational diseases in pre – symptomatic or reversible stage by means of medical examination.
   - Tertiary prevention signifies management of occupational diseases.

MEDICAL SURVILLANCE :

- PRE – EMPLOYMENT
- PRE – PLACEMENT AND
- PERIODIC MEDICAL EXAMINATION.

- PRE RETIREMENT EXAMINATION

First three are by law.
But last one is not compulsory

EXISTING STRUCTURE IN OHS- CAPACITY BUILDING

- Technology advancement and Industrialisation are increasing the factors, vulnerability and causes of various Occupational Diseases & Injuries.
- To deal with the factors, vulnerability and causes precautionary measures are designed and formulated at Global and National level in the form of Standards, Laws and Rules.
- Department and Agencies are raised by the Government for study, monitoring and enforcement of these Standards, Laws and Rules.
- All the Department and Agencies raised serve for a common purpose/goal, i.e. Health & safety of occupants, property and environment .

NATIONWIDE STRUCTURE IN FIELD OF OCCUPATIONAL HEALTH AND SAFETY

Agencies with different responsibilities in the field of Occupational Health and Safety are formalized and activated at different levels by the Central Government and State Government.

Some of these agencies are:

- Directorate General Factory Advice Service & Labour Institute (DGFASLI),
- National Safety Council (NSC),
- National Disaster Management Authority (NDMA),
- Crisis Management Group (CMG)
- Central Pollution Control Board (CPCB)
- Occupational Safety & Health Authority (Just as a guide line for framing legislation) (OSHA)
- National Institute of Occupational Health
- Etc.

LAWS AND RULES FORMULATED

The Laws and Rules formulated by the Agencies in India:

- Factories Act 1948
- Labour Act
- The Petroleum Act 1934 & Rule, 2002
- The Environmental Protection Act, 1986 (amended 1991) & Rules, 1986 (amended 2004)
- The Indian Boilers Act, 1923 & Regulation, 1950 (amended 1997)
- The Building & Other Construction Workers Act 1996
- The Static and Mobile Pressure Vessels (Unfired) Rules, 1981 (amended 2001)
- The Hazardous Waste (Management & Handling) Rule 1989 (amended, 2003)
- The Gas Cylinder Rules, 2004
- The Explosive Act, 1884 etc.

WHY A NEW CONCEPT IS REQUIRED?

- After all the efforts from the Government and the agencies the desired results are not achievable, is the reason to be bothered.
- This failure implies that the current approach is not sufficient and a new concept of the approach is to be worked out.
- The approach which would be capable to achieve the desired results to the accountable level by utilising the current structure.

ACCOUNTABILITY CRITERIA

- The Criteria for the accountability of the results could be categorised as under:
  - Savings in terms of National Asset
  - Duration of achievements in terms of Time period
- National Asset Loss, Factory's Accident, Injuries, Diagnosis and reporting of Occupational Diseases.

FACTORS RESPONSIBLE FOR FAILURE OF THE CURRENT SYSTEM:-

The major factors responsible for lack of performance of the plans on Occupational Health, Safety & Environmental measures:

- Exact Risk Assessment & Evaluation in most case is not possible
- Lack of awareness about the hazards in the neighborhood of the community
- Lack of trained personal to deal with the Occupational Health & Safety in the vicinity of the hazards.
- General public is ill-equipped mentally and physically to deal with any accident scenario.
- No Law / regulation / programme exist to cover the working conditions & statues of workers in unorganised sector.

OBJECTIVE

Objectives of the concept are:

- To improve awareness about the Occupational Heatth hazards inside and in the neighborhood of the community.
- To provide information to the public about the steps taken by the Government/ Industries in regard to the hazards/disaster associated in the location.
- To provide public with the information about preparedness required (i.e. Health & safety precautions and measures to be taken) to overcome the hazard/disaster.
- To train public on communication channel and standard communication format.
- To train public on Initial Response Activities in case of Emergency/ Disaster (Generalised and Specific based on hazard study report of the community)
- To motivate public to follow the safe procedure, process and/or action
- To train all Public/PSUs/Private employer and employees about the Health & safety measures and procedures to be followed at their respective work places

RESULTS/OUTCOME

The result/outcome of the concept expected are listed benefits;

- Number of accidents, Injuries & Occupational Health will reduce as the public will be aware of the safety precautions to be taken in the risk prone area.
- Image of the Government will improve as the steps for Prevention of Occupational health & safety of the public taken by the government will be enlightened to the public.
- Proper communication will help the respective expert teams to reach the location with accurate and sufficient preparation and resources.
- Major load at the time of Emergency / disaster for the authorities, use to be management of public which will be reduced as the trained public will be helping in management.
- Loss of the national assets will reduce.
- Finally reduce the requirement of Occupational Health & Safety personnel in future.

IMPORTANT QUESTIONS

Do you think the Factors Responsible discussed are the Primary Factors for the failure to achieve the goals?

Do you think the Objective discussed should be the Primary Objectives of this Concept?

The Answer must be No.

So; What are the factors for the failure and also What should be the Primary Objectives

PRIMARY FACTORS RESPONSIBLE FOR FAILURE

The Primary Factors responsible for lack of performance of the plans and safety measures :

- All Agencies sharing common Goals are working independently with different plans.
- Lack of coordination between the Agencies in the Government Structure
- No time frame is defined for any plan, for any level and for any Agency

PRIMARY OBJECTIVE

Primary Objectives of the concept are:

- To improve the coordination between the Agencies in the Government structure
- To bring the Agencies working independently but sharing common goals under single umbrella/roof
- Optimum utilisation of the resources already in the Government structure
- To achieve the desired level of accountable results in a time frame
- To reduce negligence and corruption at the level of enforcement

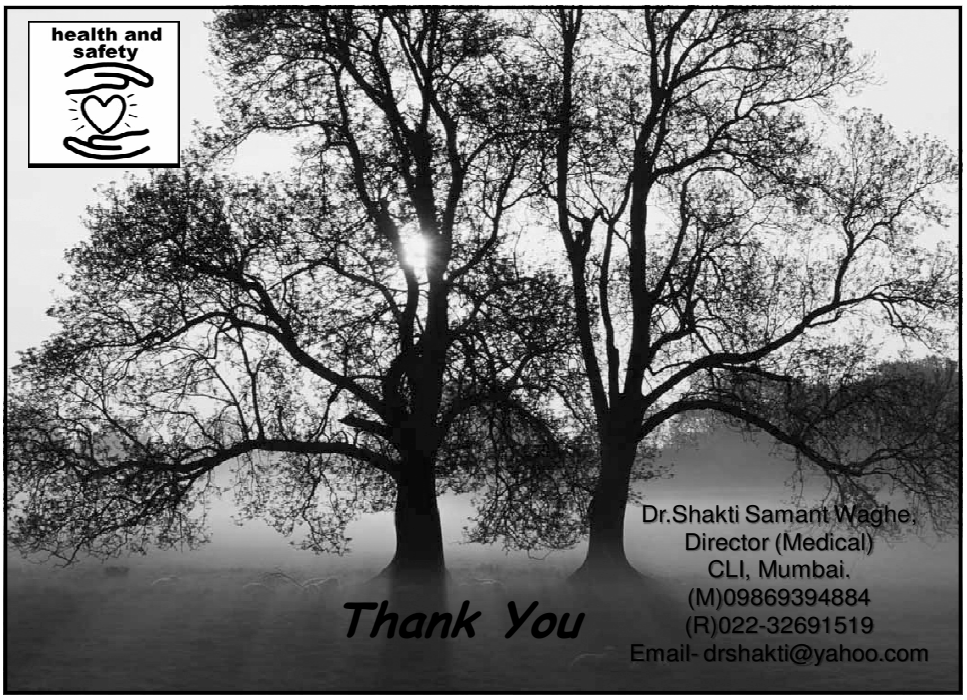
New Concept for Capacity Building

- To bring all agencies working for common goals with different plans under a single umbrella.
- Formation of a Highly technical Joint committee of existing structure without domination of single agency.
- No political elements or interference on the committee.
- Committees will have structure at National, State, District and also at the Panchayat Level.

CONCLUSION:-

It's the requirement of the time that we should think unconventionally to :-

- Cover both organised & unorganised sector,
- Improvement in the performance of current structure without any extra cost.
- Proper Monitoring & feed back channel will help in effective implementation and review.
- Most efficient Data Management can be achieved in the field of Occupational Health & Safety.


health and safety
Thank You
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Annexure-XVII

Governance Challenges for the Implementation of Workers' Rights in Hazardous Industries: A Case Study of Alang-Sosiya Ship Breaking Yard, Bhavnagar, Gujarat

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Centre for Science, Technology & Society
Tata Institute of Social Sciences (TISS)
Mumbai

Alang-Sosiya Ship Breaking Yard: An Overview

Started in February 1983 at Alang

Alang, in India, has retained its position as the world's foremost ship breaking industry, accounting for an average of 70% of tonnage, and an average of 50% of worldwide demolition sales.

There are 167 ship breaking plots (Data collected in August 2013)

Alang Ship Breaking Yard employs about 35,000 workers each year

Industry is a great source of revenue for the State of Gujarat

Provides steel to the growing Indian economy

Factors behind ship breaking's migration to Asia

Inexpensive labour force

Relatively less stringent environmental and health regulations compared to western countries

A domestic market for scrap steel. For instance, the yards now supply 100% of Bangladesh's steel. In India, steel from the yards reportedly account for 15% of the country's total steel output

Suitable physical conditions such as the availability of dry beaching facilities

Legal Status in India

Extensive regulatory framework

In 1979, the Government of India and the Government of Gujarat recognized ship dismantling as a manufacturing activity under Chapter 15 of the Central Excise Rules for the purpose of sales tax.

It is subject to inspection rules under the Indian Factories Act, 1948 for labour safety and occupational health and also by other legislations

Contd....

Gujarat Maritime Board Act 1981

Ship building policy 2010

Steel Ministry's new code for ship-breaking 2013

No Dearth of Environmental Laws

1. Environment Protection Act, 1986
2. MSIHC and Chemical Accident Rules, 1989
3. Hazardous Waste Rules, 2002
4. GMB Rules on Ship Breaking, 2006
5. Factories Act, 1948

There are also international laws and agreements to regulate the behaviour of hazardous industries like ship breaking

No Dearth of Environmental Laws

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2. MSIHC and Chemical Accident Rules, 1989
3. Hazardous Waste Rules, 2002
4. GMB Rules on Ship Breaking, 2006
5. Factories Act, 1948

There are also international laws and agreements to regulate the behaviour of hazardous industries like ship breaking

Basel Convention (1989) on the Control of Trans-boundary Movements of Hazardous Wastes and their Disposal

Article 6 states that 'the State of export shall notify, or shall require the generator or exporter to notify, in writing, through the channel of the competent authority of the State of export, the competent authority of the States concerned of any proposed trans boundary movement of hazardous wastes or other wastes' and then the State of import shall 'respond to the notifier in writing, consenting to the movement with or without conditions, denying permission for the movement, or requesting additional information'.

Hongkong International Convention (2009)

The Hongkong International Convention (2009) for Safe and Environmentally Sound Recycling of Ships is aimed at ensuring that ships, when being recycled after reaching the end of their operational lives, do not pose any unnecessary risk to human health and safety or to the environment.

The Convention intends to address all the issues around ship recycling, including the fact that ships sold for scrapping may contain environmentally hazardous substances such as asbestos, heavy metals, hydrocarbons, ozone depleting substances and others. It will address concerns raised about the working and environmental conditions at many of the world's ship recycling yards.

Extensive Regulatory Framework

1. Cargo Free Certificate
2. Decontamination Certificate
3. Atomic Radiation Free Certificate
4. Gas Free for Man Entry
5. Gas Free for Hot Work
6. Naked Light Certificate
7. Waste Disposal under Hazardous Materials and Waste Rules
8. Labour Insurance Certificate
9. Factory Inspector Certificate
10. Beaching Permission

Multiple Authorities

1. Customs Department
2. Gujarat Pollution Control Board
3. Department of Explosives
4. State Factories and Labour Commission
5. Atomic Energy and Radiation Board
6. Department of Inspection
7. Gujarat Maritime Board
8. Inter-Ministerial Committee
9. State CRZ Authority

Role of the Indian Supreme Court

The Supreme Court of India had issued directions to undertake safe & environmentally sound recycling in India. (Research Foundation for Science, Technology and Natural Resource Policy versus the Union of India and other respondents)

Technical Experts Committee was appointed by the Supreme Court in 2006.

Directions were issued to the Govt. of India to formulate a comprehensive code for ship recycling incorporating the recommendations of Technical Experts Committee

The Supreme Court of India, in its ruling in July, 2012, has banned import of ships carrying hazardous and toxic wastes and has ordered strict implementation of the Basel Convention

Ground Reality.... No End to Hazardous Waste

Asbestos: Although its use has been banned since 1986, there are still many ships with asbestos. **15 out of 94 workers** tested showed early signs of asbestosis (Gujarat-based National Institute of Occupational Health in 2006)

Polychlorinated Biphenyl (PCB): They are usually found as anti-freezing agents and oils. The use of PCBs has been banned since 1975. India does not have the proper infrastructure to recycle PCBs.

Polybrominated Biphenyl (PBB): Plastics and constituents of plastics might produce hazardous fumes on burning. PBBs were listed as one of six controlled substances under the Restriction of Hazardous Substances Directive enacted into European law in February 2003.

Contd....

Heavy metals: Found in batteries and paints, and in substantial quantities in the chemicals stored in ships.

Oil sludge: Produces hazardous polyaromatic hydrocarbon gases on evaporation. Impacted marine life at Alang

Other non-hazardous solid waste: Broken ceramic tiles, wood pieces, expanded polystyrene packing, decorative and insulating material, cement, and other waste material litter ship breaking locations.

Generation of Hazardous Waste from Ships

Hazardous materials	Tonne per annum
Asbestos	175
Glass-wool	2,000
Rubber	40
Rexene	50
Plastics and cables	20
Sludge residue	800
Contaminated materials	200
Total	3,355

Source: Gujarat Maritime Board

Generation of Non-Hazardous Waste from Ships

Non-Hazardous materials	Tonne per annum
Fibreglass	40
Iron scales	900
Cardboard and packing	35
Glass	175
Municipal solid waste for landfill	5,000
Cement tiles	10,000
Total	16,150

Source: Gujarat Maritime Board

Occupational Health and Living Conditions

Working condition at Alang is highly hazardous to the health of the workers

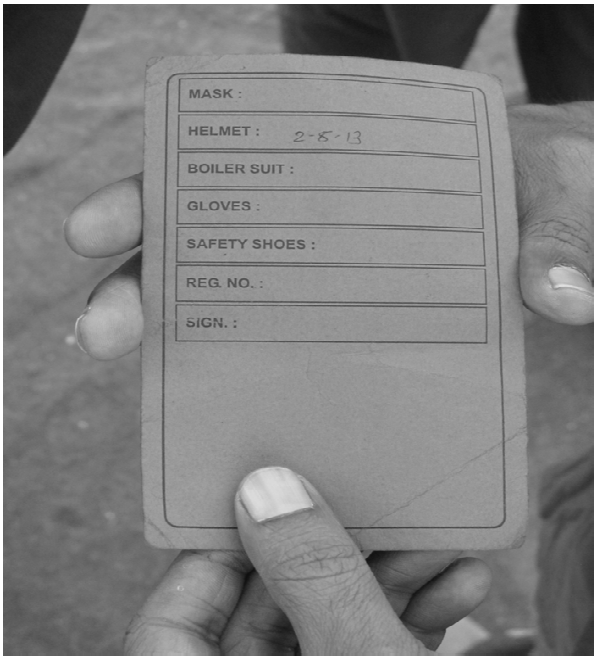
Facilities and protective gear at the work place are insufficient.

Lack of Sanitation, Water at Work Place

Housing facilities are not provided

Medical Facilities are inadequate

Number of deaths on ships at Alang (1991-2012): 434




TUNISIA ferries

Causes of Death at Alang Ship breaking yard (1991-2000)

Causes of Death	No of Deaths
Lifting Machinery	12
Transport Machinery	01
Explosion	16
Fire	44
Gassing	28
Struck by falling objects	48
Persons falling from heights	56
Fall on floor	10
Falling on pits and dumps	02
Striking against objects	30
Handling Goods	06
Others	04
Total	257
Source: Gujarat Maritime Board	

Why workers' rights and environmental concerns are neglected?

- Political Economy Factor
- Nexus among local leaders, plot owners and various government departments
- Multiple Authorities without any coordination
- Approach of the Indian Judiciary has been selective and also reflects the economic rhetoric

Role of Trade Union and Environmental Groups

Trade Union's role has been consistent but there is no local or outside support

Environmental Activism is confined to litigation but no mass mobilisation is happening

Hence, a comprehensive re-thinking is required…

- An integrated governance mechanism needs to be introduced
- Workers' representation both at the formulation and implementation level must be given due importance
- Responsibility of each institution needs to be fixed
- The national policy on OSH at workplace, adopted by the government in 2009 needs to be implemented effectively
- There is an urgent need to raise this issue at different forums, especially among SAARC countries