HEALTH CARE AS A HUMAN RIGHT

Civil Society Forum on Human Rights (CSFHR)

DO YOU KNOW YOUR HEALTHCARE RIGHTS?

ACCESS
You have a right to health care

SAFETY
You have a right to health care and high quality care

RESPECT
You have a right to respect dignity and consideration

COMMUNICATION
You have a right to be informed about services, treatment, options and costs in a clear and open way.

PARTICIPATION
You have a right to be included in decisions and choices about your care.

PRIVACY
You have a right to privacy nd confidentiality or your personal information

COMMENT
You have a right to comment on your care and to have your concerns addressed.

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PREFACE

The widely acceptable definition of health is that given by the WHO in the preamble of its constitution, according to World Health Organization, "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease." In recent years, this statement has been amplified to include the ability to lead a 'socially and economically productive life'. Through this definition, WHO has helped to move health thinking beyond a limited, biomedical and pathology-based perspective to the more positive domain of "wellbeing".

Right to health is not included directlyas fundamental right in the Indian Constitution .The Constitution maker imposed this duty on state to ensure social and economic justice. Part four (IV) of Indian constitution which is Directive Principles of State policy(DPSP) imposed duty on States. The Constitution directs the state to take measures to improve the condition of health care of the people. Thus the preamble to the Constitution of India, inter alia, seeks to secure for all its citizens justice-social and economic. It provides a framework for the achievement of the objectives laid down in the preamble. The preamble has been amplified and elaborated in the Directive Principles of State policy.

Not only the State also the Panchayats, Municipalities are liable to improve and protect public health. Article 243G says "State that the legislature of a state may endow the panchayats with necessary power and authority in relation to matters listed in the eleventh Schedule".

The DPSP are only the directives to the State. These are non-justifiable. No person can claim for non-fulfilling these directives. But the Supreme Court has brought the right to health under the preview of Article 21. The scope of this provision is very wide. It prescribes for the right of life and personal liberty. The concept of personal liberty comprehended many rights, related to indirectly to life or liberty of a person. And now a person can claim his right of health.Thus, the right to health, along with numerous other civil, political and economic rights, is afforded protection under the Indian Constitution.

In 1995, the Supreme Court in the case of ParmanandKatravs Union of India, held that whether the patient be an innocent person or be a criminal liable to punishment under the law, it is the obligation of those who are in charge of the health of the community to preserve life so that innocent may be protected and the guilty may be punished.

The Supreme Court, in PaschimBangaKhetmazdoorSamity&ors v. State of West Bengal &ors,while widening the scope of art 21 and the government's responsibility to provide medical aid to every person in the country, held that in a welfare state, the primary duty of the government is to secure the welfare of the people. Providing adequate medical facilities for the people is an obligation undertaken by the government in a welfare state.

Coming to our state Odisha, the health standards are in a deteriorating. General people and even the activist are unaware of the situation of the baseline. Many schemes declared in the health sector are being poorly implemented. Keeping this all at the backdrop CSFHR have initiated a process to amplify those ups and downs before the grass route activist who all are working at the village level. This booklet is meant to help the grassroute level activist to monitoring the health rights. We thank PRYAS, Jana SwastyaAbhijan (JSA), Sri Gouranga ch. Mohapatra and other members of CSFHR who participated in the training program and given a lot of input to develop the booklet. Hope this will help the activist to assess the situation and strength their monitoring initiative in the health system also will improve a systematic changes in the sector.

Thank you.

Dhirendra Panda
Convener
Civil Society Forum on Human Rights (CSFHR)

CONTENT

INTRODUCTION

All of us fall ill at some point of time in our lives, due to various reasons. We may need treatment in order to be cured of our illness. Sometimes, our illnesses cured naturally or may be with the help of some simple home remedy. But at other times, we need medical intervention which we seek from a clinic or health centre.

The right to health is a fundamental and universal right of all citizens in our country and this right needs to be respected and realized within a definite time frame. This Right to Health needs to be located in the context of access to underlying determinants of health, such as access to secure livelihoods, adequate food and nutrition, housing, and safe water and sanitation. Social inequities also - based on gender, caste, class, religion, ethnicity and other lines - have a profound impact on health status. Right to comprehensive and good quality health care services is also an important aspect of the right to health. To ensure the fulfillment of this right, the public health system needs to be much better resourced, expanded and made accountable so that it can provide healthcare services that are comprehensive, of good quality, accessible to all, and free at the point of access.

Today across India, people fall ill and die unnecessarily, due to a range of social and economic factors that generate ill-health and disease, as also due to poor access to affordable and effective health care. It is estimated that approximately 1.67 million children under five years of age die each year in India. This is the highest number anywhere in the world. One third of all malnourished children are estimated to be living in India. The cost of health care has become a leading cause of poverty. Consumer expenditure survey estimates by the National Sample Survey Organisation (NSSO) indicate that every year around 55 million people are pushed to poverty due to expenses on healthcare. Paradoxically, this situation exists in a context of availability of adequate resources, knowledge and skills for genuine change, for betterment and improvement of peoples' health as well as the healthcare system.

There is clear evidence that 6 crore people are pushed below the poverty line every year because of high medical expenses - i.e. out of pocket expenses paid by the patient at the point of delivery of health care. There is also evidence that around 80% of these out-of-pocket expenses are accounted for by the cost of medicines only. In India, an average family spends Rs.3,000 every year in buying medicines and on diagnostic investigations. It has been estimated that at least 50% of this expenditure is incurred on irrational or unnecessary drugs and diagnostic tests. All these irrational practices are rampant in India. The reasons are manifold. One is to do with the proliferation of a large number of drugs in the Indian market that are either irrational or useless. There are an estimated 60,000 to 80,000 brands of various drugs available in the Indian market.

Comptroller and Auditor General (CAG) of India report repelled that 31 types of time-expired medicines were administered to patients in the state 2007to 2013. By March 2013, time-expired medicines valued at Rs.74,000 were administered to patients in Cuttack, Jajpur, Mayurbhanj and Sundergarh districts during 2007-13. The CAG report also said that during audit, it found that 19 essential drugs valued at Rs. 14.84 lakh procured during 2008-09 were distributed to various rural medical institutions without any quality testing, and administered to rural patients.

What is Right?

It is the minimum conditions / entitlements for the individual to live a life with dignity.

The underlying assumptions are that:

- An authority which defines these minimum conditions
- The recognition that everyone does not enjoy these minimum conditions
- A mechanism for identifying the gaps - violation and non-fulfillment of rights
- A system that can fill the gaps, and provide justice

Authorities and Responsibility

The Authorities

- Must be articulated in constitution or law or recognized custom
- Must emerge through international agreements and treaties

The responsibility of the authority is that

- Rights must be protected
- Provide enabling conditions for exercising the rights

Just as duty bearers require adequate capacity to perform duties, rights holders also require conditions necessary for claiming or demanding of rights to hold duty bearers accountable.

The Characteristics of Rights are:

- Rights are universal (for all; everywhere at all times)
- Equality and Non-discrimination: All individuals are equal as human beings and by virtue of the inherent dignity of each human person.
- Rights are inalienable (can't be taken away or given up)
- Participation is a fundamental right (everyone is entitled to demand their rights…)
- Rights are indivisible and inter-dependant (denying certain rights undermines respect for others)
- Rights enable us to demand if necessary what is due, without having to beg for benevolence or compassion

Rights are associated with Human Dignity and Respect for each and every person … a system and acceptance of rights contributes to personal self esteem

Health Right is a Human Right

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.

India has realized these factors since long and The Bhore Committee report (18th January 1946) is historical event in this aspect. The main principles of Bhore committee report is as follows:

1. No individual should fail to secure adequate medical care because of inability to pay for it.
2. The emphasis should more on prevention of diseases rather than cure.
3. Focus should be on rural areas, with health services, as close to the people as possible.
4. Active cooperation of the people in the development of the health programme.

Where we have seen all the national and International documents recognize the Right to health is a Human Right but our Government has not move in this direction, which reflects in number of policy and program like national Health Assurance scheme, national health policy, De-pricing of essential medicine, New drug pricing formula,

RSBY etc. Negative impact of Globalisation-Liberalisation-Privatisation policies reflects on various social sector services. Growing tendency for withdrawal of the state from provision of public health services stagnant or declining investments for public health. Proliferation of an unregulated private medical sector

Health Right and Indian Judiciary

Despite India's status as the world's largest democracy and one of the fastest growing economies, its successive governments have been slow to fulfill the right to health. Despite this country's high burden of disease, it spent only 1% of its gross domestic product on health care. The nature of India's constitution might have contributed to government indifference to public-health problems; although its non-enforceable chapter IV contains directive principles for policy that are intended as guidelines for minimum standards of living and for the ways in which health-related rights should be fulfilled, it does not include an explicit right to health.

Article 42 of the directive principles, which pertains to just and humane conditions of work and maternity relief, states: "The State shall make provision for securing just and humane conditions of work and for maternity relief". Moreover, article 47 says: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health." The non-binding nature of these principles arguably allowed for complacency and lethargy by Indian policymakers and consequently encouraged systemic violations of health-related rights in that country. However, in the past two decades, robust activism and public-interest litigation, coupled with creative judicial interpretation have successfully challenged indifferent Indian health authorities, and brought relief to many people. Public-interest litigation in India has centered on the fundamental right to life, article 21 of the Indian Constitution, which guarantees an individual's right to life and is enforceable in court. Although this article does not contain an explicit and enforceable right to health, in a landmark case in 1980 regarding deaths due to accumulation of soot in the lungs of young workers in state-run pencil factories, the court ordered the government to ensure installation of safety measures in the factories. A year later the Indian Supreme Court further signalled its intention to make the right to health enforceable by inference from the right to life. It ruled that the right to life includes: "the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter.

In the case of Kirloskar Brothers Limited versus Employee's State Insurance Corporation,12 the Supreme Court ruled that the right to health is the fundamental right of workers and is equally binding against the state and the private sector. These judgments show the fulfillment of article 12(2)(b) improvement of industrial hygiene, and article 12(2)(c), control of occupational diseases, of the international covenant on

economic, social, and cultural rights,1 and cumulatively have resulted in improved health and working conditions for many Indian people.

In Parmahand Katara versus Union of India and others, the Supreme Court held that physicians are obliged to preserve life irrespective of a patient's innocence or guilt in an alleged crime. The adequacy of health services has also been brought before the Indian judiciary. In Paschim Baga Khet Mazoor Samiti versus State of West Bengal, the court was asked to establish whether non-availability of services in government health centres amounted to a violation of article 21.7 In this case the claimant was refused treatment at eight state-run medical institutions in succession because of no availability of beds or insufficient technical capacity and eventually got treatment in the private sector, at great personal expense. In awarding compensation to the claimant, the court ruled that the right to emergency medical care was a core component of the right to health, which in turn was an integral part of the right to life. As a result of this case, state hospitals in India and the medical workers employed therein are now obliged to provide timely medical treatment to people in need.

Similarly, in Mahendra Pratap Singh versus State of Orissa, the court ruled that the Indian government's failure to open a health-care centre in a village amounted to a violation of the right to life, and by extension, the right to health.

By including the right to health in the right to life the Indian judiciary has also, among other orders upheld the state's obligation to maintain health services given the High Court duty to monitor the conditions of mentally ill and insane women and children in prisons control pollution hazards ban hazardous drugs ban inhuman conditions in care homes protect the health rights of mentally ill patients subjected to inhumane conditions and prohibit passive smoking in public places. The Indian courts have also brought access to clean drinking water and stopped animals straying onto public roads, thereby increasing road safety. Most recently, the courts have turned their attention to HIV/AIDS, specifically, people experiencing discrimination as a result of their HIV/ AIDS status and those at risk of HIV infection as a result of non-disclosure of their partner's HIV status by health workers (the court ruled that the interests of third parties overrode privacy concerns of the patient). These two judgments could be important in the years to come. According to UNAIDS estimates, India has the world's third highest number of HIV-infected people, after South Africa and Nigeria thus such landmark rulings will undoubtedly play a crucial part in shaping the government's response to this growing health crisis.

India's remarkable range of judicial cases show that although India does not have an explicit and binding right to health in its constitution, its judiciary is using creative reasoning to force the government to fulfil this right. Cumulatively, this approach has brought relief from suffering to any people and shows that a rights-based approach can have great effects on human health in a functional democracy. Hopefully, the Indian government will assume greater or sole responsibility for tackling the country's neglected diseases such as tuberculosis, lymphatic filariasis, leishmaniasis, and leprosy;

NHRC and Health Right

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 Collective. 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 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 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:

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 it is these people who 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 for improve our health care system in terms of both, increased health infrastructure as well as quality so that common man can have easy accessibility to public health facilities. Further, the doctors and staff need to be not only sufficient in number and in terms of proficiency but also 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.

NHRC recommendations

"the Right to Health be expressly transformed and declared as a fundamental right, and a suitable amendment to the constitution be made to this effect … a correlative duty also be cast on the State to be enforced through legislative or executive measures"

What does Right to Health mean?

The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

The 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (art. 25). The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights.

Why are we asking for this Right today?

- Negative impact of Globalisation- Liberalisation- Privatisation policies on various social sector services

- Growing tendency for withdrawal of the state from provision of public health services, stagnant or declining investments for public health
- Proliferation of an unregulated private medical sector

The sources of health related rights:

- National Constitution, National Laws - Criminal laws relating to consent, injuries, medical negligence, age at marriage, and so on;
- Policies -related to population, health, youth, women and so on,
- Programs - reproductive health and other national programmes,
- International Law and Agreements - Right to Health UDHHR, ICESCR), CEDAW, ICPD PoA, Beijing PfA, MDG

Three generation of human rights exist:

1. Civil and Political Rights - right to life, right to information, right to freedom of movement, right to peaceful assembly etc.
2. Economic Social and Cultural Rights - right to education, right to health, etc.
3. Rights of Disadvantaged Groups - women's rights, child rights, tribal rights etc.

Successful development leads to respect for human rights. Respect for human rights contributes to sustainable development. The realization of human rights is the goal of development.

Right's Based Approach

Rights based approach (RA) means holding people and institutions, who are in authority accountable for fulfilling their responsibilities towards those who are under authority.

RA aims to increase impact of programmes and strengthen sustainability by-

- Addressing root causes
- Changing policies and practices
- Working together towards common goals
- Changing power relations

RA addresses violence and coercion and restriction of choices. It encourages people to demand their rights. It incorporates communication and behavior change interventions that encourage equitable partnerships. It could make programs accountable when rights are violated. Rights approach begins when every health situation is seen in the context of human rights. This approach includes-

- Knowledge of rights and their sources
- Identifying gaps in fulfillments and violations

- Rights education and awareness
- Claiming of the rights

Rights promoting activities are as follows:

- Rights Awareness: Community mobilization, Rights education - community and providers, Leadership development
- Building evidence - Case-studies, primary research, secondary data etc
- Sharing information - briefing kits, fact sheets, pamphlets, plays
- Media Advocacy - press conference, stories, opinion, editorial

Claiming Health rights include-

- Asking for services, respecting the rules
- Filing complaints/ making suggestions
- Dialogue with providers/ managers/ legislators, Representation, delegation
- Asking for grievance redressal/ compensation
- Public hearing, social audit, Legal action
- Direct action - dharna, protest, strike…

The Actors in Rights based approach include:

- Rights holders - community (rights claimants),
- Duty bearers - service providers, managers, bureaucrats, other government functionaries, Guardianship institutions - courts, commissions etc.,
- Human rights advocates - WE!

Understanding and assessing Health systems

A health system refers to the people, institutions and resources, arranged together to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill health. The health system of a country has the following characteristics:

- Goodness: improvement of health status
- Responsiveness: The extent to which health system meets a population's expectations of how they should be treated
- Fairness: Fairness in the distribution of resources and outcomes

They are expected to perform the following functions

- Delivering services: What services, delivered by whom and how
- Financing: Generation and allocation of funds for health systems

- Creating resources: Human resources, capital infrastructure, knowledge and technology, drugs and other consumables required to deliver services
- Stewardship: Oversight, setting the rules of the game, collating and collecting information, regulation, consumer protection

We can assess performance of all health systems for its-

- Responsiveness: Availability, access, acceptability and quality
- Efficiency: Value for money
- Equity: Investing on increasing access to health services of vulnerable groups; narrowing the health gaps between the top and bottom deciles of population

It is a usual practice to distinguish between primary, secondary and tertiary levels of health care in a country. Primary health care is the first point of contact a person encounters with the health services. Secondary health care refers to those services particularly provided by hospitals and tertiary Health Care refers to those specialist services mostly provided by the medical profession.

The health system in a country consists of public and private sector. All health care initiatives and providers financed and managed by government are in Public sector. The private sector may be defined as comprising all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat or prevent disease. They include large and small commercial companies, groups of professionals, such as doctors, national and international nongovernmental organizations and individual providers and shopkeepers. The services they provide include hospitals, nursing and maternity homes, clinics run by doctors, nurses and midwives and paramedical workers, diagnostic facilities, e.g. laboratories and radiology units, and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers, including general stores.

The key aspects of Right to Health are:

- Right to essential drugs
- Right to emergency medical care and care based on minimum standards
- Right to patient information and redressal
- Right to monitoring and accountability mechanisms

Health rights: vulnerable sections and special situations

- Women's Right to Health Care
- Children's Right to Health Care
- Health Rights of HIV-AIDS affected persons
- Right to Mental health care
- Right to Health Care for unorganised sector workers and for urban deprived communities

- Health rights in conflict situations
- Health rights of communities facing displacement
- Health rights of Disabled, elderly, migrants and other vulnerable groups

The right to health is an inclusive right.

We frequently associate the right to health with access to health care and the building of hospitals. This is correct, but the right to health extends further. It includes a wide range of factors that can help us lead a healthy life. The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the "underlying determinants of health". They include:

Right to a set of basic public health services

- Adequate physical infrastructure at various levels
- Adequate skilled human power in all health care facilities
- Availability of the complete range of specific services appropriate to the level
- Availability of all basic medications and supplies
- Safe drinking water and adequate sanitation;
- Safe food;
- Adequate nutrition and housing;
- Healthy working and environmental conditions;
- Health-related education and information;
- Gender equality.

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.

The right to health contains entitlements.

These entitlements include:

- The right to a system of health protection providing equality of opportunity for everyone 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 levels.

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.

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 a State.
- They must be accessible physically (in safe reach for all sections of the population, including children, adolescents, older persons, persons with disabilities and other vulnerable groups) as well as financially and on the basis of non-discrimination. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities), but does not impair the right to have personal health data treated confidentially.
- The facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. In other words, they should be medically and culturally acceptable.
- Finally, they must be scientifically and medically appropriate and of good quality. This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water.

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. However, good health is influenced by several factors that are outside the direct control of States, such as an individual's biological make-up and socio-economic conditions. Rather, the right to health refers to the right to the enjoyment of a variety of goods, facilities, services and conditions necessary for its realization. This is why it is more accurate to describe it as the right to the highest attainable standard of physical and mental health, rather than an unconditional right to be healthy.

The right to health is NOT only a programmatic goal to be attained in the long term.

The fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on States arise from it. In fact, States must make every

possible effort, within available resources, to realize the right to health and to take steps in that direction without delay. Notwithstanding resource constraints, some obligations have an immediate effect, such as the undertaking to guarantee the right to health in a non-discriminatory manner, to develop specific legislation and plans of action, or other similar steps towards the full realization of this right, as is the case with any other human right. States also have to ensure a minimum level of access to the essential material components of the right to health, such as the provision of essential drugs and maternal and child health services.

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

It is often argued that States that cannot afford it are not obliged to take steps to realize this right or may delay their obligations indefinitely. When considering the level of implementation of this right in a particular State, the availability of resources at that time and the development context are taken into account. Nonetheless, no State can justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight. While steps may depend on the specific context, all States must move towards meeting their obligations to respect, protect and fulfill.

Although right to health is one of the basic human right but evidence suggests that the impressive health gains achieved over recent decades are unequally distributed and have largely failed to reach the poor and other marginalized or socially excluded groups. Persistent and growing inequalities in health are increasingly evident, both between and within countries. For example, the poorest 20% of the global population are roughly 10 times more likely to die before the age of 14 than the richest 20%. This inequality is referred to as Health Equity.

Health equity is differences in the quality of health and health care across different populations.

This may include differences in the "presence of disease, health outcomes, or access to health care" across racial, ethnic, sexual orientation and socioeconomic groups. Health equity by some definitions also includes differences in access to health care between populations. For example, those in lower-status socioeconomic groups receive less consistent primary care, which is positively correlated to overall level of health in the recipient.

Government Strategies for Health (from 1st Five year Plan to 12th five Year Plan)

1st Five Year Plan (1951-56)

- Foundation for Preventive health care
- Vertical health Programme

2nd Five Year Plan (1956-61)

- Health For All
- Family Planning Programme

3rd Five Year Plan (1961-66)

- Universalisation of Preventive health care
- Control of Communicable diseases
- Environmental health like urban rural water supply

4th Plan (1969-74)

- Complete Eradication of Communicable diseases
- Widening of network of the preventive and curative health Service
- Primary Health Centers

5th plan (1974-79)

- Dittoed the strategies of the previous Plan
- Horizontal health care for the control of Leprosy, Blindness and Filariasis

6th Plan (1980-85)

- First National Health Policy 1983
- Health for All by 2000 A.D.
- Rural Health Care System based on preventive, primitive and curative care

7th Plan (1985-90)

- Health for All by 2000 A.D.
- Coordinating health services with health related services like sanitation, water supply, nutrition etc

8th Plan (1992-97)

- Health for All by 2000
- Strengthening of primary health care and expansion of secondary and tertiary health care

9th Plan (1997-2002)

- Emphasis on accessibility and utilisation of health care
- Sound provision for health infrastructure

10th Plan (2002-2007)

- Infrastructure development

- Control of communicable and non-communicable diseases
- Provision of preventive, curative, promotive and rehabilitative health care services
- Public-Private partnership

11th Plan (2007-2012)

- 'Vision for health' for inclusive growth in health
- Reduction of the disparity in the distribution of healthcare institutions and health care
- Decentralised governance
- PRIs, SHGs, Civil Societies, Grama Sabha

12th Plan (2012-17)

- Provision for Comprehensive Health Care
- Population Stabilisation
- Strengthening of Health Infrastructure
- Development of Human Resources for Health
- Facilitating Publicly Provided Healthcare
- Promotion of Child Nutrition and Restructuring ICDS

Health Care is our basic right!

The entire health structure is developed to provide essential health services to the ordinary citizen of the country, free or at a nominal cost. The health system in our country performs the dual function of providing curative services for the main health problems, and planning for appropriate preventive and promotive services. The public health system includes human power like Doctors, nurses, technical experts and administrative staff. Apart from this, medicines, and other equipment like ambulance, x-ray machines, laboratory equipments etc. are also provided for by the health department. For all this, large scale expenses are incurred by the Government, on construction of buildings, appointment of staff, obtaining medicines and other equipment.

But where does the Government get all this money from??

We all contribute to the expense incurred by the Government on health services:

The Government collects direct and indirect taxes from all citizens. We contribute to the Government's treasury by paying house tax, agricultural taxes etc. Besides this, when we purchase even small items like a matchbox, salt, or soap from the market we contribute part of the price of that item as tax to the Government. In this manner the Government collects money from us in the form of taxes, and undertakes several development programmes with this money. Sometimes, the programmes are also run

by raising money through loans and other forms of financial aid. All the citizens of the country - whether a farmer with a small piece of land, or a worker working on shift duty in a factory- contribute to the government's income, through their hard work. Any loans raised by the Government are also paid off with the help of this income. Thus, the Government runs all welfare programmes for people with the people's own money, which it collects in the form of various taxes. The same money is also used for running the public health services. Hence, ***we all have collective ownership of the public health services, since it has been set up with our own money.*** Health problems need to be tackled through the collective efforts, of the public health system and the people.

However, we also need to realistically analyse that despite setting up a large public health system and the government pouring money into it, does every person have access to quality health services? Let us understand what we expect when we say that health care is a right and it should be available to all.

What is the present general condition of public health institutions?

The people in the rural, remote and hilly areas are quite dependent on public health services. Many doctors have gained the confidence of people from remote areas by actually visiting such places and they have done a good job. There are examples of many ANMs and Health workers who have done their work despite facing several obstacles. But the reality still is that satisfactory health services are not available to most people.

For example, snakebite is a very common incident in rural areas. It is mandatory for all PHCs to keep a stock of Anti snake venom injections. But deaths keep happening because it has not been actually available to the patient at time of need. Similarly dog bites or bites by other animals, is also a common occurrence. Such bites can result in the victim contracting a disease named Rabies. The anti rabies vaccine, which can prevent this disease, however, may be available only in the CHC or the Civil Hospital, which are far from the village. In fact at several places, people may have to purchase this expensive vaccine, since it may not be available to them free of cost.

The buildings which house the public health institutions may be found in a dilapidated condition. Doctors and other staff may not always have good quality residential quarters with even the basic amenities. All medicines may not be available at all times in the public health institutions, so that patients often have to purchase medicines. The gaps in Government health services have also been described in several national surveys. There are efforts from the public health system to provide good health services, but one cannot deny that the above mentioned shortcomings do exist. The fact that these incidents occur, indicates that our right to health care is denied.

The condition of health services at the village level is similar. The main aim of village visits made by ANMs and MPWs, is often found to be family planning and immunization. In addition, these health workers should have medicines for simple ailments like fever, dysentery, body ache, children's common ailments. However, often they are unable to give these medicines. Due to this situation the people may not be fully

convinced about the importance and utility of the public health system. They may not feel a sense of ownership towards the health system. Hence, left with no option, they visit the private doctors in larger villages or block heard quarter. However, despite the hefty fees of these doctors, expenses on medicines, and transportation, there is no guarantee that they will get good quality health care.

When we claim that health care is our right, we expect that such situations where quality health care is denied should not occur anywhere for anybody.

Does everyone have access to good quality health services?

Our society comprises of several groups like rich and poor, men and women, physically able and physically challenged, besides there are differences based on caste and region. Today the situation is such, that some of these groups, which are on a higher social and economic scale in society, have better access to health services, while the other groups which are lower on this scale may be denied good quality health services due to their marginalization and vulnerability.

The poor often tend to visit public health institutions because the fees charged by private doctors are not affordable to them. But on the one hand, the quality of services given in the public health institutions has often been wanting. On the other hand, private health services are developing rapidly. Due to this in a way, a poor person's right to health care may be denied. Also, there are several examples of people becoming debt ridden due to the expenses they have incurred on health care.

There is mostly a shortage of female doctors in the public health system. So women from rural areas, visiting the public health institutions, are scared and embarrassed to share their problems related to the menstrual cycle, or the reproductive organs, with male doctors. Women's dignity may not be always respected when they are brought in for performing family planning operations. Sometimes, certain staff in the public health institutions may behave in a manner with the poor, dalit and tribal people which they find insulting.

Important reasons for poor performance of the public health system:

1. Inadequate Investment
2. Inadequate Public Health Workforce
3. Poor orientation of medical, nursing and technical education
4. High out of pocket expenditure in the public services- mainly on drugs and diagnostics
5. Narrow Range of services available
6. Poor quality of public health services
7. Corruption
8. Over-centralization and bureaucratization- or in other words - failed decentralization
9. Insufficient community participation

10. The negative influence of international aid agencies in health policy and technical assistance and the lack of support to the development of adequate independent national capacity in knowledge management.

Private health care

Need for Health rights approach to activate Medical councils

- Medical Council of India (MCI) and State Medical Councils (SMCs) have legal mandate to ensure ethical conduct by doctors, including patients rights
- However, SMCs have not taken up ethical issues seriously and proactively
- There are a few exceptions like Punjab Medical Council
- Need to demand expansion, people-oriented restructuring and social accountability of medical councils

Need for Health rights approach to activate Public authorities concerning Private medical sector

- Public authorities concerned with regulation of private hospitals need to address Patients rights while operationalising regulation
- Need to demand appropriate Clinical establishments acts in various states to ensure socially accountable, patient oriented regulation
- Private hospitals receiving significant public subsidies and PPPs must be held to account similar to publicly supported bodies - the logic of privatisation needs to be challenged

Areas of rights violations related to the private medical sector

Denial of patients rights in the private medical sector, which have some legal justification today

The high court had in 2007 ordered that "all private hospitals to whom public land has been allotted on concessional rates are obliged to provide free treatment to the extent of 25 per cent OPD and 10 per cent IPD to patients belonging to economically weaker section (EWS) category".

- Denial of **Emergency medical care** in hospital, on the grounds that emergency treatment would be started only after payment is made by patient / caregivers
- Patient / caregivers not provided **basic information** related to nature of treatment and related costs in a private hospital
- Patient is not given **records / reports** on demand during period of hospitalization
- Denial of right to **second opinion** - patient or caregivers not allowed to consult another doctor / specialist during period of hospitalisation
- Denial of right to **informed consent** - proper information not provided before operation or other invasive procedure

- Not respecting patient's **privacy,** or not keeping **confidential** the identity of the patient.
- The **dead body of a deceased patient** is not handed over to the relatives, until the full payment of all expenses has been made to the hospital. Similarly, **newborn baby** of a recently delivered mother is not handed over to the mother, until the full hospital expenses have been paid.
- Patient is coerced into buying medicines from a **specific medical** store in the hospital premises
- Patient's rights denied during a **clinical trial** - proper informed consent not taken, full information about trial not provided, treatment for trial side effects not given, insurance coverage related to trial not provided etc.
- Patient from **economically weaker section denied treatment in a private medical**
- **All doctors are supposed to display their professional rates** (MCI Code of Ethics), however very few doctors do so.
- **Doctors are not supposed to take gifts or sponsorships from** pharmaceutical companies (MCI Code of Ethics). They are also not supposed to sponsor such products. Naturally, the massive amounts that drug companies spend on doctors are recovered through charging very high drug prices from patients.
- **Doctors are not supposed to give or take commissions in any form,** in their relationships with other doctors (MCI Code of Ethics). Again, information on this is difficult to obtain except from certain ethical doctors who may have been offered but have refused such commissions in the past.
- **Doctors are supposed to prescribe medicines by generic names as far as possible,** which would lead to reduction in the cost to patients (MCI Code of Ethics). However, as we know, this does not happen usually.

Some major problems faced by patients in private hospitals, which are not included in the above categories

- ***Medical negligence*** leading to bodily damage, and in some cases even death of the patient
- ***Gross over-charging*** and arbitrary charging of patients,
- ***Irrational and unnecessary procedures*** including medication, investigation, operation or other treatment

On the whole, this means that despite the fact that the Government has set up a huge public health system, today everyone is not assured of good quality health services.

Every Indian citizen - irrespective of whether it is a man or a woman, irrespective of his/her economic condition, caste, religion, social status, and regional affiliation -

must have access to good quality health services. To make this right a reality, the Government, the health system and the people must come together. The Government should ensure that all people should have easy access to quality health services.

'Health for all' and the National Rural Health Mission:

The Central Government has launched the National Rural Health Mission (NRHM) and National Health Mission (NHM). It is not just another health programme. Rather it is an integrated expression of the Government's commitment towards overall improvement in health services. The Government runs several National Health Programmes, and the aim of the NRHM is to strengthen the public health system, integrate these programmes and remove the gaps in implementation. The Government has declared that while removing these gaps the following issues will receive special attention:

- Sufficient budgetary allocation for public health.
- Providing quality and effective health services to the rural population, with a special focus on women, children and poor people.
- Improved access to health services.
- Strengthening and decentralization of health services.
- Increasing people's participation in the health services.

Nutritious food, clean and safe drinking water, sanitation and public cleanliness are factors that directly affect health. The Government has declared that it will make improvements in all these important determinants of health, under the NRHM. Besides, special health programmes will continue to be implemented for the health of women and children.

To put it all in a simple language - there is a promise and hope that we will move towards making 'Health for all' a reality. This promise includes for example, that pregnant women will be examined regularly to identify possible cases of difficult labour and during delivery they will be given necessary care through the public health system; patients will get necessary treatment and medicines through the public health facilities; the doctors and staff members would be available and responsive; safe drinking water will be available in every village; every child will have access to nutrition and essential health services; regular steps will be taken to prevent the spread of communicable diseases; health workers will regularly visit the villages and complete all the planned tasks; and people's opinion and priorities will be taken into account while planning and providing all health services.

The Government has promised us all of this under the NRHM then in NHM. As the above mentioned promises get actually fulfilled in reality, we can say that the Government is contributing to our realizing the right to health care.

Health Care System in India

Right to health and the evolution of the Indian health system

The Indian health system is undergoing many changes both in operational and conceptual terms. Fundamentally India has a very mixed and complicated health system with a mixture of traditional and modern practices and belief systems. India has the distinction of both formal and informal traditional systems being used widely, and the formal traditional systems are now incorporated within public policy architecture through a separate Department of AYUSH (Ayurvedic, Unani, Siddha and Homoeopathy). There are separate medical colleges training health care providers in each of these different disciplines. Today many primary health centres across rural India provide modern medicine and traditional medicines concurrently, indicating a strong respect for local preferences, a key component of a right based approach. However local health traditions are not limited to the formal practitioners and include faith healers, herbal healers, bone setters and others and these systems still remain outside the ambit of policy discussions.

The broad outlines of India public health system was drawn up a little prior to independence by the Bhore committee (1946)4. The PHC (Primary Health Centre) based template of the Bhore committee report, with the aim of universal coverage and population-based parameters remains in place even now. However more than 70 years later it has not been able to meet health rights of its citizens. In the 1960's the health system became distracted by the compulsions of population control and progressively the Family Planning and Family Welfare component overwhelmed the health component of the programme, leading to the establishment of a new and better resourced Department of Family Welfare. The family planning programme with its population control focus with targets and incentives introduced a period of human rights violations being committed by the health sector. These included among others coercive sterilisations and gross negligence. Some aspects of those days continue through camps, target and incentive based sterilization programmes in some states even today. In the 1990's and later it was realised that this obsession had neither yielded the anticipated results, and the overall public funding available to health care had become very little.

While the trend in most countries was that public expenditure was the greatest component in health care expenditure, in India, it constituted only about 20 per cent5. The private health care industry had started booming in the face of economic reforms starting from 1980's and in 2000 it was found that health care cost had become the second largest cause of rural impoverishment and a large number of families became poor because of one episode of hospitalization in the family. This pointed to a gross violation of the principles of economic accessibility, a core component of the right to health. From the late 1990s onwards a series of changes, often conflicting, were introduced in the health system both at the national and state levels. According to

constitutional provisions, health remains a state subject, while public health and family planning remain in the concurrent domain, i.e. part of both central and state jurisdiction. In the changes subsequent to 2000 the area of agreement has been that the state investment in health has to increase from an abysmally low 0.9 per cent of GDP in 2000 and 1.3% in 2014. However what is uncertain has been the route of providing services. Sometimes the privatisation has been seen as the route, while at other times the public sector has been seen as most important. At one point, public sector improvement was seen through a user-fees model, but now free service at the point of delivery is being seen as the alternative. At this time the consensus appears to be that the public sector has to be the main financer of health services, while the provisioning could be through different methods like public provisioning, contracting-in of providers, health insurance or other methods which include private sector engagement. The National Rural Health Mission (NRHM), the Rashtriya Swasthya Bima Yojana6 (RSBY) a health insurance scheme for non-formal sector workers, various state level health insurance schemes for secondary and tertiary care like the Aarogyashri Scheme and others remain key platforms and mechanisms for delivering public services to the poor.

The concept of Universal Health Coverage has been discussed and deliberated through a specially constituted committee of the Planning Commission of India (High Level Expert Group or HLEG) and its report (HLEG 2011), which includes financial, managerial and regulatory guidelines remains the strongest articulation of a right to health approach in the country. However the report which was supposed to provide the basic architecture of the health chapter of the 12th Five Year Plan remains largely ignored in the 12th Plan document. Implementing a right to health informed programme in India: contemporary concerns and recommendations As India's development story is being hailed across the world there are many questions being raised about the differential nature of growth experienced by different sections of the population. Many authorities have raised concerns about an increasing gap between the rich and the poor. Against such a backdrop, the discussion about rights becomes especially relevant because rights lay down the minimum conditions for all. This section discusses the current status of right to health in the country reviewing the contemporary health scenario using the framework of state obligations ie. Respect, protect and fulfill.

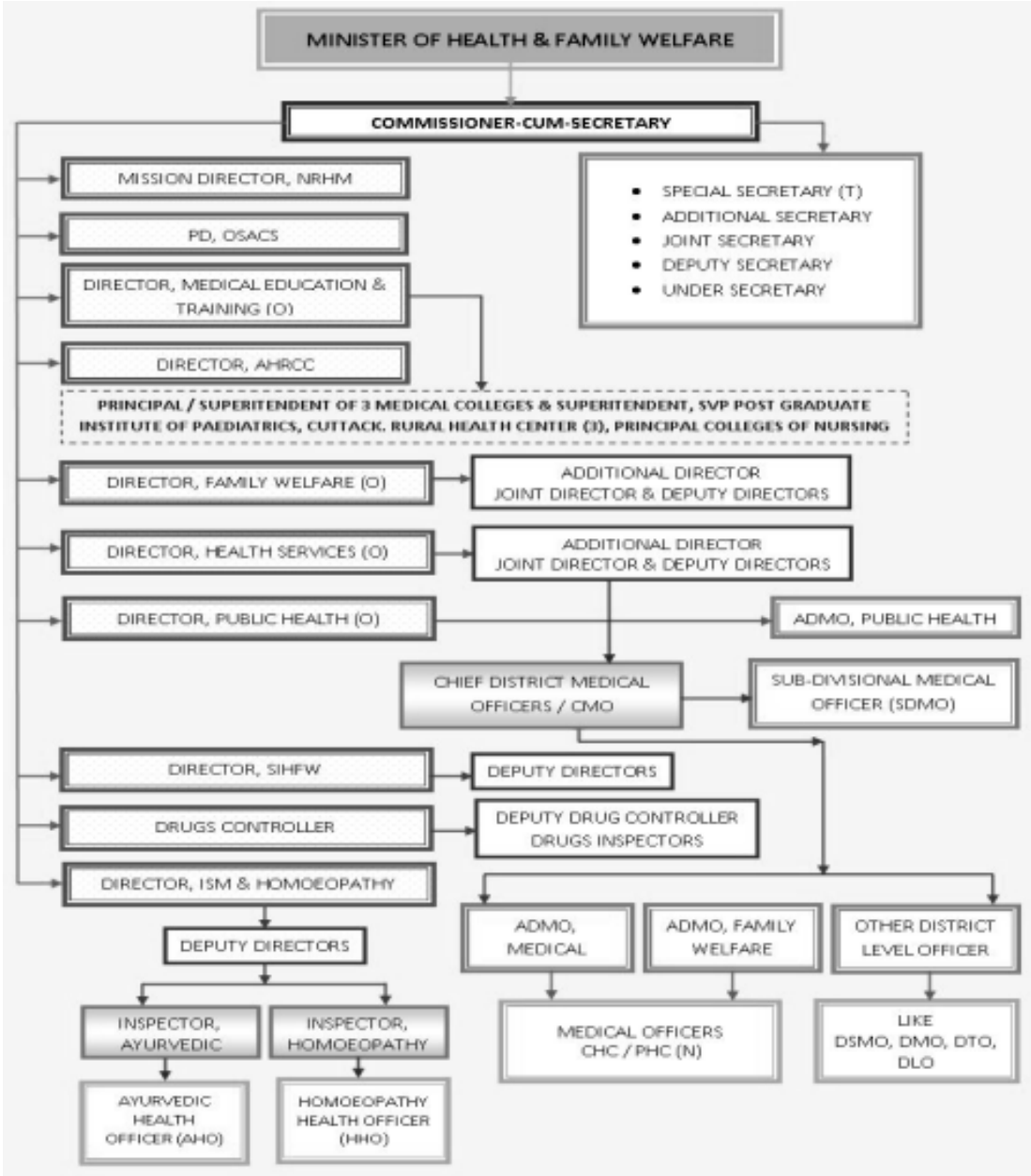
The Rural Health Care System forms an integral part of the National Health Care System. Provision of Primary Health Care is the foundation of the rural health care system. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, the Primary health care is accepted as one of the main instrument of action. Primary health care is the essential health care made universally available and accessible to individuals and acceptable to them

Through their full participation and at a cost the community and the country can afford.

Health structure at National and state levels

National level - Union Ministry of Health and Family Welfare has three departments, viz. - Health, Family Welfare, and Indian System of Medicine and Homeopathy,

State level - The organization at State level is under the State Department of Health and Family Welfare in each State headed by Minister and with a Secretariat under the charge of secretary/Commissioner (Health and Family Welfare)



Health Care Services in Odisha

The state of Orissa was formed on 1 April 1936 and had 6 districts at the time. The Public Health Act and rules of Madras Presidency were in force till 1939 in the southern part of Orissa. The major milestones in the development of health services in Orissa from 1939 onwards are mentioned below:

Milestones in the Development of Health Services in Odisha Year Event

- 1939 Orissa Service Code in force. Post of Director, Health Services and cadre of civil surgeons established.
- 1944 Cuttack Medical College established.
- 1959-60 Burla Medical College established.
- 1962-63 Berhampur Medical College established.
- 1964 State Family Planning Officer post created; basic health services scheme introduced.
- 1970 Registration of Birth and Death Rules. Birth and death registration was now the responsibility of the Health & Family Welfare Department.
- 1977 1/3 of PHCs converted to upgraded PHCs, Ayurvedic and Homoeopathic doctors attached to the UGPHCs.
- 1985 Dispensaries converted to single doctor PHCs.
- Orissa Clinical Establishments (Control and Regulation) Act, 1990
- NRHM in 2005
- Niramaya (Free Medicine Scheme) in 2014

Public Health Delivery System in Odisha

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 populations in tribal / hilly areas and 1, 20,000 populations in plain areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynecology, Surgery and Pediatrics. These centres are however fulfilling the tasks entrusted to them only to a limited extent.

For effective realization of mission objectives more than forty thousand Accredited Social Health Activist (ASHA) personnel are in position in the State. AYUSH Scheme is operational for better management of primary health care. Other important programmes operational in the State include National Programme of Prevention and Control of Cancer, Diabetics, Cardio Vascular diseases and Stroke (in five districts),

National Malaria Eradication Programme, National Programme of Health Care for Elderly (NPHCE) and National Filarial Control Programme (NFCP).

Like in other states, there exist a state health society called Odisha State Health and Family Welfare Society (OSHFWS) and district level health societies known as Zilla Swasthya Samities (ZSSs) for implementing various vertical programmes such as Reproductive and Child Health (RCH), tuberculosis, leprosy, malaria and blindness. Under National Rural Health Mission (NRHM), all the societies for individual vertical programmes are merged with the respective ZSS in all the districts.

All schemes under National Rural Health Mission (NRHM) are implemented and closely monitored by the Mission Directorate. State Programme Management Unit provides technical support to the State Health Mission. The Mission Directorate is the Secretariat to the Mission. The Directorate comprises Programme Managers and a group of specialists in the areas of social development, human resource development, Economics, BCC, M&E, Public Private Partnerships, Accounts/financial analysis etc.

State Programme Management Support Unit (SPMSU) acts as the secretariat to the State Health Mission and OSHFWS. Headed by a Mission Director, SPMSU provides technical support to the State Health Mission through its pool of skilled professionals for RCH and other National Disease Control Programmes.

The district health societies operate through the Zilla Swasthya Samities (ZSSs) and the District Programme Management Units (DPMUs). The Block Programme Management Units (BPMUs) are responsible for preparation of block and village level plans, monitoring and implementation of government programmes, training of ASHA, inter-sector co-ordination, and developing public private partnerships for health care service.

Rogi Kalyan Samities (RKSs) have been formed to undertake management of the health institutions up to PHC level through community participation. At present, RKSs are operational at 32 District Hospitals (DHs) and 377 CHCs.

Under NRHM's mandate of decentralized planning, Gaon Kalyan Samities (GKS) are being constituted in the State. Formed at the revenue village level, GKS is envisaged as a community level platform designed to facilitate health and sanitation related activities in particular and development programmes of the village in general. There are now 45,380 functional GKS in the state.

Availability Health Care Facility and Human Health Workforce

Odisha has got fairly large network of health facilities. There are now 3 states owned and 3 private medical colleges (having total intake capacity of 400 MBBS and 250 BDS); 32 districts headquarter hospitals; 27 sub-divisional hospitals; 377 community health centers; and 79 other hospitals. The state also has 8 Ayurveda hospitals (5 state owned and 3 private colleges) and 6 Homeopathic hospitals (4 state owned colleges and 2 private colleges). At the grass root level, health care services are delivered through

1226 primary health care centers; 6,688 sub-centers; 560 Homeopathic dispensaries; 619 Ayurvedic dispensaries; and 9 Unani dispensaries.

HEALTH FACILITIES IN THE STATE

Health Facility	Number
Medical College and Hospitals	3
District Hospitals (30 districts +	32
Capital Hospital, BBSR & R.G.H, RKL)	
Sub-Divisional Hospitals	27
Community Health Centers	377
Other Hospitals	79
Infectious Disease Hospitals	5
Training Centers	5
Primary Health Centers (N) & others	1,226
Sub-Centers	6,688
A.N.M. Training Schools	16
G.N.M. Training School	8
M.P.H.W.(Male) Training School	3
Ayurvedic Hospitals	2
Ayurvedic College & Hospitals	3
Ayurvedic Dispensaries	619
Homoeopathic College & Hospitals	4
Homoeopathic Dispensaries	560
Unani Dispensaries	9
Medical College - Private	3

The human resource indicator provide an overview of the availability of trained and specialized medical, nursing and paramedical personnel in India along with an understanding of the regional distribution and disparities. They provide the details of allopathic doctors, dental surgeons, AYUSH doctors, nursing staff and various paramedical healthcare workers in India. The key facts on human resources include the following:

Odisha State Medical Corporation Limited (OSMCL) has been incorporated on 8th November 2013 under the Companies Act., 1956, in pursuance to the Government Resolution No. 8844 dated 26th June 2013, to act as an independent procurement agency for the Department of Health and Family Welfare, Government of Odisha.

The OSMCL has the key functions like timely procurement of quality medicines, surgical, equipment, instruments, furniture etc. through fair, transparent and competitive bidding process.

Existing Public health Infrastructure:

The primary Health Care structure in the country has been established as per the following norms:

Health Centre and Population Norms

	Plain areas	Hilly/Tribal areas
Sub-centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1, 20,000	80,000

Service Guarantees from Sub Health Center (Services provided at the Sub Center are Free of Cost)

Sub Centre is the first peripheral contact point between community and health care delivery system. A Sub Centre is manned by one Female Health Worker (ANM) and one Male Health Worker (MPW). One Lady Health Visitor (LHV) for six sub-centres is provided for supervision at the PHC level. Department of Family Welfare is providing 100% central assistance to all the sub-centres in the country since April 2002 in the form of:

- Salary of ANMs and LHVs
- Rent@ Rs. 3000 per annum
- Contingency @ Rs. 3200 per annum
- Drugs and equipment kits

Currently there are 1,42,655 sub centres in the country and 6688 in Odisha.

Primary tasks of ANM

- Registration of all pregnancies (ANM along with ASHA will ensure that all BPL women get benefits under Janani Suraksha Yojna)
- Ensure minimum 4 antenatal checkups along with100 IFA tablets and two T.T. Injections to pregnant women
- Appropriate and prompt referral in case of high-risk pregnancies
- Provide Skilled Attendance at home deliveries, post partum care and contraceptive advice
- Newborn Care (full immunization and Vitamin A doses to children, prevention and control of childhood diseases like malnutrition, infections etc
- Curative Services like treatment for minor ailments
- Maintenance of all relevant records concerning mother, child and eligible couples in the area
- Providing information on different family planning and Contraception methods and Provision of Contraceptives
- Counseling and correct information on safe abortion services
- Coordinates services with AWWs, ASHA, Village Health & Sanitation Committee and PRI for observance of Health Day at AWW center at least once a month
- Coordination and supervision of ASHA
- The Untied grant to the Sub Center is kept in a joint account, which is operated, by the ANM and the local Sarpanch.

ANM is answerable to Village Health and Sanitation committee, which will oversee her work.

Maternal and Child Health:

(i) Antenatal care

1) Early registration of all pregnancies, ideally within first trimester (before 12th week of Pregnancy). However even if a woman comes late in her pregnancy for registration, she should be registered and care given to her according to gestational age.
2) Minimum four antenatal check-ups: First visit to the antenatal clinic as soon as pregnancy is suspected, 2nd between 4th and 6th month (around 26 weeks), 3rd at 8th month (around 32 weeks) and 4th at 9th month (around 36 weeks)
3) Associated services like general examination such as weight, BP, anaemia, abdominal examination, height and breast examination, Folic acid supplementation in the first trimester, Iron and Folic Acid supplementation from twelve weeks, Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs)
4) Minimum laboratory investigations like hemoglobin, urine albumen and sugar.
5) Identification of high-risk pregnancies and appropriate and prompt referral
6) Counseling.

(ii) Intranatal care:

1) Promotion of institutional deliveries
2) Skilled attendance at home deliveries as and when called for
3) Appropriate and prompt referral

(iii) Postnatal care:

1) A minimum of 2 postpartum home visits, first within 48 hours of delivery, 2nd within 7-10 days.
2) Initiation of early breast-feeding within half-hour of birth
3) Counseling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding.

(As per Guidelines of GOI on Essential new-born care) and STI/RTI and HIV/AIDS

(ii) Child Health:

1) Essential Newborn Care
2) Promotion of exclusive breast-feeding for 6 months.
3) Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI (Current Immunization Schedule at
4) Vitamin A prophylaxis to the children as per guidelines.
5) Prevention and control of childhood diseases like malnutrition, infections, etc.
6) Assistance to school health services

(iii) Family Planning and contraception:

1) Education, Motivation and counseling to adopt appropriate Family planning methods,
2) Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions (Wherever the ANM is trained on IUD insertion)
3) Follow up services to the Eligible couples adopting permanent methods(Tubectomy/ Vasectomy)
4) Counseling and appropriate referral for safe abortion services (MTP) for those in need.

(iv) Adolescent health care:

1) Education, counseling and referral
2) Assistance to school health services
3) Control of local endemic diseases
4) Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics

Disease surveillance

(v) Water Quality Monitoring:

1) Disinfection of water sources

2) Testing of water quality using H2S- Strip Test (Bacteriological) developed by NICD

3) Promotion of sanitation including use of toilets and appropriate garbage disposal.

4) Field visits and home care

Community needs assessment

(vi) Curative Services:

1) Provide treatment for minor ailments including fever, diarrhea, ARI, worm infestation and First Aid in accidents and emergencies

2) Appropriate and prompt referral

3) Organizing Health Day at Anganwadi centres at least once in a month with the help of Medical Officer of PHC, ASHA, AWW, PRI, self help groups etc.

(vii) Training, Monitoring and Supervision:

1) Training of Traditional Birth Attendants and ASHA

2) Monitoring of water quality in the villages

3) Keeping watch over unusual health events

4) Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRI

5) Coordination and supervision of activities of ASHA

National Health Programmes

(viii) Record of Vital events:

1) Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants.

2) Maintenance of all the relevant records concerning mother, child and eligible couples in the area.

The Sub Health Centre is accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of Village Health and Sanitation Committee.

ANM and Multipurpose Health worker MPW works from the Sub centre and deliver the above-mentioned service with the help of ASHA.

Funds available:

- The Gram Panchayat SHC Committee has the mandate to undertake construction and maintenance of SHC. An annual maintenance grant of Rupees 10,000 will be available to every SHC.
- Every SHC gets Rs.10,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand. The fund would be kept in a joint account to be operated by the ANM and the local sarpanch.

With the launch of NRHM, the Government of India proposed Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system. Since Sub centers were serving much larger population than they were expected to and ANMs were heavily overworked, one of the core strategies of NRHM is to promote access to improved healthcare at household level through ASHA.

- ASHA is a Health Activist in the community.
- Every village will have one ASHA for every 1000 persons
- She will be selected in a meeting of the Gram Sabha.
- She will be chosen from women (married/widowed/divorced between 25-45 years) residing in the village with minimum education up to VIIIth class.
- ASHA is accountable to the Panchayat.
- ASHA will work from the Anganwadi Centre
- ASHA is honorary volunteer and she is entitled to receive performance based compensation .Her services to the community are Free of cost.
- ASHA will receive trainings on care during pregnancy, delivery, post partum period, New born care, sanitation and hygiene.

Roles and Responsibilities of ASHA

ASHA is responsible for creating Awareness on Health including

- Providing information to the community on nutrition, hygiene and sanitation
- Providing information on existing health services and mobilizing and helping the community in accessing health related services available at Health Centers
- Registering pregnant women and helping poor women to get BPL certification
- Counseling women on birth preparedness, safe delivery, breast feeding, contraception RTI/STI and care of young child
- Arranging escort/accompany pregnant women and children requiring treatment /admission to the nearest health centre.
- Promoting universal immunization
- Providing primary medical care for minor ailments. Keeping a drug kit containing generic AYUSH and allopathic formulations for common ailments.
- Promoting construction of household toilets
- Facilitating preparation and implementation of the Village Health Plan through AWW, ANM,SHG members under the leadership of village health committee.
- Organizing Health Day once/twice a month at the anganwadi with the AWW and ANM
- ASHA is also a Depot holder for essential services like IFA, OCP, Condoms, ORS, DDK etc, issued by AWW.

Services Guarantees from Primary Health Centre (PHC) (All services provided at PHC are free of cost)

Every PHC has to provide OPD services, Inpatient Service, referral service and 24 hours emergency service for all cases needing routine and emergency treatment including treatment of local diseases. All services provided by Sub centers are also provided by PHC. Some additional services provided in a PHC are as follows:

PHC is the first contact point between village community and the Medical Officer. Manned by a Medical Officer and 14 other staff, it acts as a referral unit for 6 Sub-Centres and has 4-6 beds for patients. It performs curative, preventive, promotive and family welfare services. These are established and maintained by the State Governments. Currently there are 23,109 Primary Health Centres in the country and in State 1228.

Medical care:

1) OPD services: 4 hours in the morning and 2 hours in the afternoon/evening. Time schedule will vary from state to state.
2) 24 hours emergency services: appropriate management of injuries and accident, First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions
3) Referral services
4) In-patient services (6 beds)

Maternal and child health care including family planning

Maternal care

a) Antenatal care:

1) 24-hour delivery services both normal and assisted
2) Appropriate and prompt referral for cases needing specialist care.
3) Pre-referral management (Obstetric first-aid)
4) Facilities under Janani Suraksha Yojana
5) Early registration of all pregnancies ideally in the first trimester (before 12th week of pregnancy). However, even if a woman comes late in her pregnancy for registration she should be registered and care given to her according to gestational age.
6) Minimum 4 antenatal checkups and provision of complete package of services. First visit as soon as pregnancy is suspected, 2nd between 4th and 6th month (around 26 weeks), 3rd visit at 8th month(around 32 weeks) and 4th visit at 9th month(around 36 weeks). Associated services like providing iron and folic acid tablets, injection Tetanus Toxoid etc(as per the "guidelines for ante-natal care and skilled attendance at birth by ANMs and LHVs)

7) Minimum laboratory investigations like hemoglobin, urine albumin, and sugar, RPR test for syphilis
8) Nutrition and health counseling
9) Identification of high-risk pregnancies/ appropriate management
10) Chemoprophylaxis for Malaria in high malaria endemic areas as per NVBDCP guidelines.
11) Referral of high risk pregnancy beyond the capability of PHC MO to manage to FRU

b) Intranatal care: (24-hour delivery services both normal and assisted)

1) Promotion of institutional deliveries
2) Conducting of normal deliveries
3) Assisted vaginal deliveries including forceps/ vacuum delivery whenever required
4) Manual removal of placenta
5) Appropriate and prompt referral for cases needing specialist care.
6) Management of Pregnancy Induced hypertension including referral
7) Pre-referral management (Obstetric first-aid) in Obstetric emergencies that need expert assistance

(Training of staff for emergency management to be ensured)

c) Postnatal Care:

1) A minimum of 2 postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through subcentre staff.
2) Initiation of early breast-feeding within half-hour of birth
3) Education on nutrition, hygiene, contraception, essential new born care

(As per Guidelines of GOI on Essential new-born care)

Apart from the above PHC would also provide facilities under Janani Suraksha Yojana (JSY)

Child care

a) New Born care:

1) Facilities and expertise for neonatal resuscitation
2) Management of neonatal hypothermia/ jaundice

b) Care of the child:

1) Emergency care of sick children including Integrated Management of Neonatal and Childhood Illness (IMNCI)
2) Care of routine childhood illness
3) Essential Newborn Care

4) Promotion of exclusive breast-feeding for 6 months.
5) Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI
6) Vitamin A prophylaxis to the children as per guidelines.
7) Prevention and control of childhood diseases like malnutrition, infections, etc.

Family Planning:

1) Education, Motivation and counseling to adopt appropriate Family planning methods,
2) Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions
3) Permanent methods like Tubal ligation and vasectomy / NSV
4) Follow up services to the Eligible couples adopting permanent methods(Tubectomy/ Vasectomy)
5) Counselling and appropriate referral for safe abortion services (MTP) for those in need.
6) Medical Termination of Pregnancies using Manual Vacuum Aspiration technique for which appropriate training would be provided. (wherever trained personnel and facility exists)

Management of Reproductive Tract Infections/ Sexually Transmitted Infections:

1) Health education for prevention of RTI/ STIs
2) Treatment of RTI/ STIs

Nutrition services (coordinated with ICDS)

1) School health: Regular checkups, appropriate treatment, referral and follow-ups
2) Adolescent health care: Life style education, counseling, appropriate treatment.
3) Promotion of Safe water supply and basic sanitation
4) Prevention and control of locally endemic diseases like malaria, Kala-azar, Japanese Encephalitis, etc.

Disease surveillance and control of epidemics:

1) Alertness to detect unusual health events and take appropriate remedial measures
2) Disinfection of water sources
3) Testing of water quality using H2S- Strip Test (Bacteriological) developed by NICD
4) Promotion of sanitation including use of toilets and appropriate garbage disposal.

5) Collection and reporting of vital statistics

6) Education about health/Behaviour change communication(BCC)

7) National Health Programmes including HIV/AIDS control programme-as relevant

Referral services:

Appropriate and prompt referral of cases needing specialist care including:

1) Stabilization of patient

2) Appropriate support for patient during transport

3) Providing transport facilities either by PHC vehicle or hired vehicle for which funds will be made available with the medical officer.

4) Routine and emergency treatment of:

5) Cases approaching the PHC directly

6) Cases reaching the PHC on referral from sub centres or elsewhere.

This will include:

i. Providing treatment or referral for all cases reaching the PHC

ii. In-patient care for patients needing admission.

Training:

1. Health workers and trained birth attendants
2. Initial and periodic Training of paramedics in treatment of minor ailments
3. Training of ASHAs
4. Periodic training of Doctors through Continuing Medical Education, conferences, skill development training, etc. on emergency obstetric care
5. Training of Health workers in antenatal care and skilled birth attendance

Basic laboratory services:

Essential Laboratory services including:

1. Routine urine, stool and blood tests
2. Blood grouping,
3. Bleeding time, clotting time,
4. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc.
5. Sputum testing for tuberculosis
6. Blood smear examination for malarial parasite.
7. Rapid tests for pregnancy/ malaria
8. RPR test for Syphilis/YAWS surveillance

Monitoring and Supervision:

1. Monitoring and supervision of activities of sub-centre through regular meetings/ periodic visits, etc.
2. Monitoring of all National Health Programmes
3. Monitoring activities of ASHAs
4. MO should visit all sub centres at least once in a month
5. Health Assistants Male and LHV should visit sub centres once a week.

AYUSH services as per local people's preference (Mainstreaming of AYUSH)

Record of Vital events and Reporting:

1. Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants.
2. Maintenance of all the relevant records concerning services provided in PHC

A Charter of Citizen's Health Rights should be prominently displayed outside all PHCs

The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located.

The Block level PHC will have involvement of Panchayti Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

The Mission seeks to provide minimum three Staff Nurses to ensure round the clock services in every PHC.

Funds available:

- Each PHC is entitled to get an annual maintenance grant of Rs. 50,000 for construction and maintenance of physical infrastructure .Provision for water, toilets, their use and their maintenance, etc, has to be priorities. PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure.
- Every PHC is entitled to get Rs. 25,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand.

Concrete Service Guarantees that NRHM has provide:

- Skilled attendance at all Births
- Full coverage of childhood diseases / health conditions
- Full coverage of maternal diseases / health conditions
- Full coverage for blindness due to refractive errors and low vision
- Full coverage for leprosy
- Full coverage for tuberculosis
- Full coverage for vector borne diseases

- Full coverage for minor injuries / illness
- Full coverage for inpatient treatment of childhood diseases / health conditions
- Full coverage for inpatient treatment of maternal diseases / health conditions (free for 50% user charges from APL)
- Full coverage of Blindness, vector borne diseases, life style diseases, hypertension etc.
- Full coverage for providing secondary care services at District Hospital.
- Full coverage for meeting unmet needs and spacing and permanent family planning services.
- Full coverage for RI/STI and counseling for HIV - AIDS services for adolescents.
- Health education and preventive health measures.

Service Guarantees from Community Health Centre (CHC)

CHCs are established and maintained by the State Governments. Manned by four specialists i.e. Surgeon, Physician, Gynecologist and pediatrician and supported by 21 paramedical and other staff, a CHC has 30 indoor beds with one OT, X ray facility, a labour room and laboratory facility. It serves as a referral centre for 4 PHCs. Currently there are 3222 Community Health Centres in the country and in Odisha 377 CHC.

- Care of routine and emergency cases in surgery:
- This includes incision and drainage, and surgery for Hernia, Hydrocele, Appendicitis, Hemorrhoids, Fistula, etc.
- Handling of emergencies like Intestinal Obstruction, Hemorrhage, etc.
- Care of routine and emergency cases in medicine:

Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines like Dengue, Hemorrhagic Fever, Cerebral Malaria, etc. Appropriate guidelines are already available under each programme, which should be compiled in a single manual.

- 24-hour delivery services including normal and assisted deliveries.
- Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions.
- Full range of family planning services including Laparoscopic Services.
- Safe Abortion Services.
- Newborn Care.
- Routine and Emergency Care of sick children.
- Other management including nasal packing, tracheotomy, foreign body removal etc.
- All the National Health Programmes (NHP) should be delivered through the CHCs. Integration with the existing programmes like blindness control, Integrated Disease Surveillance Project, is vital to provide comprehensive

services. The requirements for the important NHPs are being annexed as separate guidelines with the document.

- RNTCP: CHCs are expected to provide diagnostic services through the microscopy centres which are already established in the CHCs and treatment services as per the Technical Guidelines and Operational guidelines for Tuberculosis Control
- HIV/AIDS Control Programme: The expected services at the CHC level are being provided with this document which may be suitably implemented.
- National Vector Borne Disease Control Programme: The CHCs are to provide diagnostic and treatment facilities for routine and complicated cases of malaria, Filaria, Dengue, Japanese Encephalitis and Kala-azar in the respective endemic zones.
- National Leprosy Eradication Programme: The minimum services that are to be available at the CHCs are for diagnosis and treatment of cases and reactions of Leprosy along with advice to patient on Prevention of Deformity.
- National Programme for Control of Blindness: The eye care services that should be available at the CHC are diagnosis and treatment of common eye diseases, refraction services and surgical services including cataract by IOL implantation at selected CHCs optionally. 1 eye surgeon is being envisaged for every 5 lakh population.
- Under Integrated disease Surveillance Project, the related services include services for diagnosis for Malaria, Tuberculosis, Typhoid and tests for detection of faecal contamination of water and chlorination level. CHC will function as peripheral surveillance unit and collate, analyse and report information to district Surveillance Unit. In outbreak situations, appropriate action will be initiated.
- Others:

Blood Storage Facility

Essential Laboratory Services

Referral (Transport) Services:

Over the Mission period, the NRHM aims at bringing all the CHCs on a par with the IPHS to provide round the clock hospital-like services. According to IPHS, it is mandatory to display Charter of Citizen's Health Rights outside all CHCs. According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability. Mission also seeks to provide separate AYUSH set up in each CHC.

Funds available

- Every CHC gets Annual maintenance grant of Rs. 1 lakh for construction and maintenance of physical infrastructure. Rogi Kalyan Samiti/ Block Panchayat Samiti has a mandate to undertake construction and maintenance of CHC.

- Every CHC gets Rupees 50,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand.

Indian Public Health Standards (IPHS)

IPHS are being prescribed to provide optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care. These standards help in monitoring and improving the functioning of public health centers.

IPHS for CHCs provides for "Assured services" that should be available in a Community health centre along with minimum requirements for delivering these services such as:

- Minimum clinical and supporting manpower requirement
- Equipments
- Drugs
- Physical Infrastructure
- Charter of Patients' rights
- Requirement of quality control
- Quality assurance in service delivery-standard treatment protocol

Similar standards are being developed for PHCs & Sub Center.

Over the Mission period, the NRHM aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs would be operationalized as first Referral Units (FRUs) with all facilities for emergency obstetric care.

Charter of Citizen's Health Rights

Charter of Citizen's Health Rights seeks to provide a framework which enables citizens to know.

- What services are available?
- The quality of services they are entitled to.
- The means through which complaints regarding denial or poor qualities of services will be addressed.

A Charter of Citizen's Health Rights should be prominently displayed outside all District Hospitals, CHCs and PHCs. While IPHS makes the display mandatory for every CHC.

While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination.

Responsibilities of the users

- Users of CHC would attempt to understand the commitments made in the charter

- User would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- Instruction of the CHC's personnel would be followed sincerely, and in case of grievances, the redressal mechanism machinery would be addressed by users without delay.

Performance audit and review of the charter

Performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified

District and sub district level

Sub-divisional - Some specialties are made available at the sub divisional hospital. At the sub divisional level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer who is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital.

District level - The district officers (DMOs and CMOs) are overall in-charge of the health and family welfare programs in the district. They are responsible for implementing the programs according to policies laid down and finalized at higher levels, i.e. State and Centre.

Grievance redressal

- Grievances that citizens have recorded
- There will be a designated officer to respond to the request deemed urgent by the person recording the grievance
- Aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC
- To have a public grievance committee outside the CHC to deal with the grievances that are not resolved within the CHC.

In order to deal with the grievances of health issues of people, the District Collector has fixed one day each week to hear and redress the grievances where head of the health functionaries must be present and redress the complain. We also complain to RKS at PHA/CHC/SDH/DHH for all health problem and to Zilla Swasthya Samitee (ZSS) at District level.

If the Collector and CDMO has not resolve the problem then we can complain to Director of Health Services and Mission Director NHM.

Similarly directly we can complain to SHRC and NHRC through simple application of any type of health denial or negligence.

Shortfall in Odisha Health structure

Type of infrastructures	Availability	Shortfall in Number	% of Shortfall
Health Sub Centre	6688	1505	18
Primary Health Centre	1226	82	7
Community Health Centre (CHC)	377	-	-
Sub Divisional Hospital	27	-	-
District Hospital	32	-	-
Mobile Medical Units	114	-	-

Source: Rural Health Statistics, 2014

As per Rural Health Statistics 2014, there are 6688 number of health sub centres, 1305 primary health centres, 377 community health centres and 114 mobile medical units running in the state.

Designation	Sanctioned	In-Place	Vacant	Percentage
Doctor	4805	4371	434	9
Pharmacist	1945	1846	99	5
Staff Nurse	2124	1868	256	12
lab Technical (Path)	843	644	199	24
Multi-Purpose Health Worker - Male	4670	3560	1110	24
Multi-Purpose Health Worker - Female	7907	7319	588	7
Radiographer	194	131	63	32
Multi-Purpose Health supervisor-Male	1597	1328	269	17
Multi-Purpose Health Supervisor - Female	1228	1017	211	17
Ophthalmic Assistant	197	183	14	7
Total	25510	22267	3243	13

Gap in Odisha Health System

- 2726 Sub centres functioning in rented building
- 11 PHCs functioning in rented building
- Only in 2738 Sub-centres ANM living in the quarter
- No Available data about the Sub Centres running as per IPHS norms

- 2408 Sub-centres functioning without regular water supply
- 2414 Sub-centre functioning without electricity supply
- 182 sub-centres functioning without all weather motor able approaches
- 292 PHCs without labor Room
- 1305 PHCs without Operation Theater
- 1277 PHCs without at least 4 beds
- 141 PHCs without electricity supply
- 292 without water supply
- 6 PHCs without all weather motor able approaches
- No Available data on PHCs functioning as per IPHS norms
- 365 CHCs functioning without 4 specialist doctors
- 317 CHCs functioning without at least 30 beds
- 68 CHCs functioning without Operation Theaters
- 57 CHCs functioning without new born care corner
- 335 CHCs have no X-Ray machine
- 85 CHCs have no building for specialists quarter
- 111 CHCs have no living quarter for specialists living
- 3068 Health workers (Male) shortfall for Sub centres
- 212 Sub Centres functioning without Health Worker (Female), 2750 Sub-centres functioning without health worker (Male) and 158 Sub centres running without both
- 597 Health assistants (Female) shortfall for PHCs
- PHCs functioning without 1305health assistants (Male)
- PHCs running with 339 doctors vacant.
- 110 PHCs running without doctor
- 1010PHCs running without lady doctor
- CHCs running with shortfall of 297surgeons
- CHCs running with shortfall of 228 Obstetricians & Gynecologists
- CHCs running with shortfall of 333 Physicians
- CHCs running with shortfall of 304 Pediatricians
- Infant Mortality Rate-51

Source: Rural health statistics 2014

Expenditure in Health Sector (Rs. in Crore)

	2008-09 Accounts	2009-10 Accounts	2010-11 Accounts	2011-12 Accounts	2012-13 Accounts	2013-14 Accounts	2014-15 RE	2015-16 RE
Medical And Public Health	800.1990	985.8994	1033.0659	1129.3401	1467.3398	1630.9819	2996.2167	3183.3168
Family Welfare	121.7126	160.3463	210.7048	195.6548	213.8300	181.6020	276.4475	45.5170
Capital Outlay On Medical And Public Health	14.9067	24.6058	28.5819	36.9287	83.7709	144.3540	474.4976	578.1145
Total Health Sector	936.8183	1170.8515	1272.3526	1361.9236	1764.9407	1956.9379	3747.1618	3806.9483

Source: Annual Financial Statement different years

Expenditure on some other purposes Rs. in Crore)

Purpose	2013-14 Accounts	2014-15 RE	2015-16 BE
Medicine	190.3643	212.645	212.645
Bedding, Clothing & Linen	1.398	1.5528	1.5538

Source: Detail Plan, Non-Plan document, Health and family welfare department,2015-16

Medicine expenditure through health and family welfare department is planned only 212.65 crore during 2015-16 finance years. Bedding, Clothing & Linen expenditure is only 1.55 crore for the same year. Having seen this expenditure how can the government ensure better health facilities in government hospitals?

Department	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 RE	2015-16 BE
House and Urban development	1.67	.36	4.70	0	0	0	0
Works Department	19.87	30.06	28.60	0	0	0	0
Labour and Employment Department	4.71	2.51	23.18	23.58	24.85	25.75	30.01
Rural Development	4.71	2.51	42.13	0	0	0	0
Health and Family Welfare	1132.5	1226.08	1481.54	1820.40	1985.00	3811.53	3855.88
Total	1163.46	1261.52	1599.1	1845.34	2009.85	3837.28	3885.89

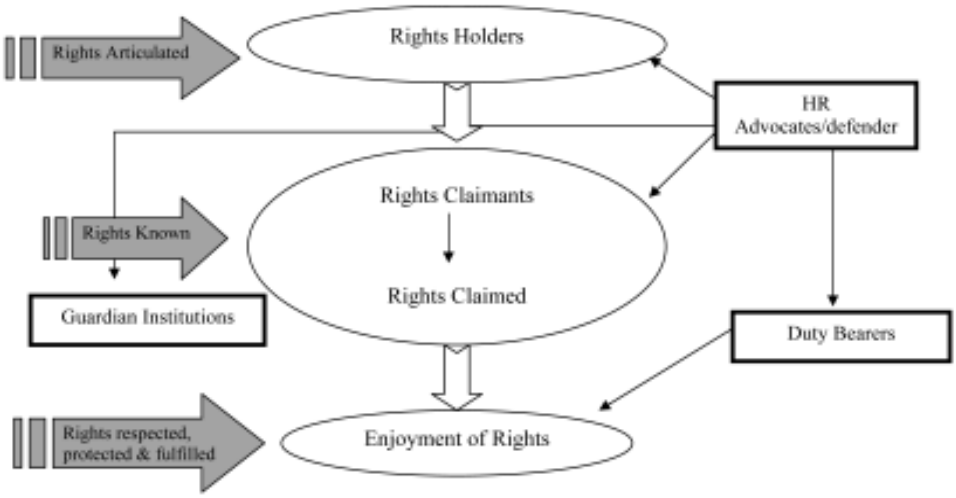
Health Advocacy

To make effective policy interventions, different strategies can be undertaken depending on the own strengths and references. These include:

- Public information and education on health issues largely through publications, meetings and other events, press conferences and media information.

- Social mobilization and protest actions by means of health enquire public hearings, health dialogues, seminars and cultural events.
- Representation to decision makers on policy concerns, grievances and gaps in health services, while seeking increased representation for communities in local health related decision making.
- Health survey and studies to understand and highlight health issues concerning the people.
- Organisation of people through community health programs, to help the poor cope with the burden of disease, gain better access to public health services and monitor health services.

Health rights, Universal Access,….



Some Action Points

1. Village/Panchayat/Block level

- Documentation of health denial
- Health need assessment in village level
- Collect information through RTI on health issue and understand.
- Involve/ motivate AWW, ANM, ASHA, health workers, PRI, Youth club, Village level social group like SMC, MTA, PTA, JFM, CFM, Mother committee, Watershed committee, VDC etc
- Identification of individual, group/NGO working and interested for this issue and create a data base
- Awareness meeting among students, youth club, SHG members, GKS/VHSC, RKS/PRI and other groups
- Conduct health class in school and collages for awareness building
- Involve NYK, NSS and Scout student in the campaign

- Disseminate message/ information of health right/entitlement in common place for awareness building
- Discuss this issue in Panchayat and zillaparisad meeting
- Strengthen Panchayat Health and women standing committee
- Initiate preparation of health plane in Palli sabha and Gram sobha
- Advocacy for utilization of all Flexi fund like RKS, AMG and untied fund at PHC, CHC, SDH & District for health
- Ensure Health citizen chatter in all level
- Preparation of health chatter of demand for advocacy
- Behavior change communication in the community level
- Develop a Network and strengthen
- Jan Sambad, jansunbai and social audit in GP, Block, District and State level on the issue of health
- Media advocacy, regular article and issue publish
- Lobby with opinion maker, politicians community leaders and stake holder
- Capacity building of partners and members
- District, Regional level workshop on this issue
- Involve in village health plan and ensure to include in district and state health PIP and in panchayat plan
- Ensure community monitoring on health services,
- Advocacy with govt. on the issue
- Comment on draft health policy
- Focus on safe delivery rather institution delivery
- Strengthen Mamota dibas and child nutrition clinic
- Mobilize community for use of latrine and proper sanitation
- Ensure IPHS in all the level
- Health expenditure tracking from village level to district level
- Minimize out of pocket expenses on health

2. District level

(Individual organization or a group of organization under the network)

- Create network among the local NGO, CBO, Youth club and other group and individuals work and interested on issue of health
- District level consultation with involving multi stake holder.
- Understand the draft health bill and different recommendation. Among the member
- Collect information through RTI on health at district level
- Media campaign on local health issue

- Initiative to involve All India Radio/community radio for program on health
- Advocacy with govt. for activate function of health programme
- Advocacy for effective utilization of health/nutrition/sanitation fund in district level
- Health budget tracking in district level
- Compile health denial case and advocate
- Compile individual and group local health cases/issue and advocate
- Regular meeting and follow up action with health and W&CD functionary on this issue
- Convergence of different stake holder
- Meeting with health functionary on this issue

3. State level

- Initiative for a E-group of health partners and people want to involve
- Circulate health related documents and draft bill among the member
- Collect information on health and circulate among the member
- Preparation of commend on draft health policy and advocate
- Translate health related document like health policy, nutrition policy and all the international commitment by the Govt. of India etc to local language for wider circulation
- Regional level workshop on this issue
- Preparation of health chatter of demand and share with member planning commission, media, MPs and MLAs and sensitize them
- A core team may be constituted and meet with Secretary Health, Secretary W&CD, Director Heath services, NRHM, W&CD, Planning commission for discussion on the health issue.
- Media campaign of the local health issue
- Formation of state level health net work for advocacy
- Adequate health training should be incorporated in training of all health care professionals
- Advocacy for greater budgetary provisions for health at the state, municipal and Zilla Parishad level
- Advocacy for increase in the number of officials and staff working on health within the State Health Department
- Advocacy for Community based health programme
- Quarterly review of the progress at state level
- Advocacy for implementation of community monitoring in hole Odisha
- Ensure redressal mechanism in all level

●

What is Primary Health Care ?

Primary health care is essential health care
based on
practical,
scientifically sound
socially acceptable methods and technology
made
universally accessible to individuals
and familites in the community
through
their full participation and
at a cost that the community and country can afford to
maintain at every stage of its development in a spirit of self-relince and self-determination.

(Alma Ata Declaration 1978)

Healthcare is a Right Not a Privilege

In association with:

CSNR

NAWO
National Alliance of Women

With Support from :

Trócaire