PROTECT IDENTITY

COM H – 84.1

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DENIAL OF HEALTH CARE: CASES FROM GUJARAT

1) *Name of the person*	H. N.
Age	60 years
Sex	Female
Complaint illness	Ovarian cancer
Date of interview	1st June 2004 (with the daughter of the deceased)

It was the summer of 2003. It all started when H. complained of white discharge and her stomach bloated up excessively. Her widowed daughter P., who stayed with her, took her to the local Primary Health Care Centre (PHC) at Sagtala. The medical officer at the PHC was not able to diagnose what the problem was, and thus, referred her to Baria.

After the one visit to the PHC, P. took her mother to the Community Health Centre (CHC) at Baria. There, the gynaecologist was also **not able to diagnose** what the problem was. In fact, he said that H. did not have any medically significant problem, so they **should go to a private practitioner** for further tests.

In spite of having very little money with herself, P. took her mother to a private practitioner and got a x-ray and sonography done. H. was given a ten days' course of medicines. The total cost borne by the family at the doctor's was around Rs.500.

Within the next ten days, H.'s condition worsened, so her daughter again took her to Baria to consult yet another private practitioner. This time the outcome was a five days' course of medicines and a total expenditure of about Rs.450 – and still no formal diagnosis! Meanwhile, H.'s condition deteriorated from bad to worse, and she did not get any relief, in spite of visiting the CHC as well as two private doctors. At this stage, P. thought that she would get better results if she took her mother to nearby Godhra. Thus, she took her to the Godhra Civil Hospital and got her mother admitted there. The sonographist was not available at that time – it seems he was on

vacation for twenty days – so the sonography could not be done at the Godhra Civil Hospital. H.'s desperate state made her daughter take her to a nearby private clinic for getting the sonography done. For this, she had to spend an additional Rs.300.

After four days of being admitted at the Godhra Civil Hospital, H. was **forced to move out, even though she was in no position to travel back**. Nevertheless, tired and worn out and disappointed, P. and her mother went back home to Sagtala.

P. brought up the topic for discussion at the next meeting of the local womens organisation. She expressed her anxiety for her mother's ill health and said that the worst part was that thus far no one had been able to diagnose anything. The organisation gave her a loan of Rs.1000, out of which she spent Rs.500 to get a private jeep to take H. to Godhra again – this time to a private nursing home – Lara Hospital, of which the doctors were known to some of the organisation leaders. This was on 26th June 2003. P. spent almost Rs.800 on the consultation fee, blood tests, urine tests and sonography (again from a private clinic), and was asked to get a second opinion before the test results were confirmed.

P. took her mother to another private clinic for a sonography, spending another Rs.300 in the process. It was on 28th June 2003, after weeks of running around, and of uncertainty that P. learnt that her mother was in the last stage of ovarian cancer. She was also told that the swelling of the abdomen was due to problems related to water retention. The doctors from Lara Hospital called a specialist from outside to get the water removed from the abdominal area; around three kilograms of water was removed. H. was kept in Lara Hospital for five days. By this time, P. had already spent Rs.2000 that she had borrowed from the organisation and Rs.1000 that her sister had sent to her for their mother's treatment. The doctors at Lara Hospital advised P. to take her mother to Ahmedabad where her mother could get specialized help at the government cancer hospital there. But **P. was broke** – she had no money to go through with the journey, nor was she in a position to bear the additional cost for her mother's treatment. She and H. came back to Sagtala.

In about a week's time, one night, H.'s abdomen began swelling again and she started vomiting violently. These symptoms were accompanied by diarrhea. H. was in no position to walk. Some neighbours helped to carry her to the road where they arranged for a jeep to go to Baria at the rate of Rs.200.

At Baria, H. was admitted to the CHC, where she stayed for the next two days. There also, she did not get any relief. The **CHC staff began telling P. to take her mother away from there**; they could find no solution to relieve her pain here at Baria. When P. asked them if they could at least draw out the water from her abdomen, the CHC staff asked her to sign an undertaking, saying that she would take the responsibility for the outcome, and further, **they asked for Rs.500 to carry out the exercise**. "Otherwise", they said, "you can go to Ahmedabad, because we will not do anything about it."

P. took the decision to take her mother to Ahmedabad. She asked the CHC whether they could give their vehicle to transport H. to Ahmedabad. The **CHC staff asked for Rs.800 for the use of the ambulance**, saying that P. would get back Rs.500 on her return to Baria. When P. asked for written proof of this agreement, The CHC staff refused. Finally, P. had to pay Rs.750 to take her mother to Ahmedabad in the CHC ambulance.

It was at 6:00 p.m. on 10th July 2003 when P. and her mother reached the Shah Cancer Hospital at Ahmedabad accompanied by P.'s brother and a nephew. Even when they got there, there was **no respite from the harassment**. They were asked to get out, to stay with relatives in Ahmedabad, and to come back the next day at 9:00 a.m. They pleaded with the doctor that they had no place to stay in Ahmedabad, and no one that they knew there; could the doctor please consider admitting H. that night itself? It was with a lot of pleading, groveling and begging that H. was finally admitted to the hospital at around 8:00 p.m.

The first question that the doctor asked them was – "How much money do you have?" The family responded that they did not have any money with them; they were poor and had already spent a lot of money on H.'s treatment in the past month or so. The doctor then asked them whether they had brought along their ration card, income certificate, and other documents that would help them to avail of government schemes for families below poverty line (BPL). P. replied in the negative, saying that they had not been aware of these schemes and had, therefore, not come prepared.

"Why have you come to Ahmedabad with no money? Don't you know – only those who earn and can spend money should come here to this cancer hospital", the doctor scolded P. and her family. The family requested the doctor to begin treatment, for which they would try to arrange for money. P. sent her nephew away immediately to his place of work and asked him to arrange for the money. When he could not do so, he even went back to Baria to try and arrange for the money back home.

Meanwhile, in Ahmedabad, the doctor saw that the family was really poor and desperate, so he began the treatment. There was, however, no help from the other staff at the hospital. P. relates how the nurse would not help even to fix the saline drip on to H.. When P. tried to do it herself, the blood started flowing in the opposite direction and filled up the connecting pipe. It was only after some trial and error that P. managed to fix the drip properly. The nurse merely looked on and refused to help. While P. attended to her mother day in, and day out, the men had to stay outside on the roads because they were not allowed inside the women's ward.

Finances were still in an uncertain stage. The family had to sell two of their 'simla' trees for Rs.500 each, and then arranged for another Rs.1000.

After nine days of being admitted to the cancer hospital at Ahmedabad, H. died at 6:00 p.m. on 19th July 2004. The family's troubles did not end here. They had to spend another Rs.1500 to get back to Baria.

Type of denial

(1) Lack of proper reference by CHC taken to District/Civil Hospital.
(2) Sonography not done at District Hospital. Referred to private.
(3) Spent money for investigations and medicines/injections.
(4) Absence of sonologist at District Hospital
(5) Asking Rs. 500/- for removing fluid from ovarian cyst at District Hospital
(6) No ambulance facility to transfer patient to Ahmedabad Cancer Hospital.
(7) Denial of admission at cancer hospital, Ahmedabad
(8) Demanding money for start treatment at cancer hospital, Ahmedabad. Patient not attended in time.
(9) Insulting behaviour of staff of CHC, District Hospital and Cancer Hospital, Ahmedabad.

Consequences

(1) Early death
(2) Severe financial loss

II) *Name of the person* N.V.
Age 35 years
Sex Female
Complaint illness Uterine cancer
Date of interview 2nd June 2004 (with the husband of the deceased person)

N.v.'s story illustrates a grave violation of the right to health care. About five years before she fell seriously ill, N.v. had a tube pregnancy wherein the fallopian tube burst because the foetus was lodged in the tube. This damaged the tube and caused excessive bleeding, and she had to be hurried to the CHC at Baria. There she was operated upon with twenty-three stitches and a tube was inserted.

After five years of this operation, N.v. complained of bleeding again. She again went with her husband to the CHC at Baria. The doctor was **not able to diagnose what her condition was due to,** but meanwhile he kept **charging them for all the medicines, saline drip bottles and tubes, etc**. Therefore, Babubhai (N.v.'s

husband) **took her to a private clinic in Baria, spending a lot of money in the process**, to see if some diagnosis could be got there. But it was to no avail.

N.v. was thus taken to the Godhra Civil Hospital. The family had to spend Rs.1150 to take her from Ruparel to Godhra. There they found out that N.v. was in the third stage of uterine cancer. **The staff at the Godhra Civil Hospital was very hostile. They allowed N.v. to be admitted there only for a day and did not attend to the medication that was required at all.** Meanwhile, N.v.'s condition was deteriorating rapidly.

With no other place to go to, Babubhai took his wife to a private practitioner to get her treatment so that she could get at least some relief. N.v. was admitted at a private clinic for fifteen days starting from 15th January 2003. The sonography, medicines, etc - all amounted to a total expenditure of Rs.2500 – maybe more. After those fifteen days, N.v.'s condition improved a little so she and her husband returned home to Ruparel.

Within a few days of their return, a camp was organized by the Baria CHC at the PHC near their house at Sevaniya. This was a camp for screening and treating those with RTIs and STIs. N.v. and Babubhai went to attend this camp. There the doctor from the Baria CHC confirmed that N.v. was suffering from cancer but said that he could do nothing for her treatment.

The medical officer at the PHC was not helpful at all. He **abused N.v. and her husband and asked them to get out of the PHC premises**. The pharmacist at the Sevaniya PHC tried to help them out. He said that his brother was a civil surgeon at Baroda, and could help them out if they went there.

But how would they get there with the little money that they had? The ANM at the PHC and a health worker from DMS **tried to get some assistance from the medical officer to arrange for to take N.v. to Baroda in the PHC jeep/ambulance, but they were rudely refused. They were asked to dish out**

Rs.2100. Finally, Babubhai arranged a jeep from Baria with the help of a relative, for which he ended up spending Rs. 900.

Once they reached Baroda, it was another series of struggles to even get a doctor's consultation. They had reached on a Monday, and were asked to go back and come on Wednesday. With no one to stay with at Baroda, and hardly any money on him, Babubhai was at a loss regarding what to do. At Baroda, the family spent about Rs.1700 – and N.v.'s condition only got worse.

Back in Ruparel, they made one more attempt to get medical attention at the Sevaniya PHC, but to no avail. After a total of eight months of suffering and being denied health care at every level, besides the additional cost of Rs.137000 that the family had to bear, N.v. died on 3rd July 2003.

Denial

(1) Spent money for medicines at CHC, Baria
(2) No ambulance facility for referral to Godhara District Hospital
(3) Insulting behaviour by staff at Godhara and PHC doctor, Sevaniya
(4) Corruption – asking Rs. 2100/- for PHC jeep to transfer the patient
(5) Not attending patient in time at SSG Hospital, Baroda
(6) No referral note given by special gynec. Camp

Consequences

(1) Death
(2) Severe financial loss

III)	*Name of the person*	Takhliben Rathwa
	Age	25 years
	Sex	Female
	Complaint illness	Maternal mortality
	Address	Patel Falia, Village Kasatiya, Devgadh Baria, District Dahod

Date of interview 29th May 2004 (with the Traditional Birth Attendant or TBA of the village, namely, Kesliben)

One-lakh women in India die every year due to complications before, after or during pregnancy. Yet another lakh of women suffer from related conditions that debilitate them in many ways. According to a World Bank report (1996), the maternal mortality rate (MMR) of India is a huge 437 per 100,000. It has further been reported that most of these deaths are due to infections caught at the time of childbirth, due to nutritional deficiencies (like anemia), early and frequent pregnancies, etc. It is sad because these situations can be totally avoided by registering the concerned woman at the neighbourhood 'anganwadi', by institutionalizing childbirth, by taking the necessary tetanus toxoid (TT) vaccine twice in the course of pregnancy, by taking a reasonably nutritious diet, and by taking regular iron folic supplements.

The national figures might be interesting, but we should also be asking ourselves, "Who is dying, and why?", instead of focusing merely on the statistics. It will clearly reveal that it is the women, children, and the elderly, the Dalits and the adivasis who are at the receiving end.

Village Kasatiya lies in the **remote and rocky area of Devgadh Baria taluka**. It is located on the periphery of the village Bara. Being around 25 km away from Devgadh Baria, Kasatiya is very **poorly connected even to the nearest PHC** at Sagtala. It is one of the regions wherein the **FHW and MPHW hardly visit the village**. On visiting a nearby 'anganwadi', the service delivery unit for the Integrated Child Development Services (ICDS) programme, the investigator also learnt that the **supplies of ORS packets and iron folic supplements had not reached the 'anganwadis' in the villages in the past year or so.** Takhliben lost her life during childbirth four months ago as a result of these **systemic loopholes** in the primary health care system.

Takhliben used to live in the Patel falia of Kasatiya. During the period of her pregnancy **she did not have access to either the iron folic supplement, nor did she have access to the TT vaccine**. The ANM never visits Kasatiya, and there are no supplies at the 'anganwadi' either, so Takhliben never took iron folic supplements. In spite of that, she made the effort to get at least one TT vaccine from a private doctor in a place called Kadwal. Kadwal is not exactly near Kasatiya, the bus fare up to it being Rs.10. But since there was no other option, Takhliben took the trouble to get the vaccine.

Kasatiya is anyway very inaccessible. At night, it is almost impossible to get a vehicle to go anywhere. The night that Takhliben went into labour was no different. The only person who was able to come to her assistance was the local 'dayan', or traditional birth attendant (TBA). ANANDI has already facilitated the training of several TBAs in the villages where it works. Unfortunately, **this 'dayan' was not one of the trained ones**.

Takhliben went into labour and had a baby boy. But immediately after the delivery, she began to bleed excessively. There was nothing the 'dayan' could do to stop her suffering. Takhliben ultimately bled to death - another addition to the already large number of maternal deaths in the country today.

Denial

(1) Non-availability of ante-natal care by ANM at village level, eg. Check up Iron supplement, Injection TT, referral , etc.
(2) Delivery not attended by trained Dai (TBA)
(3) No access to PHC on CHC

Consequences

Death

II) Name of the person Narmadaben Nayak

Age 35 years

Sex	Female
Complaint illness	Case of tuberculosis (TB)
Address	Village Mithi Bor, District Vadodra, Gujarat
Date of interview	1st June 2004 (with the sister of the aggrieved person, namely, Kusumben)

Narmadaben lives in the village called Mithi Bor, which lies in Baroda district. When she came to visit her sister in Sagtala, she complained of cough and fever. She began vomiting and her feet got swollen. Heavy breathing made it difficult for her to even walk a single step.

Her sister Kusumben, one of the health workers of the DMS, took her to a nearby PHC at Sevaniya. After three subsequent visits to the PHC, she was diagnosed as suffering from TB. However, **the medical officer at the PHC said that he could not start treatment because Mithi Bor lies in a taluka other than Devgadh Baria, and he was not authorized to dispense medicines to residents of other talukas**. Further, he said that Narmadaben should get a x-ray done at Baria.

Kusumben took her sister to the CHC at Baria, where she got her admitted on 17th May 2004. There, it was confirmed that Narmadaben was indeed suffering from TB (Category I). The doctor, however, **repeated that he could not start treatment for it because she is a resident of another taluka, and proper follow-up could not be undertaken for the period of treatment**. Kusumben assured the doctor she would keep her sister at her own house for the next six months and take full responsibility for her taking the medicines on time, as per schedule. The doctor insisted that she should be taken to the PHC at Jhojh, where she would get the appropriate treatment under the medical officer at that PHC, as per DOTS (Directly Observed Treatment Short course). Meanwhile, Kusumben has to spend a lot of money for the period that Narmadaben was admitted at the Baria CHC, and had to get even the basic medicines like paracetamol from a medical store outside.

After going back from Baria, she tried again at the Sevaniya PHC, but was disappointed again. After nine days, Narmadaben's condition improved slightly, so her husband took her home to Mithi Bor.

Once she got back home, her condition deteriorated again. The previous symptoms of coughing, vomiting and breathlessness appeared again. Narmadaben's husband then took her to the PHC at Jhojh. He explained that she had been diagnosed as suffering from TB (Category I) and had been asked to seek treatment at the Jhojh PHC. He asked them to begin her treatment immediately as she had already suffered a great deal, and was now very ill.

The medical officer at the Jhojh PHC, as well as the nurse, **made a demand of Rs.4000 for the treatment**. Narmadaben and her husband said that they were poor and could not afford the treatment if it was so expensive: would the doctor please reconsider? The doctor and the nurse said – **'Do you think it comes for free? If you want treatment here, you have to pay for it!'**

Narmadaben and her husband turned away and returned home, disappointed and unhappy. After all, they could not do anything about it. Narmadaben still gets uncontrollable bouts of coughing and vomiting. She still gets breathless when she walks a few steps. She still suffers, and no one is willing to help her.

(Update on 21st June 2004 – Narmadaben's sister Kusumben who is a health worker in the DMS kept trying hard to get her sister some relief. Due to her efforts, it has now been 10 days that Narmadaben's treatment has begun. She is receiving treatment under DOTS at the Sevaniya PHC.)

Denial

(1) Even though diagnosed at the SCM PHC/CHC, patient was denied treatment on the ground that he belongs to other PHC area which is situated far away from patient's village
(2) Corruption – demanding Rs. 4000/- for DGTs (TB) which is available at no cost
(3) Insulting behaviour by 202 PHC
(4) Delay of treatment

Consequences

(1) Spending money for frequent uncalled for visits to PHCs/CHC
(2) Treatment delayed by more than one month

V) *Name of the person*	Kokilaben Nayak
Age	30 years
Sex	Female
Complaint illness	Complications in childbirth
Address	Maal Falia, Village Jhapatiya, Devgadh Baria, District Dahod, Gujarat
Date of interview	2nd June 2004 (with Kokilaben and her husband namely, Maheshbhai who was present at the time of childbirth. Kokilaben had been almost unconscious of her surroundings at the time, while her husband was there to accompany her during childbirth.)

One can hear several cases as gruesome as that of Kokilaben's if one visits the tribal villages of the Panchmahaals and Dahod districts. This story took place around four years ago.

Kokilaben was pregnant with her first child. She had completed her term of pregnancy, and would soon go into labour. Her husband Maheshbhai made arrangements to take her to the CHC at Baria by hiring a private jeep from Jhapatiya

to Baria at the rate of Rs.500. Kokilaben was admitted there, and soon after, all the CHC staff left for the day.

The gynaecologist at the CHC (Dr. Mahetra) told Maheshbhai that his wife would have to undergo a caesarian operation, and **unabashedly asked for Rs.4000-5000 for the same**. Maheshbhai was suspicious of inducing childbirth through the caesarian operation, as most people in the villages are. However, he was further apprehensive when the doctor asked for such a large sum of money. It seemed to Maheshbhai that the doctor was merely in the business of making money, and there was possibly no real need to carry out a caesarian operation.

Maheshbhai's fears were only reinforced again and again. He was **asked to buy all the medicines from a medical store outside**, and was told that the hospital store could not provide any of the medicines. He was asked specifically to buy some 'labour-inducing' medicines that would induce labour when injected. These injections cost Rs.150 each, and he was asked to buy three of them. However, when it came to giving Kokilaben the injections, Maheshbhai observed that the nurse was giving his wife some other injection. His doubts about the intentions of the CHC staff multiplied.

Things only got worse. One of the nurses in the ward manhandled Kokilaben and **injured her very seriously**. She picked up one of her legs and turned it around so hard that it caused the bone to crack. This caused irreversible damage. Even today Kokilaben cannot walk straight, or carry heavy weights because it hurts her back and legs to do so.

Soon after this incident happened, Maheshbhai decided that enough is enough. He carried his almost unconscious wife out of the hospital, even though it was evening and they had nowhere to go at that time. The guard tried to stop him, but he had made up his mind that he would not see the birth of his firstborn in the corrupt and

callous government hospital. Kokilaben and he rested under a tree almost all night long.

In the early hours of the morning, Maheshbhai took Kokilaben to a private clinic (Maniben's) in Baria on the Dhanpur road. There, Kokilaben was made to go through a normal delivery, and little Raju was born. The total expenditure at the private clinic amounted to around Rs.1500, and further, Maheshbhai had to spend Rs.525 to book a jeep to return to Kokilaben's maternal home in Devirampura.
But the damage had already been done, and Kokilaben has to live with it everyday of her life.

Denial

(1) Corruption/scandals – indicating ceasarian section – when it was not indicated. Asking Rs. 5000/- for the same, when it is to be free
(2) Purchasing medicines from outside
(3) Insulting and injurious behaviour by staff nurse to the patient
(4) Had to seek treatment from private clinic

Consequences

(1) Disability due to injurious behaviour by the nurse (fracture and permanent walking problem).
(2) Moderate financial loss

VI) *Name of the patient* Jashodaben Udabhai Baria
Age 28 Years.
Address Godhar, Santarampur, Gujarat

Complaint Complicated delivery.

Jashodaben Udabhai Baria's family consists of her husband and a has girl child and. She registered under the local PHC for every basic immunization and other basic treatment for her pregnancy and she also has been advised by the nurse of Lunawada hospital to get in touch with the hospital in case she has any complaint during her pregnancy.

On 5/11/2003 she consulted at CHC Lunawada Hospital and the doctor told her that she is carrying twins. Later a ultra sonography in one private hospital indicated that there is no second child but the position of the infant inside her uterus was not normal and it may be serious if she did not go for an operation immediately. However, due to poor financial condition, she got back home without the operation. On her way back home she felt the pain of delivery. Next day 6th of November her husband decided to admit her in the government hospital for the delivery and finally hospitalized her at the Godhra civil hospital instead of Lunawada Hospital at mid night. The nurse of the Godhra civil hospital informed her husband that the doctor was not available and could visit her only in the next day morning. There was no doctor for the emergency.

However, by mid night Jashodaben started labour. The nurse helped Jashodaben in the emergency. She started one saline intravenous infusion and informed that the birth would be safe. This gave hope to Jashodaben's family. However, eventually Jashodaben gave birth to a dead baby. Seeing the condition of Jashodaben, the nurse prescribed four injections which cost Rs 90 per injection. She gave her some more IV fluids and prescribed another two injections, that cost something like Rs. 7000/-.

Jashodaben husband could not find one of the prescribed injections at that early hour, as the medical shop was yet to open and that cost Jashodaben's life. Her 'veins started straining' and she died due to lack of the injections on time. The hospital ambulance authority took Rs.650/- to carry home the dead body of Jashodaben.

Denial

(1) *Denied confirmation of twins (pregnancy) by CHC, Lunawala*
(2) *Spent money for sonogarphy to confirm twin). It was not twin)*
(3) *Doctor was not available at District Hospital, Godhra*
(4) *Inadequate attention – as emergency was not attended by the specialist doctor/ Nurse decided and gave treatment*
(5) *Had to spend money for medicines*

Consequences

(1) *Death of mother and foetus*
(2) *Severe financial loss*

VII) *Name of the Patient* : Sivkumari Chatur singh Tojaraf.

Age : 35 years

Sex : Female.

Address : Saptarushi no Arro.Ramji Mandir. Bavalavlavinagar. Opp.Flower Market, Jamalpur

I. Date of interview: 15.6.04

- **Location of the PHC/Location and type of Hospital-**Vadilal Sarabhai General Hospital,Ellisbridge Ahmedabad city.
- **Illness/Complaints for which PHC/Hospital was visited-**Accident . Severe burn injuries due to bursting of stove.
- **Total number of visits to PHC/Hospital for this illness-**1 Time
- **Date of last visit-**11.3.04

1. History of last visits in the patients /attendants words-
(Here we want to collect information regarding the main symptoms of the patient. who gave care and what kinds of examination, investigation and treatment were given)

Shivkumari, a 35 year old school teacher met with a accident at her residence as she was preparing the breakfast for her family –two children and her husband. Suddenly her screams were heard aloud in the neighborhood and when the complainant Ms.Gulshan Banu, her friend and colleague reached the spot along with the

neighbors they saw Shivkumari engulfed in flames along with her husband who sustained burns too.when he tried to save her.

Neighbours and the complainant immediately rushed the victim to Vadilal Sarabhai General Hospital run by Ahmedabad Municipal Corporation. The doctor on duty denied to admit the patient to the burns ward on the pretext that she does not have any chances of survival. The staff out rightly said so. in front of the patient. which added to her panic as she lost all hope of survival. She is believed to have said to the Ms.Gulshan Banu that now that doctor has already declared her to be alive for only few hours, she needs to take care of her children.

Instead of starting the treatment the doctor asked the relatives to get the medicines from outside only then they would take the case. They also added that if its too urgent for them to get her treated, patient could be rushed to Civil Hospital. which is a 30 min drive from the said hospital!
To add to the trauma, the nurse asks the relatives to cut open the clothes that were almost stuck to the skin. As they tried they couldn't continue but the hospital did not come forward to extend their hand, instead Ms.Banu had to remove the pieces of cloth and break her bangles from the flesh which oozed blood and send out unbearable stench. Still the mere thought of the entire episode makes her feel drowsy and sends a chill shiver across her body. She could not eat and sleep for days together and ran high fever.

Having spend a handsome Rs.1750/- for seven days which was collected from various sources **Shivkumari breathed her last on the seventh day struggling to get a bed in the burns wards and some soothing words of relief from the hospital staff!**

- **What were the perceived shortcomings or deficiencies in care? (As perceived by the patient or attendants)**
  They did not start the treatment timely.
- **According to patient was there any adverse outcome because of deficient care? (Death, Disability, continued or chronic health problem. severely financial lose e.g. major loan or sale assets)**

  Death. Patient lost her life after 8 days.

2. **Medical attention received:**
   - **Name of the doctor who attended to you-**They don't know the name of the doctor.
   - **If the doctor was not available at that time then who attended to you**

     1. **Nurse /ANM**
     2. **MPW** NA
     3. **Pharmacist**

4. Any other person specify

- **How long after you reach the PHC / Hospital did the medical officer /doctor attend to you?**
  After 20 minutes

- **Was examination, Treatment, Operation delayed or denied because of non-availability of a nurse, doctor or specialist?**

No they intentionally denied starting the treatment on the pretext that the patient would not survive.

- **In case of an emergency did the doctor immediately attend to patient? During hospital stay, regarding conditions that required immediate care was the doctor available to immediately attend to the patient?**

No. They attended the patient after 20 minutes.

- **Were nurses or Hospital staff available to attend the patient as and when required?**

Though the staff would be available in the nearby wards they would come only after much persuasion.

- **Do you think that non-availability of any crucial equipment or supply** (oxygen, incubator, anasthetic eqipment, blood emergency drugs etc) **adversely affected the quality of care?**

VS Hospital being one of General Hospitals of Abad city is equipped with all the modern and crucial equipments for emergency and other cases. The unwilling attitude of the staff was the only problem.

- **Were all the equipments required for the examination and treatment of the patient available in the working condition in the Hospital?**
  Yes

Diagnosis – (as told by the doctor)

3. **Medicines:**
   - **Did you get all the required medicines at the PHC /Hospital?** No
   - **Did you have to go to any Private medical shop to buy some medicines?** Yes
   - **If so which medicines you had to buy from private medical shop?** Don't know specific name of the medicine (injection and ointment)
   - **How much did it cost?** Per container 25l/ everyday.

- **Do you have the prescription?** (If yes. obtain a Xerox of the same and attach?)No

4. Expenditure:
   - **Case paper/ Card made** – no
   - **Case paper fee /indoor fees charged-**NA
   - **Did you receive a receipt for the payment made? -**NA
   - **Were you charged excess money at the PHC/ Hospital** (more than specified rates) Yes
   - **If yes. how much excess was charged?** 2500/
   - **Did your family have to sell assets (land. cattle. jewelry** etc) **take loans to pay for in the govt Hospital?**
     Yes. They had to take loans from others and they were in debt.

5. Referral:
   - **Was the patient refused admission or referred to another Hospital without giving first aid care?** NA
   - **If the patient was referred was ambulance or other vehicle made available for the same?** NA
   - **Did the govt doctor ask you to avail of any private services** (e. g Laboratory services. sonography/Xray) **while you were admitted in the govt hospital?** No
   - **In case you had to take the patient to private hospital. which hospital?**
     (Name and address of the hospital?)
     - **What was the total expenditure on care at the private hospital /private lab or imaging center?**
     - **Did your family have to sell any assets** (land. cattle, jewelry etc.) **or take loans to pay for the private hospital charges?**

Yes. Her husband's friend spends the amount. which the deceased's husband/relative not know.

Denial

1. *Doctor refused admission to burns ward on the pretext that survival chances are nil.*
2. *Purchase medicines from outside then only treatment could be given.*
3. *Delay in treatment & extreme carelessness by the staff & doctor.*
4. *Was not admitted in burns ward.*
5. *Excess charges (Rs. 2500)*

Consequences

1. *self – confidence & will to survive was shattered by the staff*
2. *Death*

3. *Moderate financial loss*
4. *Torture of relatives*

VIII) *Name of the Patient* : Rupaben Rajeshbhai Pathni.

Age : 24 years

Sex : Female

Address : Boidivat Nagar. Saraspur Ahmedabad.

Date of interview : 17.6.04

- **Location of the PHC/Location and type of Hospital** –Shardaben Govt General Hospital, Saraspur Ahmedabad.
- **Illness/Complaints for which PHC/Hospital was visited** –High fever coupled with severe vomiting and Diarrhea
- **Total number of visits to PHC/Hospital for this illness**-1 times
- **Date of last visit** - 15.5.04

3. History of last visits in the patients /attendants words-
(Here we want to collect information regarding the main symptoms of the patient. who gave care and what kinds of examination. investigation and treatment were given)

Patient visited Shardaben General Hospital one of the largest and well-equipped hospitals run by Ahmedabad Municipal Corporation as she complained of severe diarrhea and vomiting. Unable to even stand firmly she requested the doctor to start immediate treatment but he asked her to get an Injection from outside. When she got the injection the nurse asked her to get on to the table which had blood stains and dirty fluid with foul smell. She requested her to take her on to a clean table to which the nurse reacted in a wild manner and said "You lower caste (vaghri) people come her when you are at the verge of dying and disturb our sleep. If you want, you lie down here or else go way." Patient had no other option than to get herself injected.

She did not get any relief from it and hence had to visit a private practitioner. After a thorough examination she was diagnosed to have falcifarum malaria with edema in the abdomen. She felt better after having undergone the treatment at the private hospital.

- **What were the perceived shortcomings or deficiencies in care? (As perceived by the patient or attendants)**

Patient was not diagnosed properly and was ill treated by the para-medics. Patient had to bypass the public health facility for a highly paid private practitioner for the want of getting relief.

- **According to patient was there any adverse outcome because of deficient care? (Death, Disability, continued or chronic health problem, severely financial lose e.g. major loan or sale assets)**

Had she not consulted the private practitioner on time her condition would have deteriorated further as the edema in the abdomen was causing severe pain.

Medical attention received:

- **Name of the doctor who attended to you-**They don't know the name of the doctor.
- **If the doctor was not available at that time then who attended to you**

1. **Nurse /ANM** NA
2. **MPW**
3. **Pharmacist**
4. **Any other person specify**

- **How long after you reach the PHC / Hospital did the medical officer /doctor attend to you?**

After half an hour.

- **Was examination, Treatment, Operation delayed or denied because of non-availability of a nurse, doctor or specialist?**

Medical and Para Medical staff though present did not attend the patient immediately even though she was extremely weak and dehydrated and pleaded to attend her.

- **In case of an emergency did the doctor immediately attend to patient? During hospital stay, regarding conditions that required immediate care was the doctor available to immediately attend to the patient?**

No.

- **Were nurses or Hospital staff available to attend the patient as and when required?**

No.

- **Do you think that non-availability of any crucial equipment or supply (**oxygen, incubator, anasthetic eqipment, blood emergency drugs etc**) adversely affected the quality of care?**

Patient was asked to buy an injection from outside only then they would begin the treatment, it was told. Non-availability of essential

drugs even during emergency situation is a matter of serious thinking. Poor patients many of whom are not accompanied by their relatives find it difficult to run at different quarters for medicines. Care should be taken that they are not harassed unnecessarily during emergency situations.

- **Were all the equipments required for the examination and treatment of the patient available in the working condition in the Hospital?**

  Yes

Diagnosis – (as told by the doctor)

3. **Medicines:**
   - **Did you get all the required medicines at the PHC /Hospital?** -No
   - **Did you have to go to any Private medical shop to buy some medicines?** -Yes
   - **If so which medicines you had to buy from private medical shop?** She doesn't know the name of the injection.
   - **How much did it cost?** –40 Rupees for the purchase of one injection.
   - **Do you have the prescription?** (If yes, obtain a Xerox of the same and attach?)No
4. **Expenditure:**
   - **Case paper/ Card made** –no
   - **Case paper fee /indoor fees charged**-NA
   - **Did you receive a receipt for the payment made?** -NA
   - **Were you charged excess money at the PHC/ Hospital** (more than specified rates) NA
   - **If yes, how much excess was charged?**
   - **Did your family have to sell assets (land, cattle, jewelry etc) take loans to pay for in the govt Hospital?** No
5. **Referral:**

   • **Was the patient refused admission or referred to another Hospital without giving first aid care?** Yes

   • **If the patient was referred was ambulance or other vehicle made available for the same?** NA

   • **Did the govt doctor ask you to avail of any private services** (e. g Laboratory services, sonography/Xray) **while you were admitted in the govt hospital?** No

   • **In case you had to take the patient to private hospital, which hospital?**

   (Name and address of the hospital?) Private Clinic. She doesn't know the clinic's name.

   - **What was the total expenditure on care at the private hospital /private lab or imaging center?** She doesn't know, her husband paid the money.

- **Did your family have to sell any assets (land. cattle. jewelry etc.) Or take loans to pay for the private hospital charges?** No

Denial

1. *Delayed treatment only after getting medicines & injections from the market*
2. *Spent money for the medicines*
3. *Insulting behaviour of the staff*
4. *Inadequate & low quality & care*
5. *Investigation & treatment by private doctor (F. Malaria)*

Consequences

1. *Suffering for longer time*
2. *Spent money to seek better care in Pvt. Clinics*

IX) *Name of the Patient* : Rakshak Ghani Shah

Age : 45 years

Sex : Male

Address : Sangam Bavalavlavinagar. Jamalpur.

Date of interview : 15.6.04

- **Location of the PHC/Location and type of Hospital-**Vadilal Sarabhai General Hospital, run by Ahmedabad Municipal Corporation.
- **Illness/Complaints for which PHC/Hospital was visited-**V. S Hospital
- **Total number of visits to PHC/Hospital for this illness-** 2 Times.
- **Date of last visit-** 5.4.04

4. History of last visits in the patients /attendants words-
(Here we want to collect information regarding the main symptoms of the patient. who gave care and what kinds of examination, investigation and treatment were given)

Patient had stomach ache at 12 am at night. Next day morning he had taken medicine from the clinic in the chali .He was given antacid to reduce gas formation but it did not help. Then he was taken to Dr. Amin's clinic, a private practitioner. There it was told that his condition was critical. Immediately he was admitted to VS hospital. After check-up and various x-rays test he was given medicines and sent back home. His relatives were told that he is perfectly fine. Somehow after coming home he could not bear the severe pain near his abdomen. He was again taken to another clinic. There the doctor announced that his condition was critical. Then he

was taken to Chipa Welfare Trust. There, after taking sonography, they were told to arrange 20,000/ immediately, for operation. Patient was not able to arrange 20,000/ and so he goes back with sonography report. Then again he goes to V.S hospital with sonography report, to get operated with lesser amount. Doctor operates the patient and tells his relatives to arrange for medicines. Patient was not able to regain his conciousness after the operation. Relatives were informed that he would have to be operated on other kidney also. **Patient expired after seven days.**

This is a case of utter denial of the treatment at the right time. Had the patient been diagnosed properly on his first visit itself he would have rescued.

- **What were the perceived shortcomings or deficiencies in care? (As perceived by the patient or attendants)**

Mentioned above.

- **According to patient was there any adverse outcome because of deficient care? (Death, Disability, continued or chronic health problem, severely financial lose e.g. major loan or sale assets)**

Death.

5. **Medical attention received:**
   - **Name of the doctor who attended to you-** They don't know the name of the doctor.
   - **If the doctor was not available at that time then who attended to you**

     1. **Nurse /ANM** NA
     2. **MPW**
     3. **Pharmacist**
     4. **Any other person specify**

   - **How long after you reach the PHC / Hospital did the medical officer doctor attend to you?**
     Several visits to the hospital made it possible for the patient to get treatment only to die needlessly.

   - **Was examination, Treatment, Operation delayed or denied because of non-availability of a nurse, doctor or specialist?**

     Even though Doctors and specialist was available the treatment wasn't started on time.

   - **In case of an emergency did the doctor immediately attend to patient? During hospital stay, regarding conditions that required immediate care was the doctor available to immediately attend to the patient?**

Please refer to the above-mentioned details.

- **Were nurses or Hospital staff available to attend the patient as and when required?**

  No they intentionally denied starting the treatment.

- **Do you think that non-availability of any crucial equipment or supply** (oxygen, incubator, anasthetic eqipment, blood emergency drugs etc) **adversely affected the quality of care?**

  No, V.S Hospital is situated in Ahmedabad City. So any crucial equipment or supply is available all time.

- **Were all the equipments required for the examination and treatment of the patient available in the working condition in the Hospital?**

  Yes

Diagnosis – (as told by the doctor)

3. **Medicines:**
   - **Did you get all the required medicines at the PHC /Hospital?** No
   - **Did you have to go to any Private medical shop to buy some medicines?** Yes
   - **If so which medicines you had to buy from private medical shop?** They don't know the name of medicine.
   - **How much did it cost?** Total 3,000/ to 4,000/
   - **Do you have the prescription?** (If yes, obtain a Xerox of the same and attach?) No

4. **Expenditure:**
   - **Case paper/ Card made** –Yes
   - **Case paper fee /indoor fees charged** –Rs 45/
   - **Did you receive a receipt for the payment made?** - No
   - **Were you charged excess money at the PHC/ Hospital** (more than specified rates) Yes
   - **If yes, how much excess was charged?** 30/ more.
   - **Did your family have to sell assets (land, cattle, jewelry** etc) **take loans to pay for in the govt Hospital?**

     Mortgaged the peddle rickshaw and got 3000/

5. **Referral:**
   - **Was the patient refused admission or referred to another Hospital without giving first aid care?** NA
   - **If the patient was referred was ambulance or other vehicle made available for the same?** NA

• **Did the govt doctor ask you to avail of any private services** (e. g Laboratory services. sonography/Xray) **while you were admitted in the govt hospital?** No

• **In case you had to take the patient to private hospital, which hospital?**

(Name and address of the hospital?) Chipa welfare Trust Jamalpur Ahmedabad.

- **What was the total expenditure on care at the private hospital /private lab or imaging center?** NA
- **Did your family have to sell any assets** (land. cattle. jewelry etc.) **Or take loans to pay for the private hospital charges?**

NA

Denial

1. *Inadequate investigations & care*
2. *Had to seek reference in private clinics & trust hospital*
3. *Purchase medicines from outside*

Consequences

1. *Death*
2. *Loss of livelihood – (mortgaged rickshaw)*

X) *Name of the Patient* Savita Ben Daya bhai Chavda

Age 30

Sex Female

Address Hanuman ki Chali. Khodiyarnagar. Behrampura.Ahmedabad City.

Date of interview 17.6.04

- **Location of the PHC/Location and type of Hospital** – V.S Hospital Govt general Hospital
- **Illness/Complaints for which PHC/Hospital was visited** –Childbirth.
- **Total number of visits to PHC/Hospital for this illness-**1 Times.
- **Date of last visit-** February 04

6. **History of last visits in the patients /attendants words-**

(Here we want to collect information regarding the main symptoms of the patient, who gave care and what kinds of examination, investigation and treatment were given)

Patient started unbearable labor pain and she was taken to VS hospital by her husband. When she reached nurse examined her and said there is still time for childbirth and hence she should go back home and come the next day. Savitaben pleaded to get her admitted as she could not bear the pain, but the nurse was adamant on her words and did not listen to the patient. As they started to go to Behrampura Municipal Hospital she had to be taken to a private nursing home on the way as she delivered a baby boy.

This case is truly an example of denying the right treatment at the Municipal Hospital for which the poor patient had to unnecessary get in trouble of running from pillar to post just to get a safe childbirth. They had to bear the cost of getting delivered at a private clinic too which would have been avoided had the nurse at VS hospital examined her well and admitted her there itself.

- **What were the perceived shortcomings or deficiencies in care? (As perceived by the patient or attendants)**

Patient expresses her anguish over denying her the treatment even when she pleaded for it. She had to over spend on account of the lack-luster attitude of the staff. Not to mention of the panic and trauma they underwent at the last moment.

- **According to patient was there any adverse outcome because of deficient care? (Death, Disability, continued or chronic health problem, severely financial lose e.g. major loan or sale assets)**
  She had reached private hospital in time and was saved.

7. **Medical attention received:**
   - **Name of the doctor who attended to you** – Doctor was not there that time they don't know the name of the doctor.
   - **If the doctor was not available at that time then who attended to you**
     1. Nurse /ANM
     2. MPW
     3. Pharmacist
     4. Any other person specify

   - **How long after you reach the PHC / Hospital did the medical officer /doctor attend to you?**

Doctor and Medical officer not there that time. So they did not attend the patient.

- **Was examination, Treatment, Operation delayed or denied because of non-availability of a nurse, doctor or specialist?**

No. Nurse was there but intentionally denied to admit the patient.

- **In case of an emergency did the doctor immediately attend to patient? During hospital stay, regarding conditions that required immediate care was the doctor available to immediately attend to the patient?**

Doctor was not there so they did not attend the patient immediately and did not provide the treatment.

- **Were nurses or Hospital staff available to attend the patient as and when required?**
  Nurse was available but she not given the treatment and check up.

- **Do you think that non-availability of any crucial equipment or supply (**oxygen, incubator, anasthetic eqipment, blood emergency drugs etc**) adversely affected the quality of care?**

  No, V.S Hospital is situated in Ahmedabad City. So any crucial equipment or supply is available all time.
- **Were all the equipments required for the examination and treatment of the patient available in the working condition in the Hospital?**
  Yes.

Diagnosis – (as told by the doctor)

3. **Medicines:**
   - **Did you get all the required medicines at the PHC /Hospital?** No
   - **Did you have to go to any Private medical shop to buy some medicines?** Yes
   - **If so which medicines you had to buy from private medical shop?** She don't Know the name of medicine.
   - **How much did it cost?** Don't know
   - **Do you have the prescription? (**If yes, obtain a Xerox of the same and attach?) No

4. **Expenditure:** *The patient could not reach the public health center.*
   - **Case paper/ Card made –**
   - **Case paper fee /indoor fees charged-**
   - **Did you receive a receipt for the payment made?**
   - **Were you charged excess money at the PHC/ Hospital** (more than specified rates)
   - **If yes, how much excess was charged?**

- **Did your family have to sell assets (land, cattle, jewelry etc) take loans to pay for in the govt Hospital?**

5. Referral:
   - **Was the patient refused admission or referred to another Hospital without giving first aid care?** Yes
   - **If the patient was referred was ambulance or other vehicle made available for the same?** NA
   - **Did the govt doctor ask you to avail of any private services (e. g Laboratory services, sonography/Xray) while you were admitted in the govt hospital?** No
   - **In case you had to take the patient to private hospital, which hospital?**

     (Name and address of the hospital**?)**
     Krishna Hospital. Behrampura
     Ahmedabad City.

   - **What was the total expenditure on care at the private hospital /private lab or imaging center?**

     She Don't Know.

   - **Did your family have to sell any assets** (land, cattle, jewelry etc.)**or take loans to pay for the private hospital charges ?** No

Denial

1. *Doctor not present*
2. *Nurse did not examine properly even though patients was in labour pain*
3. *Patients has to seek private service*
4. *Purchase medicines*

Consequences

1. *Delivery in Riskshaw*
2. *Had to spend for private service.*

XI) *Name* Mahefujabanu Mustaqali Syed

Age 30

Address Akbarpur, Khambhat, Dist: Anand, Gujarat

Problem:

I was born at Jaipur. My father was an industrial worker. I studied up to 10th standard. When my marriage was proposed with Mustaqali. I refused because he was from

Khambhat. Through TV, I knew the problem of Silicosis in Khambhat. But, I was compelled to marry him. We married in 1987. After our marriage, my husband settled in Jaipur. But, on 20th day of the marriage he fell ill. He vomited blood. We started his treatment. For few days, he would feel better and again he would be down. After 3 years, we left Jaipur and settled in Khambhat. Here he started grinding Agate stones. He used to do the work before our marriage. His condition deteriorated day by day and he died in 1997.I would take him to Jaipur whenever he is ill. I took him several time. But no one could save him. I do not why. He was only 31 years old when he died. He left behind him our four children, namely, Shabiabanu (13), Shayarabanu (11), M.Taoufiqali(10) and Samiulhaq (7)

I passed through very bad period. I had four children to feed. I had some problems in claiming benefits offered by Government to the widows. But, that helped me a lot. A social organization helped me by giving machine for making holes in Agate stones. I earn my living by this work.

No one could save my husband from dieing. They say there is no treatment. So many young people die here each year leaving behind widows like me. No employer gives any compensation. Even Government does not give any compensation. When Government cannot protect life of young people, should it not accept some responsibility to pay compensation so that we can lead respectable life? Widows have to send their children to work instead of school for want of money. When ever there is train or plane accident Government pay compensation. Government also pays compensation to the riot victims. When ever people die of taking illicit liquor, Government pay compensation to the families of victims. It should be noted that liquor is banned in Gujarat.

Health department has not succeeded in preventing the deaths caused by Siiicosis. As a result large numbers of people like us have to lead miserable life. I want Government and Health department to do some thing urgently and save agate workers.

Denial

(1) No preventive care at all. (inspection, safety measure and education)
(2) No counseling and guidance to patients suffering from occupational problem.

XII) *Name* Mahesh Karsanbhai Makawana

Address At & Post: Shakarpur, Tal: Khambhat, Dist: Anand, Gujarat

Age: 34

Problem Lack of quality health care, lack of health education

My father, Karsanbhai was earning his living by engaging himself in agriculture labor and other petty labor jobs. Income was not regular and enough for him to meet both ends. So my Mother started grinding Agate stones. She inhaled Silica dust at work and as a result got Silicosis and /or TB. She died after remaining in bed for about one year in 1979. I was 6 years old and my younger brother Arvind was 5 years old when she died.

Our grand mother then brought us up. My Mama (Mother's Brother) was unmarried. When my mother died, he came to stay with us so that he can be of some help to my father. He was working as grinder of Agate stones. He was earning well. Hence, my Father dared to continue our schooling.

I failed in 9^{h} standard, so I left school in 85-86. I had begun working on precious stone, but later I switched to Agate grinding. Mama fell ill in the same year. His income stopped. He had helped us grow up. Now, he needed our help. My father spent all his savings in giving treatment to Mama. He had to even sell some ornaments. I started helping my father in land cultivation. Mama was cured and he restarted his work. He became ill once again. We had run out of our savings. We needed money for his treatment. So, I took Rs.4,000/- as advance from Kishan Sheth, where my Mama was employed. In lieu, I started working for Kishan Sheth.

The work place was a closed room where numbers of workers were grinding Agate stones. The place used to be laden heavily with silica dust known as *'pil'* in local language. Amount of dust used to be so high that we would be covered completely with dust by the end of the day. Our clothes, hair, nose would be full of dust. I worked there for 5 years .Then I went to another employer and then to third. In all I worked for 9 years. Then I thought of doing something of my own. My father helped me by lendingRs.3400/- to set up the unit.

I must mention here that two of my colleagues Sri.Prakash Parmar and Sri Ashok Naran died at very young age of Silicosis. Both were unmarried. Prakash died at the age of 32 and Ashok at the age of 35.

I bought machine and set up unit in front of my house. I was able to earn little more now. My brother also could not continue his school. Soon, he was in the company of bad boys He started drinking. He used to work as agate grinder. He would not save anything. He would be under debt perpetually. I had to work hard to pay back his debts. Had I not lost my mother at early age, my story would have been different.

As other youngsters engaged in agate grinding in my village, I could not marry. No one is ready to give us their girl as they know that our life is fragile. When I am sick, I was always think that, had I been married, my wife would have taken my care. Today I feel lonely. In my home, now, we are all males. I have to prepare food

for me and my father. My brother is a vagabond. Some times we do not see his face for six months.

In February 2003, I became ill I had pain in chest, cough, sputum and breathlessness. I went to TB Cetre- *Mill Dawakhana*, as popularly known- where they do not have facility for X-ray. They ask to get the x-ray done. I went to private hospital for the X-ray. They diagnosed TB In October. Udel primary Health centre put me on anti-TB drugs. In June 2004, they stopped medicines and noted on my papers `cured`!. They never diagnosed me to be suffering from Silicosis. The Doctor did ask me my occupation, which I told. Why they can not diagnosis correctly what I suffer from?

I had to work on grinding wheel even when I was under treatment for TB. Now, I have stopped working on wheels since last 2 months. Even now, I have occasional chest pain. My father works and fills my belly. I feel ashamed.

I visited TB Centre at Khambhat on 9th July accompanied by Prakash Parmar of PTRC and requested Dr.David, In charge of the Centre, to issue me a certificate regarding my correct diagnosis, particularly, Silicosis. He refused, saying they do not have X-ray facility and even if there is X-ray their job is to only diagnose TB and not Silicosis. He further clarified that he is `empowered to make such diagnoses. He also informed us that for X-ray we refer to CHC. Then, I went to CHC, popularly known as Kennedy Hospital, where we met Dr Shastri, In charge, and requested to issue me a certificate saying I suffer from Silicosis. He, too, refused saying, he can not analyse the X-ray and hence he can not diagnose `Silicosis`. He also offered us to refer me to Civil Hospital Ahmedabad for diagnosis of Silicosis. Though this area is well known for the cases of Silicosis in mass, not a single Government medical officer has made diagnosis to this effect !

Government health department has not given us any education about how this can be prevented nor do they give any advice for healthy living and healthy work.

I am not alone. In my village, people have been dieing of this disease since last so many years. I lost my mother too in this disease. I do not understand why no one can stop these deaths. There are so many orphans and single parent children.

Mahesh Makawana
Shakarpur

10/07/2004

Denial

(3) No preventive care at all. (inspection, safety measure and education)
(4) No counseling and guidance to patients suffering from occupational problem.

XIII) Smita Sonawane (Vadodara)

Smita Dagdubhai Sonawane is 22 years old F.Y.B.A. student and also a Non-Formal Education teacher is residing in Shankarnagar basti which is located in Pratapganj, Vadodara. Her family includes her father who is handicapped, mother who is a housewife, brother who is married and her sister-in-law.

Whenever anyone from the basti is not feeling well, they have to visit the dispensary located in Fatehgunj area which is quite close to their basti. Smita also takes health services from the same dispensary. Once when she had cough and cold, she went for a checkup. Dr. Jayesh Prajapati made her lie down on the examining table and examined her throat, chest and stomach and pelvic region. Smita was puzzled as to why this thorough examination for minor ailment like cough and cold, but she did not comment.

Again, after some days, she approached the doctor for obtaining a health certificate for nursing course. She was accompanied by her mother but she was made to sit outside the room. Again the doctor made her lie on the examination table and examined her thoroughly. He then told her that he would now have to check her internally. She was scared and she lied that she was having her menses and escaped the situation because she felt his touch was not one, a professional not required.

The other women and people from Smita's area and the nearby bastis, go to the same dispensary for treatment. The women have similar experience with the doctor. They go to the dispensary because the medicines that he gives are effective. They are also scared to voice their feelings so this matter is only discussed among women when they sit chatting in groups.

Denial

1. Insulting, threatening & obnoxious behaviour on part of doctor towards women participants.

Consequence

1. Women patients cannot use public healthcare service & are faced to use private services, which cost heavily.

XIV) Pratibha Prakashbai Ghare

Age – 30 years. Residence: Shankarnagar, Pratapganj, Vadodara
Interviewed on : 22.6.04

Pratibha had complaints of cold and cough and went to the Fatehganj Municipal Dispensary on 9.6.04. The doctor there, Dr. Jayesh Prajapati, made her lie down and felt her feet, legs, abdomen, chest etc. on the pretense of examining her. The patient, Pratibha felt unwarranted.

At the time of the interview, she and many other women in the basti complained that this doctor behaves like this with all women and therefore they hesitate to go for treatment to this Municipal Dispensary.

This kind of indecent behaviour of a male doctor with female patients, in our opinion constitutes sexual harassment and can be understood as a denial to health care.

Denial

1. Insulting, threatening & obnoxious behaviour on part of doctor towards women participants.

Consequence

2. Women patients cannot use public healthcare service & are faced to use private services, which cost heavily.

JUSTICE FOR ALL- SAFIYA'S POST MORTEM

I met Safiya in a hospital. She lay in a corner, adjacent to the toilet. The stench was unbearable. She was in no condition to talk. She tried but her mouth wide open, was filled with blisters. She was on I.V drips unable to eat or drink anything because her intestines had been ruptured. Suddenly somebody removed the sheet covering her body. Her intestines were exposed, raw and infected. I felt faint. It took an effort to draw closer. As I stroked her head I saw the pus oozing from the wounds. There was no skin. I felt helpless--frozen. Her daughters and family were all beside her. They told her story. I had no words then but I write for Safiya now.

Safiya lived in Jhalod, a town in Dahod district of Gujarat, seven hours drive from Ahmedabad. Hindus and Muslims - the majority of them landless agricultural labourers - had been living together for years sharing their poverty and small joys. Living under the same yoke of want had blurred any differences of religion. Occasionally there had been minor clashes between the two communities but none too serious. They went to the fields together, celebrated each others' festivals respectfully and pulled along as best they could. March 1st, the day after the Godhra carnage changed all this forever.

Safiya's brother Mohammadbhai tells the story. Returning home from his daily namaaz in the afternoon he saw a well armed mob of about 500 people, in khaki shorts with saffron headbands attacking his modest home. On second thoughts, it was not a mob. Their faces were familiar. They all had names. Most of them were his neighbours. The door was being broken in. They entered his house – his sole possession after a long and struggling life. As most of the mob left after looting and burning, a few remained behind to perform more devious crimes. His mother, Bibiben, 80 years and too old to move, was beaten on the chest, kicked in the abdomen and then hacked to death. His wife Khatoon was also stabbed in the abdomen. She collapsed. They left her for dead. His eleven-year-old niece was also stabbed in the abdomen and upper arm. By some luck she was spared from further injury. A few men grabbed his widowed sister Safiya who had come home for Eid and beat her till she could no longer stand. Then raped her, stabbed her repeatedly in the abdomen and pelvis, and for good measure beat her with metal pipes till her abdomen tore open and her intestines spilled out. They left her for dead and moved on for more. Three long hours passed. Mohammadbhai hid near the masjid, frozen, his senses not responding to anything that he saw. He watched it all. Even today he asks himself why he did nothing as a son of 45, a husband, a brother and an uncle to protect his family?

The police arrived. By then every one had left save Mohammadbhai, and a disturbing calm had settled down on his mohalla. He was taken away to another locality where he would be safe. But by some twisted official logic, the injured women were left behind. Hours later some villagers gathered courage to take Safiya and her mother to hospital. Her mother was declared dead on arrival but Safiya was operated upon. Later the police came to record her statement. She could barely speak but she told her story. The FIR records "minor injuries".

Complications developed from Safiya's first operation and she was shifted to Baroda Civil Hospital and operated upon for a second time. Still there was no improvement. After a month Safiya was shifted to Dahod Anjuman Hospital, where I met her at the end of April 2002. How she had survived for 2 months amazed me. I knew that if she lay in that hospital she would never make it. I had to shift her to Ahmedabad. But it was not an easy task. We were up against a system, which was proud of its deliberate and prolonged incompetence. Hindu owned private hospitals refused to accept her. Others demanded impossible sums of money. A Muslim owned private hospital was the last resort. The seven-hour journey from Dahod to Ahmedabad was a gamble. There were chances of complications arising on the way. The ride was a nightmare. The two doctors, her daughters and I sat in silence as we all prayed that nothing would go wrong.

Safiya was operated on for a third time the same day. For the first time in two months she thought she was going to live. When I was leaving she joined her hands. I thought she said 'thank you' and 'come again.' I promised I would. She died a week later on the 6th of May.

But Safiya's story does not end with her life. The private hospital could not do a post mortem, so Safiya had to return to Dahod. That meant another seven-hour journey, this time with a rotting dead body. At Dahod District hospital the authorities refused to do the post mortem. The body had come from a private hospital in Ahmedabad; the history of the case was not clear; and there were no supporting papers – some reasons for refusing to do a post-mortem. No amount of pleading could change their minds. No amount of questioning or pleading could change their minds or give the family any reason. Authority needs never to explain anything. So poor dead Safiya was taken to Jhalod hospital another hour's journey away and finally after six more hours of haggling the doctors agreed to do the post mortem. The final report, which came two weeks later, said it all. Death was due to '*Renal Failure and Septicemia*'.

The FIR with its record of 'minor injuries' and the cruel end-joke of 'death due to renal failure and septicemia' in the post-mortem made certain that there will be no official record of the savagery that Safiya suffered; no recognition of the pain of those first hours; no punishment for her rapists

and tormentors; no compensation for her family for all the neglect and agony of her months in hospitals and of course no investigation into her death.

Satiya was an Indian woman. She was raped, stabbed and beaten until she died of it. It took a long time to accomplish all this. In life the State could not protect her. But did it have to cheat her with so much deliberate and premeditated care in death?

(Word count 1093)

Denial

(1) Inadequate attention at all levels
(2) Torture due to behaviour of medical staff
(3) Post mortem was denied at various hospitals

Consequences

(1) Death
(2) Harassment and torture to patient and her relatives
(3) Long term – mental stress to relatives

"Building a people's movement in mental health: creating mental health friendly prison.

Definitions of mental health:

" Health is not merely the absence of disease or infirmity but rather. a state of complete physical. mental and social well-being". (WHO constitution)

"Mental health is the capacity of the individual the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice the attainment and preservation of condition s of judgmental equality".

(WHO report. 1981)

Mentally health & Law

The life of the mentally ill is totally governed by the existing law i.e. the Indian Mental Health Act 1987 which is repealed by the Old Lunacy Act 1912. The legislation's frameworks have primarily actuated to protect society from the dysfunctional and dangerous manifestations of mental illness, instead of protecting the status of the person with mental illness.

Limitations:

1. It is a custodial Act.
2. Mentally ill persons cannot stand trial. (Incapacity to stand trial due to unsoundness of mind.)
3. Discharge procedure is cumbersome.
4. The Act does not cover all aspects of Human Rights.
5. The Act does not address rehabilitation for the mentally ill.

When police perceives somebody as a "mental", they donot even file an FIR or complaint. If the person is having a crime record, it automatically cancels the patient's right to voluntary treatment. Mentally ill person shunting between different institutions e.g. police custody to jail to mental hospital to beggars home is common. For "Shankar", he was transferred between jails twice without knowing why. He was forcibly taken for psychiatric treatment at a hospital, before being finally transferred to the state mental hospital. Force is used in the admission of patients, unlike other hospital: Physical restrain and shackling was used to commit persons to the mental hospital. All commitments to the hospital were involuntary.

Case studies document the humiliation of forced treatment (*they had no right to bring me to a mental hospital*).

Human Right section:

Present Mental Health Act covers only one chapter on 'protection of human rights of mentally ill person'. Further it addresses specifically on indignity and cruelty:

Section 81 (IMHA 1987) states:

No mentally ill persons shall be subjected during treatment to any indignity (whether physical or mental) or cruelty.

Indignity & Cruelty in the form of:

1. E.C.T. (Electro convulsive therapy) 2. Solitary confinement
3. Involuntary treatment. (*"They dragged me inside by my hair. Then they took away my clothes").*

Treatment and Care:

1. The main forms of treatments are medication and shock treatment. Shock treatment without anesthesia ("Receiving shock was the most painful of all"; "Shock has helped me to remember my past") has been reported, with varying views on the impact of the treatment. Headaches and memory loss are regularly reported after shock treatment. Shock treatment is used to calm agitated patients, and regularly as an entry procedure into the hospital, without any regard for consent procedure. This goes against all International human rights standards.
2. Solitary confinement is used in "therapy" context (for calming the patient).
   Measures are used by force by parents, husband or relatives, police threat and use of sedative. "Neeta", a long stay patient, became violent after being institutionalized. In her frustration to go back home, she attacked and killed a fellow inmate in the mental hospital.
3. Some practices followed in mental hospital such as "shaving off the head", Women are not given sanitary pads or underclothes. (*"They dragged me inside by my hair. Then they took away my clothes. They gave me these to wear".)*

Advocacy issues:

1. Legal Aid:
2. Need for facilities in Pune city or in Maharashtra
   - i) Half way home
   - ii) Day care facilities and night care shelters.
   - iii) Programme for wandering mentally ill patient.
3. Co-ordination between different inter-department levels e.g. Health = Disability = State mental Health Authority
4. Specific modification in Beggary act
5. Community sensitization and working with families and carers
6. Prevention and promotion of mental health in all institutions and training for officials. .

Bapu stand:

- Rationalizing procedures (involuntary commitment, transfer, escort, admission, discharge)
- Involving local authorities
- Role of NGO, working together

Conditions of the hospital- A view from below

"If there is hell on earth, then it is at this place. But I do not abuse anyone. I just have to put up with whatever situations are there. I do not like anyone here; neither do I like the living conditions here.

"The bed linen is distributed to everyone everyday on a rotational basis. So one always has dirty linen that other people have soiled. It is never cleaned. The food is also very bad. It is half cooked. I can hardly eat my food here. I give it to others. Our clothes too are hardly changed. It is so dirty that we have body lice and eczema.

"All of us have to bathe together at the taps, naked. We are not given underclothes. We have to wipe our bodies with our clothes and wear the same wet clothes.

"It is sheer hell to live over here. It is better to die. If one protests about anything, then one is shut into the solitary cells. Those cells have no toilets. One has to urinate and defecate there itself, as well as eat and sleep over there. It is the utmost form of torture. We are forced to obey all the attendant's orders. It is very unhygienic. We are humiliated and tortured. if we refuse to do work that is degrading."

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BPL survey 2002

Some Learning from the Field

After the end of the BPL Survey 2002, delayed in Rajasthan till 2003 due to famine conditions in 2002-2003, some of our worst fears about the unsuitability of the design and administration of the survey have come true. Some of the major findings are narrated below. The findings are drawn from our analysis of the Primary Score Sheets for the Sheokar Gram Panchayat of Barmer District. Before narrating our findings it is appropriate that we state the limitations of the method used by us.

Limitations

We have used the score sheets provided by the Government to the Gram Sabha for verification. Hence the Government did provide scope for correction. However, there are a few reasons why we consider that the Gram Sabha process initiated by the Government would not have been able to make the necessary changes.

1. Detailed score sheets were not displayed before the Gram Sabha. Only total points were provided against the names of the households. This would not allow villagers to find out the specific parameters under which the information depicted in the Score Sheets is untrue.
2. Gram Sabha proceedings do not last more than five-six hours. However, a detailed discussion on the Score sheets would need much more time as scores for more than 1000 households would need to be discussed with each household being evaluated against 13 different parameters. Even at the level of Ward Sabha there would be about 70 Households, and a thorough discussion is likely to take more than two days.
3. The Gram Sabha would be allowed to make corrections in case the Score Sheet has been filled incorrectly. Hence, it would not be able to improve the selection process where the errors in selection emanate from the faulty design of the Questionnaire itself.
4. A highly erroneous score sheet would discourage the village level processes.

Findings

The BPL identification process is based on the setting of a cut off point. The cut off point would be set so as to ensure that the percentage of households selected under the BPL category roughly approximate to the Target provided by the central government to the state government. The figure provided by the center to the state of Rajasthan is 13.7% of the population. If we use the same cutoff method at the Panchayat level, the sample Panchayat would have a cut-off of 13 points. That is, all households getting 13 points or less would be selected as BPL, while those obtaining 14 points or more would be left out of the list. This would imply that about 14.7% of the households in the Panchayat would be designated as BPL households. The following table provides data regarding the caste wise details of the BPL selection.

Table 1: If cut-off is 13 Points, implying coverage of 14.3% of the Households

Category	Total Families belonging to Category	Number of Families that would be selected as BPL	% Selected as BPL	Number of BPL families from category as % of total number of BPL Families
SC	135	11	8%	6%
ST	30	8	27%	5%
OBC	1019	154	15%	89%
Others	30	0	0%	0%
Total	1214	173	14%	100%

Table 2: If cut-off is increased to 14 implying coverage of 18.7% of the Households

Category	Total Families belonging to Category	Number of Families that would be selected as BPL	% Selected as BPL	Number of BPL families from category as % of total number of BPL Families
SC	135	16	12%	7%
ST	30	13	43%	6%
OBC	1019	201	20%	87%
Others	30	0	0%	0%
Total	1214	230	19%	100%

In comparison, the actual figures from the BPL selection process carried out in 1997, gives us the following figure. These figures have been used for targeting various Government welfare schemes from the year 1998 to date. The selection process in 1997 was carried out using a different questionnaire and used exclusion criteria that could eliminate the better off households from the survey in the very beginning of the process. However, the survey of 1997 itself was biased against the SC & ST households.

Table 3: **In comparison, the selection of BPL families in the 1997 BPL census gives us the following figure.**

Category	Number of Families selected as BPL	Number of BPL families from category as % of total number of BPL Families	Change in number and % of BPL households from 1997 Census to 2002 Census. **Cut-off = 13**		Change in number and % of BPL households from 1997 Census to 2002 Census. **Cut-off = 14**	
			Number	%	Number	%
SC	44	19%	-33	-75%	-28	-64%
ST	8	4%	0	0%	5	63%
OBC	174	77%	-20	-11%	27	16%
Others	0	0%				
Total	226	100%	-53	-23%	4	2%

From the above tables we can infer that:

1. A greater proportion of households belonging to the OBC category are likely to be selected while a much lower proportion of SC households are likely to be selected. At a cut-off of 13 points about 15% of OBC households would be selected while only 8% of the SC households will be selected. At a cut-off level of 14 points, about 20% of OBC households would be selected while only about 12% of the SC households would be selected.
2. As compared to the last BPL census, the proportion of OBC BPL families to total BPL families will go up. The proportion of OBC Households among the total BPL households was 77% in the 1997 census. In the 2002 census, it is likely to be 89% at a cut-off level of 13 points and 87% at a cut-off level of 14 points.
3. As compared to the last BPL census, the proportion of SC families to total BPL families would come down. The proportion of SC Households among the total BPL households was 19% in the 1997 census. In the 2002 census, it is likely to be 6% at a cut-off level of 13 points and 7% at a cut-off level of 14 points.
4. In terms of absolute figures, the number of OBC BPL households was 174 in the 1997 census. This figure would decrease by 20 (11%) if the cut-off level is set at 13. The figure would increase by 27 (16%) if the cut-off level is set at 14.
5. In terms of absolute figures, the number of SC BPL households was 44 in the 1997 census. This figure would decrease by 33 (75%) if the cut-off level is set at 13. The figure would decrease by 28 (64%) if the cut-off level is set at 14.

In the sample Panchayat, thus, the current survey is likely to favor OBC households at the cost of SC households. This in spite of the common knowledge – as well as the belief of the villagers – the proportion of the poor is far greater among the SC communities than the OBC communities.

Apart from the households covered under the survey report, there are some households that have been left out from the survey report. In the sample Panchayat all such households as have been left out from the BPL Survey Report of the Government, belong to the Scheduled Caste Communities. The following is a list of left out Families from the village 'Devanioyn ki Dhani' of the sample Panchayat. All these families belong to the SC community.

1. Channaram s/o Hemaram
2. Bhagwanaram s/o Naggarama
3. Rekharam s/o Bhagwanaram
4. Bhuraram s/o Nimbaram
5. Paparam s/o Nimbaram
6. Hemi w/o Chatraram
7. Phuli w/o Pokraram
8. Herajram s/o Amrarram

Comparison between Score as collected by the Government Enumerator and score as enumerated through participation of respondents.

Sl	Name	Govt. Survey		People's Assessment		People's Score as % of Govt. Score
		Score	Rank	Score	Rank	
1	Ajtaram S/o Keshraram Bhil (Dhanne Ka Tala)	19	10	8	9	42%
2	**Chandanaram Malanaram Bhil (Dhanne Ka Tala)**	**23**	**14**	**7**	**7**	**30%**
3	Derajram S/o Gumanaram Garg (Shivker)	17	8	9	10	53%
4	Doongraram S/o Neenuram Meghwal (shivker)	17	9	9	13	53%
5	**Herajram S.o Durgaram Garg (Shivker)**	**25**	**15**	**9**	**11**	**36%**
6	Kanaram / S/o Udaram Meghwal (shivker)	20	11	9	12	45%
7	**Kishnaram, s/o Haruram, Garg, Shivker**	**17**	**7**	**7**	**4**	**41%**
8	Ms. Jhamku, W/o Genaram, Shivker	15	5	8	8	53%
9	**Patta Ram, s/o Moolaram, Garg, Shivker**	**23**	**13**	**7**	**3**	**30%**
10	Prabhuram s/o Junjaram Bhil, Dhanne Ka tala	14	3	7	5	50%
11	Sankararam S/o Ghamuram Bhil (Dhanne Ka Tala)	8	1	4	1	50%
12	Sardara Ram s/o Gumanaram, Garg, Shivker	12	2	7	2	58%
13	**Sejuram S/o Pabudaan Bhil (Dhanne Ka Tala)**	**21**	**12**	**7**	**6**	**33%**
14	***Shanti w/o Lt Tillaram Rana Rajpoot(Shivker)***	***16***	***6***	***10***	***15***	***63%***
15	***Veeraram S/o Jalalram Bhil (Dhanne Ka Tala)***	***14***	***4***	***10***	***14***	***71%***

The households shown in **bold** letters are those who are likely to lose BPL status due to error in Government survey. The households who are likely to get and advantage in getting BPL status over households that are poorer than them are shown in ***bold italics***.

Errors in the Questionnaire Design brought out during the BPL Survey 2002

1. Under the first point on Land, land ownership information should depict actual ownership. This has not been the case. There have been the following errors:
    a. In case of poor and less influential households staying and farming separately, but with land papers being in the name of a common ancestor, the total land figure has been used for each of the brothers. This has not been done for the influential families.
    b. Even when poor families have mortgaged their land for loans from moneylenders, the land is shown against their name and increases their points, thus, reducing their chances of getting selected as BPL.
    c. Poor people have poor quality land, but the quality of land has not been considered in the survey.
2. Under the heading of house, poorest people who have obtained support under Indira Awaas Yojana have been given higher points which reduces their chances of getting BPL status.
3. The question on clothing has led to large-scale misjudgment and nepotism. As such the question is difficult to administer.
4. Misjudgment and nepotism is rampant also in the case of the question on Food Security. The question, as administered, does not address the issue of amount of food available and only deals with the number of times a family eats in a day.
5. The question on Sanitation has had a few misjudgments.
6. No Comments
7. Question on qualification of highest educated person in family gives higher points for educational qualification irrespective of whether the higher qualification is enabling them to earn a higher income.
8. There has been large-scale misjudgment on this. Families sending children to school are penalized while families sending children for work are rewarded. This can have adverse impact on the abolition of child labor and enrolment in schools.
9. Families who have been given 4 points as falling under the 'Other' category are not necessarily better off than families falling under the 'Salary' category. In some cases families with large landholdings have been depicted as surviving on Wage Labor, while families, which have no land, have been depicted as being dependent on subsistence cultivation.
10. The scoring pattern under the Status of children is incomplete. Thus families not having children have been given a score of 4. In fact this question can be answered only for families with children in

school-going age and hence can not be used as a scoring point. Further, families sending their children to school are penalized while families not sending their children to school are rewarded.

11. Large scale misjudgment & nepotism has happened under this head with poorest families being categorized as having no debts and being resource rich, while richer families have been shown as being dependent on informal credit for daily needs.
12. The question on migration can be applicable to only such families, as have members able to migrate. This discriminates especially against women headed households and households with old people alone or with young children.
13. This question too has been the source of serious misjudgment & nepotism. Influential people knowing that asking for TPDS and wage employment would give them lower scores, have asked for the same. On the other hand poor people have often been persuaded to ask for housing so that they get higher scores. In fact, seen in conjunction with the question on housing (Q2) this is a self-defeating question. A family having a Pucca house and asking for TPDS and Wage Employment would get 3 points on the two questions together. On the other hand a family having a Kutcha house and asking for housing support would get 4 points on the two questions put together.

Annexure I

Case Studies

There have been severe malpractices in the BPL survey. Some of the better off households have received much lower -scores implying greater poverty leading to greater probability of their being selected in the BPL list- then the really poor families. Some of the cases of such households have been compared below:

Case: 1

Jugtaram s/o Bijaram , OBC, serial 34 Panchayat Shivkar has enough food throughout the year and has at least one hectare of land. He has received 13 points meaning that he will be included in the BPL list on the other hand Thanaram s/o Chutraram serial 192 in the same panchayat has less then one hectare of land and he also does not get one square meal a day(*as indicated in the government survey list*) but his score is much above Jugtaram i.e. 20. This is because one of the family member in Thanaram's family has studied up to class 10th. And also because his children are studying in schools and not working. This has increased his score tally by 4 points. He has got 4 points as he is not indebted and owns assets. Whereas a previous question of the same survey clearly states that he doesn't own any assets(0 score in question no 6). Also, the villagers in his panchayat informed that he doses takes debts for daily consumption purposes. This clearly reflects a case of misjudgment on part of the government surveyor.

Case II

Ruparam, Serial Number 78, Village Dhanne Ka Tala, Village Panchayat Shivkar has at least one hectare of land and has two meals a day almost throughout the year has got 11 points. On the other hand Kaluram Serial no 98 of village Shivkar has received 23 points because of following factors. The government survey says that the average availability of normal wear clothing (per person) is 10 or more sets of cloth. This has fetched him 4 points. Whereas Ruparam has received no score for this question meaning average availability is less than two. KAluram has also received one point more than Ruparam as one of the family members in his family has studied up to class 5. The government list has given him a full score of 4 points saying that he has enough food throughout the year. Whereas he himself and his neighbors informed that normally he gets one square meal per day, but less than one square meal occasionally. This has increased his score by two points as compared to Ruparam. Under the means of livelihood the government survey gives him a score of 4 but according to him and his villagers he is a casual labor and should have received no score for that. The government survey further gives him 4 points as he isn't an indebted and own asset. On the other hand in a previous question (NO.6) it says that he owns only one assets that in itself in contradictory. And according to his villagers he often takes loans for consumption purposes from non formal sources.

From this it is clear that there has been no cross verification of the survey done and individual bias of the enumerator has played a key role in determining the BPL list.

Annexure II

Name		1	2	3	4	5	6	7	8	9	10	11	12	13	Total
Sardara Ram s/o Gumanaram, Garg, Shivker	GS	1	1	1	4	0	0	1	3	1	0	0	0	0	12
Sardara Ram s/o Gumanaram, Garg, Shivker	PS	1	1	0	0	0	0	1	3	0	0	1	0	0	7
Patta Ram, s/o Moolaram, Garg, Shivker	GS	2	3	1	4	0	0	1	3	1	4	3	1	0	23
Patta Ram, s/o Moolaram, Garg, Shivker	PS	1	1	0	0	0	0	1	3	0	1	0	0	0	7
Ms. Jhamku, W/o Genaram, Shivker	GS	1	3	1	3	0	0	1	1	1	4	0	0	0	15
Ms. Jhamku, W/o Genaram, Shivker	PS	2	1	0	0	0	0	0	2	0	0	0	3	0	8
Kishnaram, s/o Haruram, Garg, Shivker	GS	1	2	1	3	0	0	1	3	1	4	0	1	0	17
Kishnaram, s/o Haruram, Garg, Shivker	PS	0	1	0	0	0	0	1	3	0	1	1	0	0	7
Herajram s/o Amraram, Dewaniyon Ki Dhani	GS														
Herajram s/o Amraram, Dewaniyon Ki Dhani	PS	1	1	0	0	0	0	1	1	0	1	0	3	0	8
Hemi w/o Lt. Chutraram Meghwal, DKD	GS														
Hemi w/o Lt. Chutraram Meghwal, DKD	PS	1	1	0	0	0	0	1	1	1	1	0	3	0	9
Prabhuram s/o Junjaram Bhil, Dhanne Ka tala	GS	3	1	0	2	0	0	0	3	1	0	1	3	0	14
Prabhuram s/o Junjaram Bhil, Dhanne Ka tala	PS	3	1	0	0	0	0	0	3	0	0	0	0	0	7
Sejuram S/o Pabudaan Bhil (Dhanne Ka Tala)	GS	4	0	1	3	0	0	0	3	1	0	4	2	3	21
Sejuram S/o Pabudaan Bhil (Dhanne Ka Tala)	PS	4	0	0	0	0	0	0	3	0	0	0	0	0	7
Ajbaram S/o Keshraram Bhil (Dhanne Ka Tala)	GS	2	1	1	3	0	0	1	3	1	1	0	3	3	19
Ajbaram S/o Keshraram Bhil (Dhanne Ka Tala)	PS	2	1	0	0	0	0	1	3	0	1	0	0	0	8
Chandanaram Malanaram Bhil (Dhanne Ka Tala)	GS	2	1	2	3	0	0	1	3	1	0	4	3	3	23
Chandanaram Malanaram Bhil (Dhanne Ka Tala)	PS	1	1	0	1	0	0	1	3	0	0	0	0	0	7
Veeraram S/o Jalalram Bhil (Dhanne Ka Tala)	GS	3	2	0	2	0	0	1	3	1	1	0	1	0	14
Veeraram S/o Jalalram Bhil (Dhanne Ka Tala)	PS	3	1	0	0	0	0	1	3	0	1	1	0	0	10
Sankararam S/o Ghamuram Bhil (Dhanne Ka Tala)	GS	3	1	0	0	0	0	0	2	1	0	1	0	0	8
Sankararam S/o Ghamuram Bhil (Dhanne Ka Tala)	PS	1	0	0	0	0	0	0	3	0	0	0	0	0	4
Derajram S/o Gumanaram Garg (Shivker)	GS	1	2	1	4	0	0	1	3	1	4	0	0	0	17
Derajram S/o Gumanaram Garg (Shivker)	PS	1	1	0	0	0	0	1	2	0	1	0	3	0	9
Herajram S.o Durgaram Garg (Shivker)	GS	2	3	1	4	0	0	1	3	1	4	3	1	2	25
Herajram S.o Durgaram Garg (Shivker)	PS	1	1	0	0	0	0	1	3	1	1	1	0	0	9
shanti w/o Lt Tillaram Rana Rajpoot(Shivker)	GS	0	1	1	3	0	0	1	2	1	4	0	3	0	16
shanti w/o Lt Tillaram Rana Rajpoot(Shivker)	PS	2	1	0	2	0	0	0	2	0	0	0	3	0	10
Kanaram / S/o Udaram Meghwal (shivker)	GS	2	2	1	3	0	0	1	3	1	4	2	1	0	20
Kanaram / S/o Udaram Meghwal (shivker)	PS	3	2	0	3	0	0	0	1	0	0	0	0	0	9
Doongraram S/o Neenuram Meghwal (shivker)	GS	2	1	1	3	0	0	1	3	1	4	0	1	0	17
Doongraram S/o Neenuram Meghwal (shivker)	PS	4	1	0	1	0	0	1	0	2	0	0	0	0	9

Explanation of Headings

GS: Govt. Survey, PS: People's Survey	
1	Size group of operational holding of land
2	Type of house
3	Average Availability of normal wear clothing (per person in pieces)
4	Food Security
5	Sanitation
6	Ownership of consumer durables

7	Literacy status of the highest literate adult
8	Status of the Household Labor Force
9	Means of livelihood
10	Status of children (5-14 years) [any child]
11	Type of indebtedness
12	Reason for migration from household
13	Preference of Assistance

CONVENTION ON RIGHT TO FOOD AND WORK

Bhopal, 11-13 June 2004

WORKSHOP ON PUBLIC DISTRIBUTION SYSTEM (PDS)

BACKGROUND NOTE

Kiran Moghe

The Beginning: The Public Distribution System (PDS) was set up in India originally as a rationing system to cope with the food shortages during the Second World War period. From 1965, it was expanded into a universal system for delivering cheap foodgrain such as wheat and rice and certain other essential commodities such as sugar, edible oil and kerosene. While the major objective of the PDS has been to act as a welfare measure to provide these goods at prices that are relatively lower than the market, it has also acted as a countervailing force to prevent speculation in prices by profit-oriented private traders. Since the PDS constitutes a major outlet for the sale of grain procured by the procurement agencies, it is an important link in the support system provided to farmers by the government. Over the years, the buffer stocks maintained by the PDS have served to ensure price stability and self-sufficiency in food even in years of severe drought, and thereby helped to maintain the economic sovereignty of the country.

Interstate Variations in Implementation: However, the implementation of the PDS has been uneven across the country. There have been large interstate variations, with the four southern states accounting for almost half (49%) of the total offtake of wheat and rice, while the largely populated states of Bihar, Uttar Pradesh, Madhya Pradesh and Rajasthan accounted for only 10%. In terms of average per capita quantities, Kerela's offtake was 53.3 kgs: in Bihar it was only 2.3 kgs per person. Most importantly, there have been differences in the coverage and utilization of the PDS by the public. For e.g., studies show that the PDS served hardly 2% of the rural and 7% of the urban population in UP and Bihar, whereas it served 87% of both the rural and the urban population in Kerela. In terms of serving the poor, NSS consumption data indicates that poor families met between 8 to 20% of their needs from the PDS, being dependent on the open market for the rest of their requirements. In general, studies indicate that the access of the poor to the PDS by and large depended on the extent of coverage in the state. Hence the poor in states with low coverage (such as Bihar and UP, MP, etc.) lost out in comparison to states such as Andhra Pradesh and Kerela. In fact the Kerela example proves that truly universal coverage, which consisted of a massive expansion of fair price shops and the adequate and continuous availability of good quality grain at prices lower than the market, allowed the PDS to make a significant contribution to the purchases of poor families and also enhance their nutritional status. On the other hand, large scale diversion of foodgrain, wastage, poor quality, coupled with mismanagement and lack of sensitivity of the bureaucracy to meet the needs of the people in other states resulted in the failure of the PDS to meet its avowed objective of enhancing the welfare of the poor.

NSS data indicates that average calorie intake in both rural and urban areas declined steadily in the twenty-year period between 1972 and 1993, and that on an average, 44% of total households were calorie deficient by normal nutritional standards. This called for a major restructuring of the PDS to do away with the food insecurity of the majority of the Indian people. Unfortunately, the kind of restructuring that was implemented with the advent of neo-liberal economic policies of structural adjustment since 1991 has furthered worsened the situation.

Impact of Neo-Liberal Policies on the PDS: A key characteristic of these policies has been their strong emphasis on reduction of public expenditure in order to reduce the fiscal deficit. This has taken the form of cutting back on several types of subsidies, particularly the 'food

subsidy'. Although the food subsidy has remained virtually stagnant at around 0.6% of the GDP over the last 20 years, reducing the 'burden' of food subsidy has been a central theme in the policies of so-called economic reform. This has taken three forms; one has been a steep increase in the prices of wheat and rice sold in the fair price shops, the second has been a reduction in the quantum of foodgrain supplied to families through the PDS and finally there has been a major policy shift from universal coverage to targeting the subsidy to selected families that are identified as 'poor' on the basis of certain criteria laid down by the government. Needless to say, such a 'reform' of the PDS has been one of the conditionalities imposed by the World Bank while granting several types of loans to the central and several state governments. The Andhra Pradesh Restructuring Project financed by the World Bank for instance, required the state government to reduce the number of ration card holders eligible for subsidised rice from 72% to 35%.

Increase in Prices of PDS Rice and Wheat: There has been a substantial increase in the issue prices of rice and wheat supplied on the PDS over the last decade and a half, as seen in the following tables.

Changes in Central Issue Prices of Rice and Wheat: Pre-Targeting

Year	Common Rice (Rs/kg)	%Change	Wheat (Rs/kg)	%Change
June 1990	2.89	-	2.34	-
Dec 1991	3.77	30	2.80	20
Jan 1993	4.37	16	3.30	18
Feb 1994	5.37	23	4.02	22

Changes in Central Issue Prices of Rice: Post-Targeting

Year	Common Rice (Rs/kg)		%Change	
	APL	BPL	APL	BPL
June 1997	5.50	3.50	-	
Feb 1999	7.00	3.50	27	-
July 2000	11.35	5.90	62	68
August 2002	7.95	5.65	-30	-04

Changes in Central Issue Prices of Wheat: Post-Targeting

Year	Wheat (Rs/kg)		% Change	
	APL	BPL	APL	BPL
June 1997	4.50	2.50	-	
Feb 1999	6.50	2.50	44	-
July 2000	9.00	4.50	38	80
August 2002	6.10	4.15	-32	-07

The steady increase in prices was done with a view to fix the central issue price as near the 'economic cost' (the procurement and distribution costs) as possible, and bring down the food subsidy bill. It also meant that any increase in procurement prices would automatically be linked to an increase in issue prices. What is worse is that after targeting was introduced, the price increase faced by the 'poor' BPL families was even higher the so-called 'non-poor' APL! As PDS prices approached the level of market prices, there was a corresponding decline in the offtake from the PDS (from 20 million tonnes in 1996 to around 12 million tonnes in 2000). As procurement continued and offtake declined, buffer stocks of wheat and

rice rose to an unprecedented 60 million tonnes in the year 2000, around 5 times the required norm. As a result, the inventory carrying cost of the government went up to around Rs 14000 crores, which is around 44% of the total food subsidy. However per capita availability of foodgrain declined from 505.5 gms per day in 1997 to 458.6 gms in 2000. In short, while grains rotted and rats ran riot in government warehouses, millions of poor people in the country faced growing starvation and malnourishment. In the face of a severe drought, prices were somewhat reduced in 2002, but it was not enough to induce people to buy from the PDS.

Reduction in quantities supplied: The massive increase in prices went hand in hand with a reduction in quantities made available on the PDS. The allocation was changed from a per capita basis to a per family basis. While the original monthly allocation was around 10 kg per person (against an ICMR recommendation of 15 kg), the government brought down the allocation to 20 kg per family (35 kg for BPL households), which is around 4 kg per person in a family of 5. This meant that the poor had to increasingly depend on the open market for meeting their requirements.

Targeting the Subsidy: The increase in prices and reduction in quantities went hand in hand with the principle of 'targeting' the food subsidy; that is moving from universal access to a system where only certain chosen families were entitled to rice and wheat at prices below the market price. Initially targeting was introduced in 1992 for drought prone and backward areas (Revamped PDS), but full-fledged targeting came in with the Targeted PDS (TPDS) in 1997. The Planning Commission unilaterally determined the quota of families termed BPL (Below the Poverty Line) who would be eligible for cheap food. These were in turn to be determined by applying a criterion of annual household income of Rs 11000 per annum as per the IRDP survey of 1996-97. The Planning Commission announced that only 36% of families in the country were BPL and hence eligible for food subsidy, the others would henceforth have to pay the 'economic cost' of rice and wheat.

Since the introduction of the TPDS was initially accompanied by a substantial reduction in prices of rice and wheat for BPL families, it was welcomed by some quarters as a positive measure in favour of the poor. However, it soon became clear that the purpose of targeting was not to increase the welfare of the poor, but to eventually dismantle the entire PDS so that the entire market for foodgrain could eventually be privatised.

The introduction of the Poverty Line criterion was essentially a masterstroke by the Central government to abdicate its responsibility towards the food security of the people. For example the Planning Commission determined that 32.65 lakhs (22.9%) of all households in Andhra Pradesh were BPL, while the state government's own survey indicated 113.02 lakhs (68.67%) as BPL. Similarly for Karnataka, they assessed the level of BPL at 28.75 lakh households (33.16%) whereas the state has determined the number of BPL ration cardholders to be 64.83 lakh households (58.34%). For Kerela, the central government figure was 15.35 lakh (25.43%) and the state's assessment was 20.59 lakhs. In Maharashtra the BPL quota was 65.45 lakhs against a state total of 77 lakhs only for rural areas. States that could not adjust their previously high offtake to the new quotas of the Planning Commission had to find ways of coping with the new situation. Each responded according to their commitment to the people. States such as Kerela and West Bengal had to allocate additional state funds to meet the cost of continuing to subsidise those families henceforth characterised as Above the Poverty Line (APL). States such as Maharashtra, Uttar Pradesh and Andhra Pradesh simply 'adjusted' their poverty lines to accommodate the numbers determined by the Planning Commission, while others such as Delhi simply abdicated their responsibility by declaring that no BPL families existed.

Further, through successive surveys that use criteria such as possession of gas connections, television sets, bicycles, permanent dwellings, etc. the government has successively reduced the number of BPL families. For eg, in Pune district of Maharashtra, the number of BPL beneficiaries identified at the outset of the TPDS was 59,340; it now stands reduced to 34,000. In one zone of Pune city, which incidentally has a large number of slums populated by poor Dalit families, the number of BPL families was reduced from 12000 to 261!

This serves two purposes: one is to further reduce the food subsidy and the second is to artificially deflate poverty figures and create a picture of growing prosperity when the situation is in fact quite the reverse. The government's latest figures indicate an overall poverty ratio of 26%, and the latest IRDP survey (for the 10th Five Year Plan) that has been conducted to determine poverty on the basis of consumption indicators will no doubt be 'adjusted' to this figure. That is precisely why the survey date has not yet been made public.

Since the IRDP survey has been conducted for rural areas there has been a genuine problem of determining the poverty ratio in urban areas. For this purpose, some states have resorted to using families selected for urban employment schemes, but the criteria are different and there have been many difficulties; as a result, large numbers of the urban poor have been excluded, the famous example being that of Dharavi, Mumbai's largest slum where the number of BPL families last counted was 128 (95 BPL and 32 Antyodaya) in a total of 83,855 ration card holders!

Dividing the Poor: Large-scale criticism of the manner in which the poor were being excluded led the government to announce the Antyodaya Anna Yojana for the 'poorest of the poor' in 2001. This meant that from the BPL list, the lowest 10% of families was selected to be eligible for rice and wheat at Rs 2 and Rs 3 per kg respectively. This has led to a further division of the poor. Another scheme, the Annapurna Yojana, was introduced in the year 2000 to provide 10 kgs of foodgrain free to those who have no supporting families and are not beneficiaries of other types of government schemes (eg widow pensions, etc.). It exists virtually on paper because it is impossible to find the kind of destitute beneficiaries required as per the rules of the scheme, who are literally the dispossessed. By creating a hierarchy of beneficiaries within one system, the government has created further scope for corruption. Since the grain is the same but priced differently, it can be easily diverted and sold for a profit.

Most importantly, dividing the poor has disrupted their unity; each person hopes and strives for the BPL card, because it gives much-needed relief, but in the bargain, loses sight of the benefits of the universal system that actually needs to be conserved and strengthened. The larger political implications of targeting should not be underestimated.

Targeted out of the System: The reason touted to justify targeting is to exclude the 'non-poor' from the benefits of the subsidy. However, the experience of the universal PDS shows that the non-poor usually practise self-exclusion, that is they voluntarily do not make use of the system. In that sense, they do not benefit from the subsidy. In contrast, a system of faulty targeting based on erroneous income and consumption poverty indicators ends up excluding the poor who need the subsidy the most. For e.g. a survey done by AIDWA in 2002 of 810 families in a Lucknow slum showed that 355 families (44%) did not possess a ration card, BPL or otherwise. There were only 13 BPL cards, and not a single Antyodaya or Annapoorna beneficiary! In the entire state of Uttaranchal, only 216 families have been identified as Antyodaya beneficiaries! The social costs of excluding the poor in a targeted system are much higher than the administrative costs of including the non-poor in a universal system. Eight years after the Targeted PDS has been in existence, there is growing evidence of increasing food insecurity in terms of hunger, malnourishment and overall poverty. The

qualitatively negative impact on different vulnerable sections within the poor, particularly single women, Dalits, Adivasis, minorities, project-displaced families, migrant workers, etc. has also been raised and documented by different organizations and groups that have been mobilizing people around the right to cheap food.

The present PDS as it stands today is characterised by -

- Frequent and bewildering changes in prices and lack of information in the public about these changes
- Lack of availability of quotas in fair price shops at the appropriate time
- Arbitrary cancellation of BPL cards on the basis of flimsy criteria and subjective opinions of fair price shop owners and ration officials
- Wrongful allotment of BPL and Antyodaya cards to the relatively better off due to local political patronage
- Massive corruption in the issue of BPL cards
- Diversion of BPL and Antyodaya grain to the open market
- Lack of viability of fair price shops leading to further corrupt practices

All these factors have combined to throw needy families out the ambit of the PDS. To many it has become virtually non-existent. Instead of restructuring it towards the poor, this is being used as a rationale by the bureaucracy to justify the dismantling of the system. The food stocks that accumulated two years ago as a result of these wrong policies were eventually sold to exporters and private traders at Rs 4 per kg, a price well below the BPL price. The food subsidy therefore ended up being targeted towards profiteers, not the poor.

What is even worse is that the BPL criterion has now become a tool to target other types of social sector expenditure such as on health and education; It is now the BPL card which determines the access of the poor to free health care or loans for self-help groups, housing schemes, etc. It is becoming increasingly evident that the targeting of food subsidy is merely the first step in the direction of bringing down total public expenditure meant for the poor.

There is also an additional issue of other items such as sugar and kerosene that are distributed on the PDS. Despite large stocks of sugar, the PDS price of sugar was doubled; initially it was restricted to BPL cardholders, but now sugar is no longer sold on the PDS. Similarly, after the administered price system in the oil sector was dismantled, and the domestic prices of petroleum products linked to the international market, the price of kerosene on the PDS has risen from Rs 2.50 a litre to Rs 10 per litre. The quotas allotted to state governments have been linked to the number of gas connections released to the state, and the resulting shortages has provided the basis for a burgeoning black market in kerosene, which is available at Rs 20-25 per litre in the open market. This is a source of great hardship to common people, and needs urgent attention. Any measures to strengthen the PDS must also include expanding the number of essential commodities sold through it.

Political Consensus on Targeting: There has been a remarkable consensus within the two major political parties, the BJP and the Congress on the issue of targeting food subsidy. Despite pressure from Left parties who have been demanding a return to universalisation of the PDS and a reduction in prices, the Common Minimum Programme of the recently elected United Progressive Alliance states the intention of the government to "move towards universal food security over time, ***if found feasible***" (emphasis added).

Urgency of the Situation: Several nutrition and other indicators point to the growing food insecurity of the Indian people. The situation is urgent; it requires immediate attention by policy makers. The right to cheap foodgrain through a strengthened public distribution system must be made a fundamental right. As a first step, rice and wheat need to be made

available to all BPL households at highly reduced prices, (say Antodaya prices of Rs. 2 per kg of wheat and Rs. 2 per kg rice. The BPL category needs to be extended to all vulnerable sections including all agricultural labour, migrant workers, urban unorganised sector workers, retrenched industrial workers, widows, single adult women, disabled persons, persons over the age of sixty, female headed families, etc. Special attention needs to be paid to the food security of Dalit and Adivasi households, The quantity of foodgrain supplied on the PDS needs to be vastly increased and should be individual and not family based. The foodgrain component of all employment-related schemes needs be calculated at current Antodaya prices. A radical change is required in the methodology used to measure poverty.

Even amongst organisations that are mobilising people around the issue of cheap food, there is still a debate about whether there should be a return to the universal PDS, or whether the Targeted PDS should be further 'reformed' to take care of the distortions introduced in the system (for e.g.by rationalising the criteria for BPL selection, including more and more categories of eligible households, etc).

It must be pointed out that the crucial issue is not one of better delivery and implementation, but that of a basic policy choice of whether food security is a fundamental right that must be available to all citizens regardless of their position (class, caste, region, gender, etc.) in society. Targeting is not simply about ensuring that the poor get their due, but also about excluding those whom ***the state*** believes does not have the right to access the subsidized system, be it food or health of education. What is the basis for selecting some households and excluding others in a country where more than half the population is impoverished, as evident from several other social and economic indicators? What about crop failures, fluctuations in input prices, crash in output prices, changing cropping patterns, closure of industries, drought, floods etc, which can contribute to converting the 'non-poor' into the poor in a matter of moments?

This workshop is intended to resolve some of these issues, and on the basis of concrete experiences, formulate concrete demands that can form the basis for future struggles around the Public Distribution System. In particular, it is intended to bring to:

- Bring to the fore the experience of the TPDS, Antyodaya Anna Yojana and Annapurna Yojana in different states
- Share the experience of struggles built up around these schemes
- Explore alternative forms of food security systems
- Formulate tactical and strategic demands about the PDS
- Discuss possible forms of future struggles around these demands

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Denial of Health Care

Testimonies from Rajasthan

- A 65 year-old-man of village Dhirji Ka Kheda, tehsil Bhadesar, district Chittorgarh developed cough and breathlessness. He was taken to district hospital, Chittorgarh where he was admitted. The doctors prescribed medicines that had to be bought from private medical store. For one and a half years the patient took treatment from the district hospital and spent around Rs.35000/-for the treatment but still did not get well. He was taken to Udaipur referral hospital where he was admitted for 15 days and told that he had liver problem. While he took medicines he felt better but as soon as he stopped taking the medicines he would develop swelling in the abdomen and legs. The treatment at Udaipur cost Rs.40,000/- despite it being a Government hospital. The family had to mortgage and even sell some off their land to arrange for the money. Yet the doctors at the referral hospital told them to take the patient to Jaipur or Ahmedabad for further treatment. The family had no more money left to take the patient and therefore they were forced to bring the ill patient back home. For 2 months the patient suffered lot of pain and discomfort and due to unavailability of proper treatment eventually he died a very painful death.

Denial: Despite having a BPL card all the medicines had to be bought from private medical store
No proper diagnosis was done
Consequence: The patient lost his life due to lack of money
The family fell into heavy debt

- A 62-year-old man of village Lakshmi Pura, district Nimach (adjacent to village Vijaypur, district Chittorgarh) felt pain in his stomach in June 2001. He sought treatment in Chittorgarh district hospital (which is closer than the district hospital in Nimach). The patient was admitted in the hospital for 15 days during which blood test, urine test and X-ray were done. In all these tests and medicines the patient had to spend Rs.40,000/-. The doctor then told him that he needed an operation for which blood would also have to be arranged and this would involve an amount of R.10,000/-. The patient is too poor to arrange for this much money again. Thus he has not get the operation done. He has swelling in his abdomen which is very painful. For temporary relief he seeks treatment from a local private doctor. The doctor charges Rs.200-300 every time and gives him 2 injections and some tablets. This gives temporary relief and every month/ couple of months he repeats this treatment. For 3 years the patient has been suffering in pain. In this whole process he has had to sell off his 2 bullocks to arrange for the money. Today he has no money for treatment and is extremely weak wit visible wasting of muscles.

Denial: Denied operation due to lack of money
No free medicines form the government hospital.
Consequence: Patient has been suffering for the last 3 years and can die any day if he does not receive immediate treatment.

He had to sell off his bullocks to arrange money for the treatment in the government hospital.

- In may 1990, a 38 year old man of village Pithalwadi Khurd, tehsil Chhoti Sadri, district chittorgarh, developed headache and suddenly became unconscious. The family went to CHC, Chotti Sadri to call the doctor. Instead of coming himself the doctor sent the compounder. The compounder gave 2 injections in the patient's head. After some time the patient recovered. After 3 days he again fell unconscious. Then he was brought to the CHC & admitted. The doctor who had admitted him went on a long leave after admitting the patient. The other doctor at the CHC refused to treat the patient and scolded the family for consulting the doctor earlier and then later approaching him. The patient remained admitted in the CHC for 14 days without the doctors looking at him. The nurse and the compounder kept giving some treatment for temporary relief. During this time the family spent Rs.15000/-. After 14 days the doctor came back from leave and told the family to take the patient to Udaipur as he could not be treated at the CHC. The family sold off thir land and jewellery and took the patient to Udaipur referral hospital. He took treatment for 3 months but it did not help. Initially one of his legs got paralysed and eventually both the legs got paralysed. The family borrowed rs.4000/- from relatives and took him to a private hospital at Nimach but it did not help either. Today the patient is paralysed below the waist and is completely bedridden.

Denial: The doctor did not visit the patient himself and sent the compounder.
The doctor who had admitted the patient went on leave and the other doctor refused to see the patient.
All the tests and medicines had to be arranged from outside the hospital.
Consequence: Despite so much effort the patient is bedridden
The family has lost most of its assets

- A 20-year-old woman of village Akhepur, tehsil Chhoti Sadri, district Chittorgarh, was pregnant and was taken to the area CHC for delivery on 6th June 2004. The patient reached the hospital at 12 o'clock in the night and nobody was available at the CHC. Two doctors were on leave. The patient's husband went to the third doctor's house to call him. The doctor answered from the window and told the patient's husband to call the LHV. He went to call the LHV but the LHV did not answer. He came to back to CHC where he saw the wife's pain had increased. He went back to the LHV's house. After knocking at the door for about 15 minutes the LHV came out. The LHV admitted the patient in the labour room, gave a bottle of glucose, assured the husband that everything was fine and that there was still some time for the delivery and she went back home. The patient's pain became unbearable and the husband went to the ward boy's house. By the time the ward boy came it was 4-4.30 AM. At around 5 o'clock in the morning the patient finally delivered but the child was born dead. The LHV came back and told the family that the child had died two days ago in the womb itself.

Denial: There was nobody at the CHC in emergency.
The doctor did not come to attend the patient, instead asked the family to call the LHV

The LHV went back home without attending to the patient
The patient was left at the mercy of the ward boy.
All the service providers charged money
Consequence: The child did not survive.
The parents had to suffer lot of agony because of losing their child

- A 21 year-old-woman of village Raju khera. tehsil Chhoti Sadri, district Chittorgarh delivered a child in July 2003. She developed breast engorgement and could not feed the child. The patient went to the area CHC where she was suggested an operation to heal the breasts. She got scared of the operation and took local treatment in the village itself. Since she was not able to feed the child the child became very weak and developed vomiting/diarrhoea. She took the infant to the CHC where medicines were prescribed. The patient bought the medicines from private medical store but they did not help. Then they took the child to the Nimach district hospital where he was admitted for 2 days and told that it was necessary to breast-feed the child. The doctor suggested that they take the child back to the village and get some other lactating woman to breast feed the child. The family brought the child back but there was no other woman in the village who could feed the child and eventually the child died after 3 days.

Denial: The patient was directly told for operation without giving any other alternatives.
The child was not given any supplementary feed in the absence of mother's milk.
Consequence: Pain in the patient's breasts continued.
The child lost his life

- 3 years ago in August 2001, a 48-year-old woman of village Lader, tehsil Bhadesar, district Chittorgarh felt pain in her right eye. She went to the area PHC at Bhadesar where the doctors prescribed medicines and asked her to go to some other hospital, as she could not be treated at the PHC. She went to district hospital, Chittorgarh where she was given dressing for 5 days but it did not help and the pain continued. The patient also went to an eye camp held at SanvariyaJi where she was given a tube which brought no relief. In the hope to save her eye the patient went to Udaipur referral hospital where she was told that eye replacement could not be done. Instead if she arranged for around Rs.5000/-, she could be given an artificial eye. The patient is too poor to arrange for this much amount of money. She has already spent around Rs.1500- in the treatment for which she has had to mortgage her silver jewellery. Now the patient has lost her right eye.

Denial: The patient was denied operation because she did not have money
Consequence: The patient has lost her eye.

- Another woman of village Jaliya Peepliya, tehsil Nimbahera, Chittorgarh district had itching/irritation and running water in her eyes in April 2002. She consulted the doctors at eye camps held at SanvariyaJi and Chittorgarh where she was given some medicines and tube but they did not help. Having got no relief in the government camps the patient went to private doctors where she spent around Rs.2000/- and was finally told that she needed an operation which would cost rs.

10,000/-. Being from a very poor family the patient does not have so much money and today she remains without any treatment with her eyes still paining and reduced visibility.

Similar is the situation of another woman of village Lader. tehsil Bhadesar. district Chittorgarh.

Denial: In government facility proper examination& treatment was not given

Consequence: Patient suffered economic loss in private hospitals.

She now has reduced visibility due to lack of treatment in the government facilities and money.

- A 45 year old man of village Siyakhedi. tehsil Chhoti Sadri. district Chittorgarh. developed fever, breathlessness and weakness in November 2001. He was taken to the area CHC where blood, urine and sputum tests were prescribed. The tests had to be done from private laboratory. After seeing the reports the doctor admitted the patient but after that did not visit the patient in the ward. The patient went to the doctor's residence and the doctor prescribed some medicines. The family bought these medicines from private medical store and the ward boy administered these medicines. The treatment was not being effective and the patient was referred to Pratapgarh district hospital. At the district hospital, X-ray was done and the patient was sent back to the CHC after prescribing some medicines. Since the treatment in government hospital was not helpful so the patient consulted a private doctor. In the entire treatment the family spent about Rs. 11,000/- for which the had to mortgage their land. Yet they were not able to save the patient.

Denial: Doctor at the CHC did not visit the patient in the ward.

The patient was made to run from one hospital to the other.

Patient had to spend money in the government hospital and proper treatment was not given either at CHC or at district hospital.

Consequence: The patient had to ultimately go to the private doctor.

Family suffered economic loss

Family and patient went through lot of mental agony and trauma in trying to seek treatment from the Government facilities.

Despite all efforts the patient lost his life.

- A 60-year-old man of village Jaliya Peepliya, tehsil Nimbahera, district Chittorgarh .has been suffering from white discharge for the last 6 years. The extent of problem is such that he has to change his clothes thrice in a day. He took treatment at Nimbahera CHC where he spent Rs.3000/- in treatment and medicines. Gradually his condition kept deteriorating and he developed weakness, breathlessness and cough. Having got no respite at the government hospital the patient sought treatment at a private hospital in Mandsaur where he spent Rs. 6500/-. As the treatment was of no use, the patient went to another private clinic in Nimach where he was given 5 injections and medicines for Rs.3500/-. Finally he went back to the Nimbahera CHC as he had no more money for treatment in private. Urine and sputum tests were done and he was referred to Udaipur referral hospital. But by then the patient had exhausted all his resources and did not have

any more money to go to Udaipur. So for the last one and a half years he has not taken any treatment and continues to suffer.

Denial: Patient did not get any free medicines in the hospital.
Patient was not informed about the illness or given proper treatment.
Consequence: Patient kept running around from one hospital to the other.
Suffered economic loss
Did not get any relief and is still ill and suffering.

- A 30-year-old man working in the stone mines in Jodhpur district developed TB in November 1998 and sought treatment at Kamla Nehru TB hospital. Jodhpur. The patient was admitted for 1 week during which X-ray and blood test were done from private laboratory even including medications. After a week in the hospital the patient was discharged. He took rest at home for a week and went back to work. His condition deteriorated despite raking medicines and he went back to the hospital and was again admitted. He continued taking medicines bought form private medical store. This time the patient was discharged after 15 days but after a week at home his condition started deteriorating severely and was again admitted for 3 months. Once again examinations like X-ray and sputum were done in private laboratory. In this entire treatment of 6 months the patient's family spent an amount of about Rs. 20000/- by selling their land. jewellery and borrowing money on interest. Despite all these efforts the family could not save the patient, as they were unable to arrange for any more money.

Denial: X-ray, blood test & sputum test were done from private laboratory.
The family spent huge amount of money on treatment
Consequence: Because of lack of adequate money the patient could not continue the treatment and died.
Family suffered lot of mental anguish and distress.
Family's land and jewellery were sold.
Family fell into heavy debt. Now wife is the only earning member to repay the debt and take care of children.

- Another 29-year-old mineworker from Jodhpur was hurt while blasting the stones on 31st march 1996. The patient was taken to Mahatma Gandhi hospital in Jodhpur and admitted for a week. The patient spent around Rs. 7000/- on X-ray, sonography & medicines all of which were arranged from outside the government hospital. Treatment was not effective and the doctors told him to go to a private hospital for better treatment. The patient was forced to seek treatment in private hospital where he spent Rs. 20,000/-, which he arranged by borrowing form relatives and taking loan on interest. Still the patient has not recovered completely and finds it difficult to stand for more than half an hour at a stretch. He even continues to repay the debt.

Denial: No test were done in the government hospital for detection of TB, instead had to be done from private laboratory.
No free medicines were provided from the Government hospital.
Consequences: The patient was forced to seek treatment in private hospital.
The family fell into heavy debt which they are repaying even after eight years.

These are just two examples of thousands of mine workers who continue to suffer in Jodhpur stone mines. The work conditions in these mines provide little security to the workers. No security is being provided by the employer. Neither is the government health system of any use to the poor and the resourceless. As a result of this thousands of workers face numerous health hazards which lead to loss of life and money.

On 6th June 2004 a 25 year old woman from Tilawala village, Panchayat samiti, Sanganer, district Jaipur, died due to ecxessive bleeding after delivering her second child (who survived) at the CHC, Sanganer, Jaipur district. When the woman was beought in by her family at 4.00PM that evening she was in labour. The LHV took her into the labour room. At 6.15 PM after delivering the child the nurde came out and told the patient's husband to get an injection to stop the bleeding. FOr 45 minutes the nurse kept handling the serious matter on her own. The family kept asking her to call a doctor, to call an expert. The hospital incharge is a gynaecologist. The nurse paid no heed. Then she said that the patient should be taken to the State Hospital or the Women's Hospital, 10 Km away in the city. There was no ambulance. The family hired a private taxi. When the patient's condition started deteriorating the nurse suggested the private hospital nearby. The private hospital said that they could not do anything. By the time she was brought to the SMS State Medical College/Hopital by 8.30PM she had died.

Denial:
The hospital did not have the injection to stop the bleeding and the patient was asked to get the injection from outside.
The doctor was not called to attend the patient despite the patient repeatedly asking the nurse to do so.
There was no ambulance in the hospital.

consequences:
The patient suffered in severe pain for a long time.
Family went through lot of mental agony in the whole process.
The patient lost her life.

The above matter shows how women's lives are treated with callousness in the CHC. This is also significant that at this CHC during last 10 months 3 such incidents have taken place and this CHC has shown no accountability to the people. On 6th August 2003 a labourer woman came to the CHC for delivery. In this case midway during the operation the husbnad ws called and the doctors told him that the child had died and since the child's bosywas half in the woman's body, which the doctor did not know how to handle, she should be taken to the State medical college/hospital. The child's head was wrapped ina polythene and the patient was taken to a closeby private hospital where fortunately the woman's life was saved. On 30th August 2003 in yet another delivery matter the child died.

The CHC incharge who is a gynaecologist is never available. The other 2 doctors appointed are dentists. There is no drinking water. Garbage lies all around. The ambulance is used personally by doctors and other staff. The bedsheets are never washed. The CHC is in such a state of neglect which is unavailable. There is no accountability inspite of protests. FIRs have been lodged in all the above cases.

This CHC in such a pathetic state as above, is being used by people from 100 villages.

Comm - 89.4

HEALTH STATUS OF RAJASTHAN

Jan Swasthya Abhiyan
Rajasthan Unit
B -8, Bapu Nagar, Senthi,
Chittorgarh 312 025

Demography

Total Population		5,64,73122
	Male	2,93,31657
	Female	2,70,91465
Sex Ratio		922
	Urban	890
	Rural	932
Juvenile sex ratio		909
	Urban	886
	Rural	914
Literacy rate	M 76.46	F 44.34
urban :	M 87.10	F 65.42
rural :	M 72.96	F 37.74

(Source: Census 2001)

Demography & infrastructure (contd.)

Population density	165
Percent rural population	76.62
Percent with access to safe water	49.6
Percent with no toilet facility	71.8
Percent with access to electricity	64.4

Source: Census 2001
NFHS-II

Health indices of Rajasthan

Infant mortality rate	80.4
Under five mortality rate	114.9
Maternal mortality rate	677
Total fertility rate	3.78
% of women with anaemia	48.5
% of women with severe anaemia	16.2

(contd.)

Health indices of Rajasthan (contd.)

% of children with anaemia	82.3
% of children with chronic undernutrition	52.0

Source:NFHS-II

Status of health facilities

CHCs

- State norm: A CHC for every 1 lakh population
  Total rural population to CHC ratio 1,45,680
  141 CHCs less than required

PHCs

- In tribal & desert areas
  Population to PHC ratio 23708
  153 PHCs less than required
- In non-tribal areas
  Population to PHC ratio 27951
  54 PHCs more than required

(Contd.)

Sub Centres

- In tribal & desert areas
  Population to sub-centre ratio 4118
  1793 sub-centres less than required

- In non-tribal areas
  Population to sub-centre ratio 4586
  421 sub centres more than required .

Percentage of vacant posts

MPW (M)	63.7
Gynaecologists	34.59
Paediatricians	28.81
Anaesthetists	33.87
Surgeons	46.06
Medical officers	5.78
Medical officers Dental	24.77

Health governance systems

- The state does have an essential drug list but few people are aware of it & it is hardly used. Over medication is rampant.

- A set of standard treatment guidelines has been recently prepared

- User fees is charged at CHCs & higher level hospitals under DMRS.

- There is no such provision (except the 'Right to Information Act') whereby the public can know what drugs are available at the public health facility. People are often denied medicines from the public health facilities and have to spend huge amounts of money on drugs.
- Consumer protection Act .
- There is no functional system for people to lodge complaints regarding negligence/poor quality services. Complaint boxes may be existing but they are usually placed in such a way that the public does not know about them.

Health sector budget

- Annual health budget in relation to GDP

1998-1999	1.17%
1999-2000	1.12%
2000-2001	1.12%
2001-2002	1.12%
2002-2003	1.06%

(contd.)

- Annual health budget in relation to total population
  Rs.158 per capita in 2002-03
  Rs.189 as per modified budget of 2004-05

- Annual health budget for drugs
  - A meagre 2.86% of total health budget was spent on drugs in 2002-03

  - Per capita population expenditure on drugs has been abysmally low at
    Rs.4.51 per capita in 2002-03
    Rs.4.03 as per BE for 2004-05

Policy Matters

- The state does not have a health policy
- Neither is there any policy for regulating the private medical sector
- But what definitely exists & is practiced is the population policy
  - Rajasthan has a very coercive population control programme based on incentives & disincentives

(Contd.)

- Target approach is being adopted & service providers are penalised for not meeting targets
- Standardised norms for sterilisation camps are compromised in the zeal to achieve targets
- Two-child norm is applicable in the Panchayats, Municipalities & State government

- The civil society has no role in monitoring the availability & delivery of health services
- Despite the Regulation Gram Panchayats too do not have any effective role in planning & implementation of local health services

Externally funded projects

- The state has an external aid of about Rs.1913.47 crores for health related projects
- These are supported by World Bank, UNICEF, UNFPA, European Commision, GTZ
- The World Bank grant of Rs.472 crores is in the form of loan
- There is no system for civil society monitoring of these projects

Comm - 84.5

Cases of Denial of Health Care from Maharashtra

Human rights violations to be presented to NHRC at Public Hearing, Bhopal

The Jan Arogya Abhiyan (JSA-Maharashtra) has documented over 80 cases of denial of health care, from various regions of Maharashtra during the last several months. A brief description of a sample of these cases, drawn from various parts of the state and exemplifying various types of denial, are given below. These cases would be presented to the National Human Rights Commission during the Western region public hearing on Right to Health Care at Bhopal on 29th July, 2004.

1. Place: Nandurbar District, Northern Maharashtra

In one of the Narmada Bachao Andolan's 'Jeevan Shala' schools, a girl student was bitten by a snake. The resident teacher hurriedly took her to the Rural Hospital. Incidence of snakebite in this area is very high, especially in rainy season. However, because of non-availability of snake anti-venin in that hospital, the girl died after few hours. As it was a rainy season, activists from NBA tried to persuade Rural Hospital authorities to make anti-venin available immediately so that similar cases would not occur in the future. Unfortunately anti-venin remained unavailable in the hospital for more than a fortnight. During this period, two more girls died of snakebite due to non-availability of the life-saving anti-venin.

Type of Denial:

Nonavailability of snake anti-venin in the Rural Hospital, although incidence of snakebite in this area is very high

Consequences:

Completely avoidable deaths of three girl students, studying in Jeevan Shala.

2. Place: Nandurbar District, Northern Maharashtra

On 4th April 2004 Nagu Hadku Godse went to Akkalkuwa PHC along with his daughter, in her ninth month of pregnancy. When they reached the PHC his daughter was already in labour. Mr.Godse tried to call the Medical Officer on duty but he was untraceable. Although the ANM was in the campus of the PHC, inspite of pleas of Mr.Godse, she refused to see the daughter who was in labour. Sensing that he will not get help, Mr. Godse rushed to hire a private vehicle to take his daughter to a private clinic, which was around 15 Km away from this PHC. But in the mean while the daughter delivered in the open ground of the PHC. Mr.Godse again went to ANM to seek her help. She accompanied him very reluctantly but after watching his daughter plainly refused to cut the umbilical cord and did not bother to provide essential care to the new born. More over she scolded her helper for allowing Mr. Godse to enter in PHC campus. Mr.Godse at last took his daughter to a private clinic where the Doctor had separated the placenta.

Type of Denial:

Nonavailability of services of the Doctor or ANM in the PHC.

Denial to provide essential delivery care, in extremely insensitive manner.

Consequences:

Severe financial loss, health risk and mental anguish to patient and relatives.

3.Place: Khodala PHC, Thane District, Coastal Maharashtra

In one of the villages under Khodala PHC, an epidemic of diarrhea and vomiting occurred in October 2003. Sensing the danger, a villager Mr. Dattu Vad

rushed to inform about the epidemic to Block Development Officer (BDO) who unfortunately ignored this warning. Mr.Vad then tried to contact concerned authorities in the PHC. However in PHC on duty Medical Officer was not available to take a stock of the situation. All efforts of Mr Vad to contact the MO were in vain so at last he called the CEO of Thane District. Finally the CEO arranged for a doctor and vehicle. In the mean while, one women lost her life in this epidemic where as 5 others were taken seriously ill. Paradoxically rather than complimenting the efforts taken by Mr.Vad, PHC officials were furious that he had dared to contact the CEO directly. In spite of specific instructions by the District authorities to PHC doctor to monitor the situation regularly, he visited the epidemic area subsequently on only three occasions in 2 months.

Type of denial:

Medical Officer was not on duty in the PHC. BDO ignored the information about an epidemic. No proper surveillance system to monitor outbreak of epidemic. Warning by the local resident was ignored locally.

Consequences:

One death and five others became seriously ill.

4.Place: Vashila PHC, Thane Distict, Coastal Maharashtra

One-year-old Pinty Bhanwar was taken to Vashila PHC with acute breathing problems and swelling around the eyes. Although she was taken to the PHC during working hours, the on duty Doctor was not present in the campus, compunder in the PHC gave some local application for eyes. Pinty's parent waited for the Doctor to come for around four hours; when the doctor failed to appear at last they decided to shift her to adjacent Nandgaon PHC. The Doctor in this PHC gave some injection and tablets and assured her parents that everything would be all right within few hours, and left the place. Inspite of repeated requests, nobody in the PHC bothered to tell them what is wrong with their daughter, nor was the child admitted in the PHC. The parents had to keep the patient in a nearby relative's house. Unfortunately the child died without proper care and in absence of the Doctor on the same day.

Type of denial:

No Doctor was available in the first PHC, where as in the second PHC although Doctor was available, there was no provision for admitting the patient. Doctor left the PHC, abandoning the patient.

Consequences:

Death of the child.

5.Place: Kurkheda Rural Hospital, Gadchiroli District, Vidarbha region, Maharashtra

Mrs Uttara Rupchand Dakhane is about 25 years old woman residing at Village Ghati, Taluka Kurkheda, Dist: Gadchiroli.

Mrs. Dakhane registered herself at Kurkheda PHC for Ante-natal care in mid-2003. On 5th August 2003 she developed labour pains and was taken to Rural Hospital Kurkheda. Medical Officers were present in Hospital. Mr. Rupchand Dakhne asked the Nurse to admit the patient in labour. The Nurse told him to first get the patient registered. After that he went to the MO. He told to take her at labour room. Once the patient was in labour room, the Nurse came and put the patient in position for

delivery, left the room and did not bother to revisit the patient again. In the meanwhile Mr. Dakhane asked to meet another medical officer. He wrote something on paper and again sent him to the previous MO. This MO had a look at the patient and warned her husband that since the mother was very weak, this could be a complicated delivery and could be dangerous to her life. Ironically in spite of understanding complications associated with the delivery, the MO did not visit labor room again. Finally the delivery took place without medical assistance. When the patient's husband reported to the nurse about the delivery, she came and cut the cord. The only thing the Nurse did was to take the weight of the baby, she did not even care to see that the baby should cry. The baby cried only when the Dai cleaned her, nearly half an hour after birth. The Doctor did not pay any attention even after that.

After four –five months, the mother and father of the baby realised that the development of the child was not proper and they took her to a child specialist in Nagpur. He diagnosed mental retardation, due to negligence at the time of birth.

Type of denial:

Although being present in the campus, neither Doctor nor Nurse came to conduct the delivery. Essential care of the newborn was not taken.

Consequences:

Negligence at time of delivery resulted in the child developing lifelong mental retardation.

6.Place: PHC Haveli, Pune District, Western Maharashtra

Mrs. Asha Shelar presented the plight of the women who were herded for tubectomy in PHCs in Haveli taluka. She reported an incidence where the women were given anaesthesia many hours before the operating surgeon arrived at the PHC. Thus by the time the doctor started operating, the effect of anesthesia had already worn off. The women were screaming with pain during the operation. The doctor physically hit one of the patients when she was screaming. On top of that, loud music was put on to prevent the screaming of the woman from reaching outside.

Type of denial:

Absence of proper planning at the PHC level leading to performance of tubectomy operations without anaesthesia. Extremely inhuman and callous attitude of the Doctors during Tubectomy camps.

Consequences:

Extreme physical pain, mental agony and humiliation to women undergoing sterilisation at camps.

7. Place: Rural Hospital Osmanabad, Marathwada region, Maharashtra

Mrs. Kusum Mali was taken to the Osmanabad civil hospital with complaint of high fever, numbness in the extremities, anorexia etc. She was diagnosed as having typhoid (without laboratory test) and accordingly treatment was started. However since her condition deteriorated, she was taken to a private hospital where she was diagnosed to have not typhoid but much more serious illness, G.B. Syndrome. Since her family could not afford to treat her in the private hospital, she was again shifted to the Civil Hospital. In the mean while her condition deteriorated further and she had acute respiratory problems. She was in urgent need of a respirator, which was not available in this Civil hospital, furthermore it was not even available in the main hospital in neighbouring district, Solapur Civil Hospital. Hence relatives of the patient had to rent

because the operation was not successful. Thus in addition to the financial burden, is the added emotional strife of a new disability. A woman who injured her hand was made to wait more than a week before being admitted for an operation, her husband had to borrow a large sum of money to pay for this operation, which in the end, was not effective. The woman now also has to deal with the physical and emotional burden of having an amputated arm, while the family has to struggle with a major financial loss and debt.

Type of denial:
Operative treatment was significantly delayed, forced to pay large sums of money in a Government hospital.
Consequences:
Irreversible disability, severe financial loss.

10. Place: Civil Hospital, Parbhani, Marathwada region, Maharashtra
In the Civil hospital, Parbhani, a 16 years old girl was admitted with 15% burns on 25th November. On 14th December nobody was present in that ward, taking advantage of the situation a ward boy tried to sexually assault the patient. The girl narrated this incident to her mother who works as a domestic worker. Her mother lodged an FIR in the police station. What happened next was unexpected and extremely inhuman. According to reports, shortly later, the same ward boy raped this girl in the hospital. Her mother went to the police station again to lodge a new complaint. The Police demanded a medical report of the patient, to be given from same hospital, as a condition to lodge the FIR. The Hospital refused to provide this report, hence FIR could not be lodged. Despite the fact that the burns were not major in nature, the girl died after 15 days. This matter needs to be investigated thoroughly and necessary action needs to be taken.

Type of denial:
Gross Human Rights violation in the campus of the civil hospital.
Consequences:
Extreme violation of dignity, girl died after 15 days.

Draft Report

Public hearing on availability of basic health services in Thane District, Maharashtra

'Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems. Overt or implicit discrimination violates a fundamental human rights principle that often lies at the root of poor health status. In practice, discrimination can manifest itself in inadequately targeted health programmes and restricted access to health services.'

- WHO, 2002

Background

Health has been universally acknowledged as a basic human right, and health care has been recognised as an essential public good that is required for the full realisation of the Right to life and other basic human rights. India, as a signatory to the UN Declaration of Human Rights (1948), the International Covenant on Economic, Social and Cultural Rights (1966) and the Alma Ata 'Health for All' declaration (1978) has explicitly recognised the right to health. Interpreting sections of the Indian Constitution, such as Article 47 of the Directive Principles and Article 21 of the Fundamental Rights, various Supreme Court and High Court judgements have further outlined the duty of the state to provide essential health care, and have specified correlative health rights of citizens.

However, access to quality health care remains elusive for a large proportion of the Indian population, especially the Adivasis. Adivasi people today face an onerous triple burden of unhealthy factors. The first is increased susceptibility to ill health in the context of poverty, because of denial of access to traditional resources, displacement, and erosion of sustainable livelihoods and lifestyles. The second is poor physical access to health services, and limited provision of health services in adivasi areas. And the third is the discriminatory attitude of health care providers and administrators, which constitutes a serious human rights violation and effectively completes the circle of denial, depriving adivasis of their right to health.

In this situation, organisations that have emerged from adivasi struggles for identity and survival have begun to question this serious denial, and have started raising the issue of their right to health and health care. Some such organisations, like Kashtakari Sanghatna in Thane district of Maharashtra, have been involved in developing people's health initiatives, while also demanding accountability of public health services in a Rights-based framework. Meanwhile, in September 2003 the Jan Swasthya Abhiyan (Peoples Health Campaign), a national level platform of health related networks and organisations, working on the issue of Health rights and strengthening of public health systems, organized a National level workshop presided by Justice Anand, former Chief Justice of the Supreme Court and Chairman of the National Human Rights Commission on the Denial of Health Care. Subsequently, District level Public Hearings on Denial of Health Care were planned. It is in this context that a coalition of peoples' organisations, Shoshit Jan Andolan, organised a public hearing on health rights in Mokhada town of Thane district on 9th January 2004. This report attempts to bring out the main issues raised during the public hearing, to facilitate further advocacy and action.

Framework of the Public Hearing

The organisers of the public hearing held on 9th January 2004 in Mokhada were *Shoshit Jan Andolan* (SJA, Movement of oppressed people), a coalition of peoples'

organisations involved in organising the adivasi and rural poor population on various livelihood issues, particularly in Thane and Raigad districts of Maharashtra. The hearing was hosted by Kashtakari Sanghatana, a people's organisation which is one of the constituents of SJA, and has been working with toiling adivasi people in the northern part of Thane District since the last 25 years. Representatives of the Sanghatna collected information about health facilities and cases of denial of health care from Dahanu, Jawhar,Vikramgad and Mokhada talukas. The peoples' organisations Shramik Mukti Sanghatana (Murbad and Shahapur talukas) and Eklavya Kashtakari Sanghatana (Shahapur taluka) also actively participated in collecting information from their talukas and in mobilising people for the public hearing.

Public health officials who were present as respondents on behalf of the Maharashtra health department included Dr. T.M. Suryavanshi (Additional District Health Officer, Thane Dist.) and Dr. Sabde (Medical superintendent Jawhar Cottage hospital, Taluka Jawahar and Mokhada Rural Hospital, Taluka Mokhada) along with other medical officers.

Panelists for the public hearing included Justice B.G. Kolse Patil (Retd. Judge, Mumbai High Court), Dr. Kamakshi Bhate (Asst. Professor, G.S. Medical College, Mumbai) and Dr. Chhaya Datar (Head, Women's Studies Unit, Tata Institute of Social Sciences, Mumbai).

Health related technical inputs for the public hearing, including analysis of the survey information, were given by CEHAT, a health sector organisation. Dr. Nilangi Nanal represented the Jan Swasthya Abhiyan

The programme of the hearing consisted of:

- Presentation of issues by people's representatives (including survey findings and cases of denial of health care)
- Response by Health officials
- Discussion on key issues and opinions by panelists

Issues presented by people's representatives

Representatives of Shoshit Jan Andolan presented the findings of the survey of six PHCs and one Rural Hospital in Thane district, exemplifying the deficiencies in these facilities (summary given below). Cases of denial of health care were also presented, where individuals gave testimony of how they had been denied essential services from specific public health facilities (some examples given below). These were the context in which health officials were invited to respond and clarify as to how relevant improvements would be made.

Summary findings of survey of public health facilities

A total of seven Primary health centers (PHCs) and one Rural hospital were surveyed as ground preparation for the public hearing. Information about the infrastrucural facilities, staffing position and availability of various services such as Reproductive and child health services, laboratory services, emergency services etc. was collected during this survey. Similarly specific cases where health care was denied and the denial of health care had led to serious consequences were collected. Protocols developed by CEHAT were utilised for data collection, and interviews with village representatives along with site visits to the health facilities and interviews with health care providers were employed to collect the information.

The seven PHCs from which the data was collected were from Vikramgad (Vikramgad PHC), Dahanu (Saiwan PHC, Dhundalwadi PHC) Mokhada (Washele PHC, Aase PHC), Jawhar (Nandgaon PHC) and Shahapur (Vashind PHC) talukas of Thane District. Key findings related to the various health facilities surveyed are as follows:

Issues related to coverage and infrastructure:

- In tribal areas, there should be one PHC catering to a population of 20,000 people. But in the present survey, it was seen that out of 7 PHCs, 5 were *providing services to a much larger population than stipulated*, between 30,000 and 40,000 people. This overburdening was found to be affecting the quality of the services provided.
- *In all of the PHCs, the ambulance was not regularly functional.* An ambulance in working condition was present only in the RH, which was given to the patients at the rate of Rs. 5 per kilometer, not affordable to many impoverished families. In some places, patients had to even hire private vehicles to transport seriously ill patients.
- The condition of the operation theatres was similar, with most of the PHCs being without regularly functioning minor OTs. In one of the Rural hospitals, the staff even reported that the operation theatre was not in use because the culture swab had been found positive for presence of micro organisms.
- The level of hygiene was found to be grossly deficient in most of the PHCs.
- In most of the PHCs, indoor facility to admit six patients at any time was not fully functional.
- No toilet facility for patients was found to be existent in most of the PHCs.

Issues related to the number and availability of staff:

- In some PHCs, there was only one Medical Officer. Thus he / she could not regularly visit the Subcentres in the PHC area as required. Even the other PHC staff such as ANMs and MPWs was found to be not visiting the remote hamlets regularly.
- The staffing situation of the only Rural hospital which was surveyed, was reported to be grossly deficient. *There was no separate resident doctor for the Rural Hospital.* It was understaffed with only 3 people working there, most of them not resident there. Most of the patients approaching the hospital were referred to other Government facilities.
- Since there were no adequate residential facilities for the staff, in most of the PHCs the staff never stayed at the PHC campus.

Issues related to discrimination against Adivasi patients:

- A large number of people surveyed reported that certain of the PHC staff had a callous attitude towards tribal patients. The doctors often asked the nurses or the peons to examine the patients. In one PHC, certain staff including the doctor was often found under influence of alcohol during duty hours. In another PHC, the doctor was found to be playing cards, and in a third PHC playing cricket, during duty hours.
- Women complained of abusive language and ill treatment at the time of delivery. Some PHC staff demanded 100 to 150 rupees for conducting the delivery.

Issues related to the provision of essential services at the PHC:

- In most of the PHCs, *delivery services were not available around the clock.*
- Since there were no women doctors in any of the PHCs, the *treatment for women's reproductive health problems was not available* in these facilities, denying women one of the basic services under the Reproductive and Child Health (RCH) programme.
- In *none of the PHCs was the facility to test haemoglobin levels to confirm anaemia available.*
- In *none of the PHCs was the facility for safe MTP (abortions) available.*
- Important services such as *operations for cataract* (under National Blindness control programme) and *Male / Female sterilisation operations* were *not being carried out in any of the PHCs.*

Issues related to the availability of the medicines and supplies:

- In *none of the PHCs, all medicines were being given free to the patients.*
- The PHC staff reported in some PHCs that they have adequate stock of medicines. But in reality almost in all the PHC areas the villagers reported that they had to buy many of the medicines from outside. In one of the PHCs, *even basic medications like ORS packets had to be purchased from medical stores.*
- Though Government officials claimed to have enough stocks of *Iron and Folic acid tablets, in none of the PHCs, they were being regularly given to the non-pregnant women.*
- Patients were *asked to buy basic supplies like needles and antiseptic lotion* etc. from outside private medical stores.

Cases of Denial of Health Care

During the public hearing, thirteen cases were presented to the Panelists. These cases are representative in nature. Out of these, the denial of health care was serious enough to have been associated with the death of six patients. The cases of denial of health care are summarised below:

Case 1

Tokavda PHC, Taluka Murbad, Dist. Thane

Soni Shiva Wagh, age 45 years, was suffering from low grade fever and weakness for 3-4 months so she went to the Tokavde PHC for treatment. She was given some medicine but did not feel any better so she went to a private doctor who diagnosed her as having T.B. He then directed her to go back to the PHC as she could not afford to buy the expensive drugs required for her treatment. She told the PHC doctor that she had been diagnosed for T.B. and requested him to give her the medicine. The PHC doctor got irritated with her and gave her medicine for Malaria. She then went to the Cottage Hospital in Murbad and told the doctor that she had been diagnosed for T.B. Since the X-ray machine was not functional she was asked to get a chest X-ray done in a private X-ray centre. She was then asked to return to the hospital after four days for the blood and sputum examination, however the technician was not available. On the fourth day when she went back to the hospital the technician was still unavailable. She was asked to return to the hospital on three consecutive days for the tests which were ultimately never done. After having spent a small fortune and considerable time

and energy on travelling to the Rural Hospital in the taluka place. the patient gave up hope for treatment in a government hospital.

Basic investigations for diagnosis of Tuberculosis, expected under the National TB Control Programme, could not be given by a taluka level Cottage Hospital.

Case 2

Tokavda PHC, Taluka Murbad, Dist. Thane

A girl aged 12 years was bitten by a scorpion on her finger. She was rushed to Tokavda PHC but without giving her any treatment she was referred to Rural Hospital Murbad. There she was not treated but referred to the Civil Hospital in Ulhasnagar. Even in Ulhasnagar they refused to admit her, and referred her to Sion Hospital where the patient died. The family then had to spend an additional Rs. 2500 to bring the dead body back to their village as they were refused a hearse.

Neither the PHC, nor the Rural Hospital, nor the Civil Hospital could treat a case of scorpion bite, with fatal consequences.

Case 3

Tokavda PHC, Taluka Murbad, Dist. Thane

Gurunath Madhukar Bangara, age 2 years, r/o Bangarwadi, Village Karponde, was suffering from diarrohea and vomiting so he was taken to the Tokavda PHC by his mother on the morning of December 25, 2003. The doctor did not examine the child and gave a packet of ORS. A couple of hours later the mother informed the doctor that the child was running temperature. The doctor did not examine the child but wrote out a prescription for medicine. injection and disposable syringe, all to be purchased from outside. The child was administered the medicines purchased from the private medical store and sent home. The next day the mother returned with the child and she was once again asked to purchase medicines from outside. On the third day the mother did not return with the child as she had no more money to purchase medicines.

Adequate treatment for diarrhoea, one the simplest and commonest illnesses, could not be given by the PHC.

Case 4

Saralgaon PHC, Taluka Murbad, Dist Thane

Narayan Ghude, age 40 years, suffered a snake bite in the very early morning of 1/8/03. He was rushed to the Saralgaon PHC where he was not given anti-snake venom and rather was sent to the R.H. in Murbad. Two hours later he died. Later the doctor of Saralgaon PHC threatened the relatives that if they try to make a complaint they will be sued for defamation.

The PHC failed to treat a case of snakebite, leading to considerable delay and fatal consequences.

Case 5

Vikramgad PHC cum R.H., Taluka Vikramgad, Dist. Thane

Santaram Laxman Malkari, age 8 months and Sagar Lahu Kunwra, age 1.5 years, both r/o Village Khuded, Taluka Vikramgad, were suffering from diarrohea and vomiting and were taken to the Vikramgad R.H..as it is nearest to their village on 7/11/03. The doctor on duty examined them and prescribed ORS packet to be bought from the medical store. The parents of the children were accompanied by a local activist, who confronted the doctor when

he gave them a prescription for ORS, rather than supplying this from the PHC. They then took the children to the Cottage Hospital in Jawhar where they were given treatment.

Essential supplies such as ORS, to be given under the Diarrheal Diseases Control Programme, have to be purchased by the adivasi patients.

Case 6

Kasa PHC cum R.H., Taluka Dahanu, Dist. Thane

Sevanti Shankar Baswat, age 45 years, r/o Chinch Pada, Pawan, taluka Dahanu had patches on her body and a sore on her leg. She went to the Kasa R.H. for treatment for leprosy. She was admitted for one night, illegally charged Rs. 25 and asked to go home the next morning. She was told she could not be given any treatment as her name was not registered under the leprosy programme. Even her repeated requests to dress her wound went unheeded.

The Rural Hospital denied essential care to a leprosy patient, to which she was entitled under the National Leprosy Control Programme.

Case 7

Kasa PHC cum R.H., Taluka Dahanu, Dist. Thane

Jayram Balu Rawtya, age 62 years, r/o Chari- Pawan, taluka Dahanu, was suffering from continuous cough and breathlessness so he approached the Multi Purpose Worker (MPW) of his village working through Kasa PHC for help. The MPW did not give him any assistance so he came to the Cottage Hospital in Dahanu where an X-ray was taken, they examined his blood and sputum and directed him to go to the Kasa PHC to get his treatment for T.B. under the DOTS programme. He was told that the MPW would come to his house and give him his tablets daily, which he was supposed to consume in the presence of the MPW. After a few days the MPW went on leave for 15 days and the treatment stopped. The patient went to the MPW's house to ask for the tablets but he refused to give them to him and said that he would personally administer them to him at his house. After repeated requests to the MPW, the patient complained to the doctor about the abrupt stoppage of his treatment. The MPW made only one visit, gave him tablets for a few days after which the treatment was stopped completely.

Regular treatment for a case of tuberculosis, the core activity of the National TB Control Programme, was denied despite his taking repeated initiative to obtain treatment and the patient being enrolled under the much-publicised 'DOTS' programme.

Case 8

Khodala PHC, Taluka Mokhada, Dist. Thane.

In the month of October 2003, Dadu Chander Vad of Village Kurlod accompanied a small boy of his village suffering from diarrhoea and vomiting to Pethechapada, a hamlet of the same village where the doctor of Khodala PHC was supposed to be stationed as part of a 'Rescue Unit' under the Nav Sanjeevani Yojana. The doctor was unavailable. Dadu found that there were four to five other patients also suffering from diarrhoea and vomiting, so he rushed to Mokhada to inform the authorities. By the time he reached the taluka place from his remote village it was lunch time, the BDO therefore asked him to contact him after lunch. He then went to the Resident Tehsildar (RNT) who asked him for a written application. The RNT then went to the Panchayat Samiti Office personally along with Dadu but no one except the peon was available. The RNT tried calling the Khodala PHC but the phone kept ringing, with no response. He called the Jawhar hospital but they did not assure any action. Finally, the RNT asked Dadu to wait for the BDO. Dadu took initiative and went to an STD booth, and

directly phoned the CEO of Thane district. The CEO then instructed the staff in Jawhar Cottage Hospital to go to the village. Ultimately by the time help reached the village, one woman had died. Another child from the same village who was taken to the Nandgaon PHC for treatment earlier was prematurely discharged by the doctor and died in the village the same night.

While an epidemic of gastroenteritis had erupted in a village, the nearby 'Rescue unit', supposed to deal with such emergencies, was non-functional. The concerned PHC did not respond to telephone calls, and the Cottage hospital of the taluka also failed to take effective action, until an ordinary villager contacted the CEO of the district and managed to activate the government machinery. Meanwhile, two persons lost their lives due to the unresponsiveness of the health system.

Case 9

Khodala PHC, Taluka Mokhada, Dist. Thane.

Navsu Sajan Rathad, age 65 years, r/o Village Kurlod, taluka Mokhada had diarrohea. On June 7, 2003 after four to five bouts of loose motions he got dizzy, broke into a cold sweat and became semi-conscious. His wife and some other villagers carried him to the Khodala PHC and the wife went to look out for the lady doctor. It was about 5.00 p.m. The wife met the doctor and told her about her husband's condition. The doctor got very irritated and told the woman that her duty hours were over and she was about to go home. She then asked her to move the patient to Mokhada Rural hospital and left the premises. The woman then went to the residences of the three resident nurses and begged them to treat her husband. They refused saying that they were not on duty and the nurse on night duty would attend to him. The nurse on night duty never turned up so once again she went to the houses of the resident nurses. Finally one nurse Ms. Zule took pity and came to the PHC. She gave the patient an injection and administered a bottle of saline. The nurse told them they could not stay in the PHC as there was nobody to attend to them, and she could not stay any longer. Finally the patient was taken to a private doctor, one Dr. Kadav in Khodala. He administered another bottle of saline and asked them to go home and return the next day as there was no facility to admit him. The patient spent a total of Rs. 300 for treatment with the private doctor.

A patient with diarrhoea, requiring rehydration could not get admission in a PHC. The doctor, supposed to be on call around the clock, refused to attend to the patient and no nurse was available to attend to an admitted patient, forcing the relatives to pay for the expensive services of a private doctor.

Case 10

Mokhada Rural Hospital, Taluka Mokhada, Dist. Thane

Mahadu Jivlya Wagh, age 44 years, r/o Village Neelmati, Chinchutara, Taluka Mokhada, fell from a tree on 15/11/03. He was brought to the Mokhada Rural hospital immediately. The doctor admitted him and asked the relatives of the patient to purchase two bottles of saline which were administered to him. They then asked them to shift the patient to Nashik Civil Hospital and informed them to hire a private vehicle as no ambulance was available. The next day the patient was taken to Nashik Civil hospital where he was admitted. The doctors there advised the relatives to take him to a private hospital for a C.T. scan as the equipment in the Civil hospital was out of order. The relatives could not afford a C.T. scan so the patient was discharged after fourteen days and has now become crippled due to lack of proper treatment.

A taluka level Rural Hospital did not have intravenous fluids to be given to a patient with a fracture. No ambulance was available to transport such a needy patient. The Civil

Hospital in a large city like Nashik could not provide the CT scan facility, resulting in a person becoming perhaps permanently disabled due to denial of health care.

Case 11

Nandgaon PHC, Taluka Jawhar, Dist. Thane.

Vimal Yeshwant Zugre, age 25, r/o Thakur Pada, Nandgaon, taluka Jawhar had three fingers crushed while she was pounding rice with a pestle and mortar on 5/11/03 at about 8.30 p.m. Her husband rushed her to the PHC in the same village. The Multi Purpose Worker of Bhuritek who resides in the PHC premises was present. A number of villagers gathered around the PHC. They requested the MPW to open the PHC and give some first aid but he refused. The angry villagers threatened to break the lock, following which he opened the PHC. The villagers then located an ANM attached to the PHC and asked her for help. She too did not administer the dressing, and asked a peon of the PHC to do the dressing. The patient was advised to go to Jawhar or Mokhada hospital. The villagers begged for the vehicle, as there was no other means to transport the patient. The vehicle was refused. Finally the MPW dropped the patient back to her house in the PHC vehicle. The next day the patient was taken to Jawhar Cottage Hospital where her fingers were sutured. She was asked to return after a few days to remove the stitches. She has gone to the hospital on three occasions, but the stitches have not been removed. The patient is still unable to use her fingers.

No doctor was available at a PHC to attend to an injured patient. Neither the MPW nor the ANM obliged to apply a dressing, which was finally done by the peon. Despite a vehicle being available to transport the patient, it was refused.

Case 12

Jawhar Cottage Hospital, taluka Jawhar, Dist. Thane.

Ujwalla Pandu Vad, age 12 years, r/o Village Alivmal, taluka Jawhar went to school on 27/11/03 as usual, after an early lunch at about 10.00 a.m. She vomited three times in school and then came home. She continued vomiting a number of times. At about 7.00 p.m. when her parents returned from work they rushed her to the Jawhar Cottage Hospital. She was admitted in the hospital, given one injection and some tablets but she continued vomiting. Her father requested the nurse on duty to attend to her but she did not pay any heed instead she scolded the parents, saying that the girl was dirtying the hospital. The parents were asked to give her glucose water orally which they administered the whole night. The child could not sleep, she had high fever and she was crying incessantly, however no medical staff came to see her despite several requests. At about 6.00 a.m. the child's stomach began to become distended. Even then no medical staff on duty attended the patient. At 11.00 the doctor came on his routine round, examined her pulse and moved on. The parents requested the doctor to give the child intravenous saline, since she was not able to swallow the glucose water but he did not pay any heed. At about 12 noon the child became unconscious. The father rushed to Dr. Marad and informed him. The doctor asked him to bring the patient to his chamber. By the time they brought the patient to the chamber, she had expired. The doctors then put tubes through her nose and mouth but it was of no use. They then insisted on doing a post mortem to which the relatives took objection, saying what is the use of diagnosing her illness after she is dead. They took the body of the child home without a post mortem examination.

While in the Cottage hospital, the child was in severe distress for over 12 hours, but was not given adequate attention required to diagnose or treat the underlying problem. The child died, and adequate medical attention not being given in time was a likely contributory cause.

Case 13

Washele PHC, Taluka Mokhada and Nandgaon PHC, Taluka Jawhar, Dist. Thane

A one-year old girl, daughter of Kashinath Bhovar, r/o Dhamanshet Pendkyachawadi, Taluka Mokhada, who had rapid breathing and swollen eyes was taken about 6 kms. away to PHC Washale, taluka Mokhada for treatment in the morning. The medical officer was not present. In the afternoon, the peon gave the father of the patient some eye applicabs for application. The father of the patient waited till the evening, but as the medical officer remained absent the patient was taken back to her village. The next day the patient was taken to another PHC another 6-7 kms. away at Nandgaon, where despite the severity of the illness, the child was treated but not admitted, apparently due to non-availability of admission facilities. The parents were however instructed by the Medical officer to keep the child in a neighbouring house to continue the treatment there. The next day the Medical officer left Nandgaon, leaving the PHC without any Medical officer. The child died the next morning, denied of adequate medical attention.

No doctor was available at the first PHC to treat a child patient suffering with pneumonia. At the second PHC the patient was denied admission despite the severity of the case. Here the doctor subsequently left the premises leaving the patient without any medical attention, followed by her death.

In summary, the denial of health care brought forth in the various cases presented was mainly of following types:

- Non-availability of doctor at PHC to treat patients
- Denial of admission of serious patients in PHC
- Non-functioning of "Rescue Unit" when gastroenteritis epidemic spreads, non response of taluka medical staff
- Non-availability of essential supplies like ORS at PHC
- Non-availability of essential life-saving drugs like Antidote to snake and scorpion venom at PHC, Rural Hospital and Civil Hospital.
- Non-diagnosis of diseases like tuberculosis and denial of, or irregular treatment under National Tuberculosis Control Programme and National Leprosy Control Programme
- Referring the patient to higher facility (Rural hospital) even for elementary services such as suturing of an ordinary wound
- Non-availability of child health services.
- Failure of nursing staff to dress a wound
- Refusal of ambulance facilities to transfer patients
- Significant delay in treatment forcing patient to access private medical facility
- Medical negligence by Doctor on duty

Note on unavailability of water in Mokhada hospital

On 5th, 6th and 7th January, 2004 there was not a drop of water available for the patients of Mokhada hospital for drinking and washing. The residential staff on the

premises managed to procure water in a bullock cart for their personal use, but relatives of the patients had to trudge more than a kilometre to the market place with plastic bottles and request for water for the patients, from the local teashops. When an activist of the Kashtakari Sanghatna went to the hospital and asked the doctors to submit a written complaint to the tehsildar, and arrange for a tanker, the doctors refused to do so saying they had to get the permission of the Medical Superintendent. Since the Medical Superintendent Dr. Sabde, is holding the charge of two hospitals in two separate talukas, Jawhar and Mokhada, he could not be contacted. This matter was also raised during the Jan Sunwai, since the Mokhada Rural Hospital is often without water, being on a hill and having no independent water source. Lack of water for drinking or other basic needs is a major obstacle to be overcome by patients.

Summary of responses by officials, discussion on key issues and opinions by panelists

Response by Health officials

The ADHO, Thane and the Medical Superintendent, Jawhar Cottage Hospital responded to some of the issues that were raised. The ADHO, Thane opined that the cases and issues raised were not serious in nature. However, he and the Medical Superintendent admitted that many of the issues were structural in nature, and were related to policy level deficiencies, such as lack of adequate buildings, intermittent water supply, insufficient humanpower lack of vehicles, and lack of doctors. They also pointed out that the provisions for diesel for the vehicle to transport patients is inadequate, and the rates need to be revised. Similarly, they conceded that treatment for anaemia is focussed on pregnant women. They claimed that only deserving patients are referred to higher facilities, and that records are maintained in the various centres, to prove the same. The M.S. also claimed that medical supplies were adequately available, and that immunization programmes were being well implemented.

However, despite the obvious deficiencies in various health centres and the denial of patient care that had been presented, there was no categorical assurance of improvements, and many of the specific issues pointed out were not addressed. This led to some further discussion followed by opinions being given by the panelists.

Discussion on key issues and opinions by public and panelists

Brian Lobo, Convenor, S.J.A. – Strongly objected to the statement by ADHO that the issues raised were not serious. It is improper to pass the entire buck for non-performance on to the higher authorities. While conceding that some matters needed to be handled at the higher levels, many issues raised can be remedied at the local level by the District level officials eg. such as insulting behaviour towards patients, abdication of duty and callousness of medical officers and other staff, cleanliness in health centre premises and siphoning off of essential services and drugs. The officials have not stated as to what action they will take against erring medical staff. Suggested that a meeting with the Andolan representatives be called by DHO to discuss all relevant issues raised.

Dr. Kamakshi Bhate, Panelist – Are medical officers trained in dealing with shortages of essential supplies like snake-bite antidotes?

Response of ADHO – No training received, forced to learn on the job.

Dr. Kamakshi Bhate, Panelist - Illtreatment and derogatory behaviour towards adivasi patients by medical staff must be stopped.

Response of ADHO – It is more a case of non-communication because health staff are not familiar with the local language. training is being evolved for the same. As far as behaviour is concerned. it is an individual matter.

Dr. Chhaya Datar, Panelist – People prefer to approach private doctors. this points to inadequacies in the public health system.

Response of M.S. Jawhar Cottage Hospital – We have less doctors and many more patients. hence are unable to give adequate attention to individual patients. It is not always possible to state what action will be taken against errant staff. some things are best left unsaid.

Dr. Dravid - Private medical practitioner visiting from Pune - Considering the status of the Public Health facilities . if I were to set up private practice in Mokhada I would have a prosperous future as everyone will flock to me. I have also worked in the government set-up. Private doctors are accountable to their patients since non-delivery of services results in fall in patients. However government doctors are not accountable or concerned about drop in patients. Medicine is not a depersonalized profession devoid of ethics and attitudes.

Justice B.G. Kolse Patil – The economy is being influenced by World Bank, hence the interests of the poor are being ignored. One should not expect too much from this health system. It is therefore necessary to revitalize traditional health practices and systems.

However, the state of the public health system is absolutely deplorable. The report and the case studies presented exemplify this. He strongly condemned the insensitive and inhuman treatment meted out to adivasi patients. He urged the people to organise themselves and demand services, and if necessary to resort to gheraoing of doctors and even elected representatives if they fail to deliver the goods. He also suggested to the ADHO that a meeting with the Andolan representatives should be immediately called by the DHO to discuss all relevant issues raised.

Conclusions and Recommendations

A. Coverage and infrastructure

1. Increase in number and upgradation of PHCs to conform to population and six-bed norms.
2. Upgradation of all newly commissioned Rural Hospitals eg. Vikramgad RH.
3. Construction of commissioned PHCs eg. Aase (Mokhada taluka), and sub-centres.
4. All non-functional essential facilities and equipment at PHCs and Rural Hospitals to be made operational eg. minor OTs in PHCs, X-Ray machine at Mokhada Rural Hospital.
5. Strict implementation of sanitation norms at all medical centres

   Immediate provision of water facilities at all PHCs and Mokhada RH.

   Construction of toilet facilities in every PHC.

   Regular cleaning of premises of PHC and other medical centres.

B. Staffing pattern and facilities for staff

1. Filling up of all vacancies in all medical centres, especially vacant doctors' posts.
2. Provision of staff to newly commissioned Rural Hospitals eg. Vikramgad.

3. Appointment of woman medical officers in every PHC or weekly visits by gynaecologist.
4. Provision of adequate housing facilities at PHCs and sub-centres for staff.
5. Regular visits as per Advance Tour Programme by ANMs and MPW's to villages.
6. Regular weekly doctors' clinics at all sub-centres.

C. Services

1. Provision of 24 hour delivery services at every PHC.
2. Provision of facilities to perform safe MTPs in every PHC.
3. Proper diagnosis and regular treatment of cases under the National Programmes.
4. Inquiry into alleged siphoning off of drugs from PHCs, RHs etc.
5. Re-imbursement to patients for expenses incurred on essential drugs and other items that are to be available at medical centres as per norms.
6. Provision of iron tablets to non-pregnant anaemic women patients.
7. 24 hour availability of free Ambulance with driver at every medical centre.
8. Changes in OPD timings to suit local needs eg. 9 a.m.to 3 p.m. in Mokhada RH.
9. Sterilisation of all equipment used wherever not done eg. Nandgaon PHC.

D. Monitoring of services

1. Immediate inquiry into and strict action against all staff against whom complaints of callousness, discrimination against adivasi patients, abdication of duty, demanding of monetary payments etc. are lodged.
2. Institution of Calendar Public Register Programme in all villages to ensure regular visits by all PHC staff.
3. Regular (quarterly) PHC level, Rural Hospital and District level meetings between village and peoples' organisations' representatives and health staff.

MOHAN FOUNDATION

Liver Patient Support Group

Date: 1 July 2004

To,
The Panelists.
NHRC, Public Hearing

Sub: Covering letter and background of the petitioner.

Dear Sir or Madam:

I am a 37-year-old woman suffering from end stage liver failure disease and waiting for cadaver liver transplantation for last 5 months. One year before, I came to know that the only solution, which could give me an extra lease of life, is cadaver liver transplantation. In my own interest and in the interest of other end stage organ failure patients in the same situation, I started working as a volunteer of MOHAN (Multi Organ Harvesting Aid Network) Foundation in Pune.

For the last one year, we as a group are interacting with relevant government officials and concerned doctors and thereby experiencing the various hurdles in the process of cadaver organ donation. Fortunately, we could make significant contribution towards one successful multiorgan cadaver donation in Pune where the liver was shared with one of the hospitals in Andhra Pradesh for a very critical patient. There were also a few unsuccessful attempts.

Our efforts have given us a good insight in to the various problems in this field. The practical experiences gained in the fieldwork prompt us to make this petition. It is a great opportunity for us to present this petition to you where we have mentioned all the issues and proposed legal and structural policy changes.

Looking forward to interact with you.
Thank you,
Yours truly,

Nayan

Nayan Dhamdhere
Member-in-charge
Enclosure: Petition document with annexure (2+1=3 pages), News paper article

Liver Patient Support Group, MOHAN Foundation
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nndhamdhere @ hotmail.com

MOHAN FOUNDATION
Liver Patient Support Group

Date: July 1, 2004

PETITION

(Document to be forwarded to the NHRC, 3 pages)

Across the country, there are thousands of end stage organ (kidney, liver, heart, lung, pancreas) failure patients. Many of them are waiting for organs for transplantation. Every year, hundreds of them die due to unavailability of organs on time. The most ethical way of getting the organs for them is by cadaver organ donation (donation of vital organs of a brain dead person).

Majority of these end stage organ failure patients suffer from denial of their right to get the cadaver organs on time and do not receive mandated help in this regard from the medical fraternity and concerned government health officials, mainly due to the legal and structural deficiencies. The issues are listed down as follows.

1. Brain deaths are often not diagnosed or diagnosed late by the local teams of treating doctors (neurologists, neurosurgeons, critical care doctors and intensivists).
2. The families of brain dead persons are not informed immediately after the occurrence of brain death. In most of the cases they are not counseled about brain death and also are not given a chance to select the option of donating the vital organs of their cadaver before terminating the ventilator.
3. Majority of the hospitals either do not have infrastructure for brain death and organ donation counseling or often the counselors are not well trained. Hospital managements and social work departments are often reluctant to allow volunteers of NGOs to enter in to the brain death situations for counseling and other coordination work. They are kept away by maintaining unnecessary secrecy.
4. The law allows only the hospitals, which are registered transplant centers to retrieve cadaver organs. These are very few in number and whilst there are hospitals, which do not have their own transplant programs but nevertheless fulfill the basic requirements for organ retrieval and are willing to support the cadaver organ donation program. The cadaver organ donation program needs the support of these hospitals, as there is a large scarcity of cadaver organs. The alternative option of moving the brain dead cadaver on ventilator to a registered retrieval center, is in practice very difficult, adds to the distress of the donor family and there is a further risk of loosing the cadaver and thereby the invaluable cadaver organs.
5. The hospitals that are recognized and registered as transplant centers show interest in counseling for and retrieval of only the organs in which they are interested. They do not care to counsel for other organs (multiorgan) as they do not think of sharing the other organs with others hospitals, cities or states. It is an extremely selfish and irresponsible approach, as the cadaver organs wasted are lives lost.
6. The end stage organ failure patients are counting down their lives minute-by-minute, hour-by-hour and day-by-day. At the same time the relevant medical fraternity and the relevant government departments do not understand the importance of time to take the policy decisions. They delay the process by pointing out to the lacunae in the laws, rules and regulations that are often misinterpreted.

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In reality, cadaver organ donation program is the only way to overcome malpractices like organ trade and scandals in the field of organ transplantation. There are many doctors and hospital managements who in principle agree with the cadaver organ donation program and wish to support it in earnest. But are reticent to do so for want of acequate legislative enactments (support) as they fear allegations of malpractice from the public. other hospitals and media.

We pray and plead that the following changes be made in law and policies.

1. Diagnosis and first brain death declaration on time should be made mandatory for the local team of doctors. Likewise it must also be mandatory for the government authorized committee to be available round the clock on call to visit the donor hospital and certify brain death (Second brain death declaration) on time. Records should be maintained.
2. Brain death counseling should also be made mandatory thereby provicing the family with the option of cadaver organ donation. Records should be kept.
3. The counselors should counsel for multiorgan donation and provide correct information about all the organs that can possibly be donated. If there is lack of manpower or any other difficulty in counseling, Relevant NGO workers should be allowed to assist in counseling and coordination. (Records)
4. All those hospitals which fulfill the basic requirements for being a multiorgan retrieval center should be registered and be given the permission to retrieve the cadaver organs instead of expecting the cadavers to be moved to a transplant center.
5. The transplant centers must share the organs with the other hospitals, cities and states if they are not having their own transplant program for that particular organs. This sharing can be achieved by networking of all organ-procuring agencies in the country. Records should be maintained.
6. The concerned medical fraternity and the government health officials must become proactive and take fast decisions and prepare quick protocols for promoting the process of cadaver organ donation. We must realize that organs wasted are lives lost and time wasted reduces the success rates of transplantations that are otherwise miracles in the modern medicine giving new lease of quality life to the end stage organ failure patients.
7. Government health department and hospital managements should take initiative in public education about cadaver organ and tissue donation and enthuse other hospitals and doctors in their jurisdiction to support the cadaver organ donation program.
8. Recorded statistical information must be shared with NGO & public

As an NGO and a patient support group dedicated towards the noble cause of cadaver organ donation, we expect proactive actions from the NHRC regarding these issues and look forward to the process of change in law and policies. We request you to help end stage organ failure patients suffering from denial of right to get the cadaver organs and the families of brain dead patients who should not be denied the satisfaction, solace and comfort to be had from donating the organs of their loved ones due to legal and structural deficiencies.

Nayan Dhamdhere.
Nayan
Member in – charge

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Annexure

Why declare the brain death?

"It is agreed that permanent functional death of the brain stem constitutes the brain death and that once this has occurred further artificial support is fruitless and should be withdrawn. It is good medical practice to recognize when brain death has occurred and to act accordingly, sparing relatives from the further emotional trauma of sterile hope."

Source: Brain stem death; Information for healthcare professionals; Written and Produced by the UK Transplant Coordinators Association

Why ask (counsel) for cadaver organ donation?

"We know from past experiences and research that the act of donation can actually help the family. They can feel comforted through the knowledge that they have given hope to others. Donation may be the one positive thing that can come out of an otherwise tragic situation and the family should always be given this option."

Source: Approaching the family; Information for healthcare professional; Written and Produced by the UK Transplant Coordinators Association.

NOW YOU KNOW! .....

Transplants are modern miracles. It only happens because people care about people and share these priceless gifts.

Source: Be a part of something good; A public service publication from – South Carolina Organ Procurement Agency, Inc.

Required request

A policy of "required request" or required referral is operated in the United States. Required referral is defined "that it shall be illegal, as well as irresponsible and immoral to disconnect a ventilator from an individual who is declared dead following brain stem testing without first making proper enquiry as to the possibility of that individual's tissues and organs being used for the purposes of transplantation".

The policy means opportunities for donation are less likely to be overlooked. Many individuals may be having their right to donate removed if their relatives are not approached. The next of kin also have a moral and legal right to know they can donate organs and tissue if they or the family so wish. Many families report that such a donation was helpful rather than harmful.

Source: UK transplant website.

Road I Pune- 411001 I India I E-MAIL: punenewsline@expressindia.com & letters-pune@expressindia.com I Phone: 26131541-6 I Fax: 26131547

PUNE I TUESDAY I MARCH 2, 2004 | MOONSET 0328

She lives in their eyes, liver & kidney

LIVERAGING HOPE I Family of 28-year-old who died of thrombosis donates her organs

EXPRESS NEWS SERVICE
MARCH 1

REKHA Sardar's little daughters wail every night, crying out for their mother. Helpless, their father tries to console the children who fail to come to terms with their mother's death.

Rekha (28) died of painful thrombosis. But she continues to live even today — in someone's eyes, kidneys and liver. She gave a lease of life to five people through organ transplant.


Rekha Sardar

Rekha's cadaver liver was retrieved in Pune and transplanted on a patient in Hyderabad after a rare liver extraction operation was performed at Ruby Hall Clinic recently. What was remarkable was the accuracy and speed with which the operation was performed. Even before obtaining a sanction for the transplant from the Directorate of Health Services, a group of dedicated liver patients from the Multi Organ Harvesting Aid Network (MOHAN) swung into action to motivate the deceased's family to donate the organs.

Raghu Ram, whose son died died a while back, tried to convince Rekha's family. "I told them how my son's eyes went to an eight-month-old infant and a four-year-old child. His kidneys and liver were also donated."

Wiping away his tears, Rekha's father R Sandanshiv says at first he did not understand the meaning of the term 'brain dead'. "But they told me that Rekha would continue to live and so I couldn't refuse them." Hence, Rekha's body was shifted to Ruby Hall Clinic and on seeing the potential of a cadaver liver transplant (the extraction of an organ from a deceased body for transplantation to a needy patient), Dr Sheetal Dhadphale did her bit to get a team of liver transplant surgeons trained at King's College Hospital, UK to be flown from Global Transplant Hospital, Hyderabad for the operation.

The team extracted the liver and kidney and flew back with the liver to Hyderabad, implanting it in the needy patient.

Both the kidneys and liver were transplanted in the bodies of three end-stage organ failure patients while the eyes were retrieved and donated to two others.


The team who performed the cadaver liver transplant

EXORBITANT, BUT THERE'S HOPE

THERE are barely four or five transplant centres in India and the cost of a transplant is Rs 25 lakh upwards. Keeping this in mind, a group of liver patients and doctors have formed a support group to create awareness about cadaver organ donation. They share success stories with patients and their relatives and provide accurate information about liver transplantation.

'लक्ष शून्यातूनि काही श्रेय आकारत आहे..'

असा अनुभव देणारं माणसकीचं दान काही माणसांनी पुण्यात दिलं. तसं पाहिलं तर ते दान अवयवांचं होतं. सभोवतालच्या गर्दीत कुठंतरी 'माणूस' आहे, असं आश्वस्त करणाऱ्या या घटनेविषयी, आजच्या 'महाराष्ट्र अवयवरोपण दिना'निमित्त....

इघन व (कै.) रेखा सरदार, प्रणिती (डावीकडील) व प्रचिती या मुलींसह. -

दीनदयाळ वैद्य \ सकाळ वृत्तसेवा

कोणी घडलेल्या गोष्टी पाहतो अन् 'का? कसं?' विचारतो
पूर्वी कोणी कधीच न पाहिलेली स्वप्नं मी पाहतो....
अन् 'का नाही?' असं स्वतःलाच विचारतो...

जॉर्ज बर्नार्ड शॉ

माणुसकीचं दान

जगावेगळी घटना! किती सहज म्हणतो आपण! पण त्यात जगावेगळं काय असतं? ती घटना, की ती माणसं, ज्यांच्यामुळे ती घडली, ज्यांनी 'का नाही' हा प्रश्न स्वतःला विचारला?

पुण्यात काही दिवसांपूर्वी 'ब्रेन डेड' तरुणीचे पाच अवयव काढून घेऊन त्यांचे रोपण अन्य रुग्णांवर करण्याची शस्त्रक्रिया झाली. रोपणासाठी यकृत काढण्याची तर ही पुण्यातील पहिलीच शस्त्रक्रिया. वैद्यकशास्त्राच्या दृष्टीने या घटनेत विशेष काहीच नाही; पण तरीही ती विशेष आहे!

दोन गोजिरवाण्या मुली आणि सालस पती असलेल्या रेखा सरदार या विवाहित तरुणीवर मेंदूतील रक्त गोठण्याच्या विकारामुळे पुण्यातील लोकमान्य रुग्णालयात उपचार सुरू होते. रेखा फार दिवसांची सोबती नाही, हे सर्व नातेवाइकांना समजलं होतं. तसंच झालं. मेंदूतील पेशी मृत झाल्यानं रेखा 'ब्रेन डेड' असल्याचं मेंदूविकार तज्ज्ञांनी जाहीर केलं. वैद्यकशास्त्रात याला 'क्लिनिकल डेथ' असं नाव आहे. मेंदूतील पेशी मृत झाल्या, तरी कृत्रिम श्वसनाद्वारे त्या शरीराचे अंतर्गत अवयव विशिष्ट मर्यादेपर्यंत कार्यरत राहू शकतात. रेखाच्या नातेवाइकांवर आभाळच कोसळलं होतं. त्या मनःस्थितीत देहदानाचा विचार त्यांच्या मनात येणं शक्यच नव्हतं. (पान १० पाहा)

(पान १ वरून)

लोकमान्य रुग्णालयाचे प्रशासक रघुराम यांना हे सगळं माहीत होतं. त्यांनी तातडीनं 'मोहन फाउंडेशन' या स्वयंसेवी संस्थेचं काम करणारे राजन ढमढेरे व त्यांच्या पत्नी नयन ढमढेरे यांच्याशी संपर्क साधला. स्वतःच्या मुलाचा अकाली मरण पावल्यानंतर रघुराम यांनी स्वतःला सावरून त्याचा देह दान केला होता. रेखाचे पती इघन सरदार आणि वडील राजाराम संदनशीव यांनीही तेवढ्याच धीरोदात्तपणे रेखाची दोन मूत्रपिंडे, दोन पारपटल (कॉर्निया), यकृत असे पाच अवयव दान करण्यास होकार दिला.

यकृतारोपणाचे अग्निदिव्य

आता डॉक्टरांची परीक्षा होती. मूत्रपिंडरोपणाच्या शस्त्रक्रिया जितक्या सहजपणे होतात तितक्या सहजपणे यकृतरोपणाची शस्त्रक्रिया संपूर्ण देशात होत नाही. यकृत काढण्याची परवानगी लोकमान्य रुग्णालयाकडे नाही. रघुराम यांनी तातडीनं रुबी हॉल क्लिनिकशी संपर्क साधला. त्यांनीही त्वरेनं होकार दिला. मधल्या वेळेत 'रुबी'नं डॉ. शीतल घडफळे यांच्याशी संपर्क साधला. डॉ. शीतल यांनी लंडनच्या किंग्ज कॉलेजमधून यकृतरोपणावर फेलोशिप केली आहे. पण यकृत काढलं, तरी ते रोपण करण्यासाठी रुग्ण कुठं होता? अवयवांच्या रोपणावर देखरेख ठेवण्यासाठी सरकारनं विभागीय अवयवारोपण समन्वय समित्या घनविल्या आहेत. अवयवांची गरज असलेल्या रुग्णांची यादी या समित्यांकडे असते. मात्र, यकृत हवं असलेल्या रुग्णांची यादी या समितीकडे नव्हती. डॉ. शीतल म्हणाल्या, "हैदराबादच्या 'ग्लोबल हॉस्पिटल्स'मध्ये एका रुग्णाला यकृताची गरज आहे, हे मला माहीत होतं. मात्र यकृत हैदराबादला देण्यात एक अडचण होती. रोपणासाठी यापूर्वी राज्याबाहेर अवयव पाठविण्यात आला नव्हता. मी राज्याचे आरोग्य उपमहासंचालक डॉ. डोके यांच्याशी संपर्क साधला. त्यांचा होकार मिळताच 'ग्लोबल'शी संपर्क साधून तेथील सर्जनना बोलावून घेतलं."

रोपणासाठी शरीरातून अवयव काढल्यानंतर त्यातील पेशी जिवंत राहाव्यात, म्हणून तो एका विशिष्ट द्रावणात ठेवण्यात येतो. तरीही प्रत्येक अवयव व्यवस्थित राहण्याचा वेळ (cold ischaemic time) ठरलेला आहे. यकृतासाठी हा वेळ चौदा तास आहे. डॉ. कपिल झिरपे, डॉ. ए. जी. हपसीकर, डॉ. यंदे, डॉ. देशपांडे आणि हैदराबादच्या सर्जननी तीन तासांच्या गुंतागुंतीच्या शस्त्रक्रियेनंतर रेखाचे पाचही अवयव काढले. यकृत तातडीनं हैदराबादला नेऊन तिथं त्याचं गरजू रुग्णावर रोपण करण्यात आलं. दोन मूत्रपिंडं आणि दोन पारपटलं पुण्यातील रुग्णांना देण्यात आली.

भारतात यकृत रोपणाच्या फक्त ७० शस्त्रक्रिया झाल्या आहेत. असं का? डॉ. घडफळे म्हणाल्या, "आपल्याकडे 'ब्रेन डेथ'चे प्रकार बऱ्याचदा घडतात. रस्त्यांवरील अपघातांत डोक्याला मार बसून अनेकांचा मृत्यू होतो. तेही 'ब्रेन डेथ'चेच प्रकार आहेत. मात्र अवयव दानाचा विचारच नातेवाईक करीत नाहीत. रुग्णालयांतील अतिदक्षता विभागांनी चांगला समन्वय ठेवला, तर ते शक्य आहे."

'मी जगेन...कायमचा....'

नेमकं हेच काम 'मल्टी ऑर्गन हार्वेस्टिंग' या नेटवर्क (पान ४)

माणुसकीचं दान

हे सगळं ज्यांच्यामुळे घडलं ती सरदार व संदनशीव कुटुंबं आदी साधी आहेत. (कै.) रेखा व इघन सरदार यांना प्रचिती (वय ११) व प्रणिती (वय ८) या गोंडस मुली आहेत. इघन भोसरीत तुटपुंज्या पगारावर ग्राईंडर म्हणून काम करतात. रेखाचे अवयव दान करण्याविषयी ढमढेरे व रघुराम पहिल्यांदा बोलले, या कुटुंबांचे स्नेही पंडित बावीस्कर यांच्याशी. डॉ. बाबासाहेब आंबेडकर यांचे शरीररक्षक पीतांबर बावीस्कर यांचे पंडित हे चिरंजीव. ते म्हणाले, "डॉ. बाबासाहेबांचे संस्कार आणि बुद्धाच्या तत्त्वज्ञानामुळे रेखाच्या अवयवांचे दान करण्याचा विचार मला पटला. इघन आणि रेखाच्या घरातल्यांनीही धीरोदात्तपणे संमती दिली." पत्नीविषयी सोगताना इघन पोटा गेला दाटून आला होता. ते म्हणाले, "रेखाचा अंश पार्थिव जगण्याच्या रूपाने या जगात राहणार, याचंच समाधान होतं. तिच्या डोळ्यांतून कोणी तरी हे जग पाहत आहे."

मरणदुःख शीतल करण्यासाठी स्वतःचे दुःख बाजूला ठेवणाऱ्या या माणसांना एकच शल्य आहे. रेखाचे अवयव ज्यांना देण्यात आले, त्या व्यक्तींविषयी त्यांना कळलेले नाही. आईचे डोळे दोघा मुलींना डोळे भरून पाहायचे आहेत, तिचा अंश पाहायचय... पण ते शक्य नाही! कारण अवयवरोपणासाठीचे नियम, अवयव कोणाला दिले याची माहिती गोपनीय ठेवण्याची तरतूद सरदार कुटुंबीयांच्या एका साध्या मागणीच्या आड येत आहे.

बावीस्कर यांच्या घरातील फळ्यावर लिहिलेले एक वाक्य सगळ्यांचे सार आहे... If life gives you thousand reasons to cry, then you show, you have million reasons to smile.

फाउंडेशनच्या माध्यमातून ढमढेरे पती-पत्नी करीत आहेत. नयन ढमढेरे या स्वतः यकृताच्या विकाराने त्रासलेल्या आहेत. त्यातून आलेलं नैराश्य झटकून दोघं देहदानाचा प्रचार करीत रुग्णालयांतून फिरतात. अनेक रुग्णालयांनी सुरवातीला त्यांना दारातही उभं केलं नाही. पैसे घेऊन श्रीमंतांसाठी काम करत असल्याचे घाणेरडे आरोपही त्यांनी सहन केले. भित्तिपत्रके, कवितांच्या माध्यमातून ते अवयव दानाचा प्रचार करतात.

त्यांच्याकडील एक कविता फार सुंदर आहे. "माझे डोळे देऊन टाका, हृदय, मूत्रपिंड, यकृत दान करा. आम्ही उपयोगी असतील ते घेऊन, स्वायूही घ्या; असं सांगत कवी म्हणतो,

"काही उरलंच माझं, तर त्याची
राख करून वाऱ्यावर फेका,
काही जाळायचंच असेल तुम्हाला
तर माझे दोष, त्रुटी जाळो;
माझ्या मनात असलेल्या
आळो, गैरसमज जाळो;
माझी पापं सैतानाला द्या
अन् आत्मा परमेश्वराला
मी म्हटलं तसं केलंत तर मी
जगेन....कायमचा...."

MOHAN FOUNDATION
Liver Patient Support Group

July 28, 2004

Rejoinder

In reality, cadaver organ donation program is the only way to overcome malpractices like organ trade and scandals in the field of organ transplantation. There are many doctors and hospital managements who in principle agree with the cadaver organ donation program and wish to support it in earnest. But are reticent to do so for want of adequate legislative enactments (support) as they fear allegations of malpractice from the public, other hospitals and media.

We pray, plead and suggest that the following amendments be made in law and policies.

1. A local representative from NGOs like MOHAN FOUNDATION should be included in ZTCC so as to implement Multi–Organ retrieval and Transplant program for the region, in a true spirit.
2. Local ZTCC should have balanced (& dynamic in time domain) structure of all concerned Medical discipline' representatives; relevant to the various organ Transplant. This is again to implement Multi–Organ retrieval and Transplant program for the region, in a true spirit.
3. In case of **unclaimed cadaver** (Brain–Death) , whether in mass disaster situation or in individual accident case, over a period of 36 Hours after the declaration of brain-Death for a particular case, Local ZTCC should be empowered to retrieve the relevant organs for the benefits of the suffering patients. In such situation, the Cadaver maintenance expenses should be borne by the state, as unclaimed cadavers are the national resource or the national property. Any claim on the death body and subsequent denial to donate the organs, by the concerned claimants, after the elapse of **36 hours** from the declaration of brain- death; should legally be overridden.

As an NGO and a patient support group dedicated towards the noble cause of cadaver organ donation, we expect proactive actions from the NHRC regarding these issues and look forward to the process of change in law and policies. We request you to help end stage organ failure patients suffering from denial of right to get the cadaver organs and the families of brain dead patients who should not be denied the satisfaction. solace and comfort to be had from donating the organs of their loved ones due to legal and structural deficiencies.

Prashant P. Joshi.
July 29, 2004 @ Bhopal
Member – in – charge .MOHAN FOUNDATION Nagpur.

Nayan Dhamdhere
Member-in-charge, MOHAN Foundation, Pune

Liver Patient Support Group. MOHAN Foundation
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Com H-37.8

GOA CASES OF DENIAL OF HEALTH CARE

On 11/7/2004, Mrs H (name changed) went to Chicalim Cottage Hospital complaining of pain in her abdomen. The doctors at CCH referred her case to Goa Medical College (GMC) for surgery, as they did not have the proper facilities and equipment to handle her case. She was then admitted to Ward No 106 at the GMC and was diagnosed as having fluid in her stomach. As she required surgery, the ELISA test was done. After her results tested positive, the doctors were unwilling to perform surgery and instead have been keeping her on drips. As on 23/7/04 she is still in hospital without surgery having been performed.

On 2/7/2004, Ms Mahadevi who is an orphan was admitted into TB Hospital Margao due to severe cough and chest pain. Sputum tests conducted revealed signs of activated tuberculosis. On 14.07.2004, following her discharge the doctors issued her a prescription to purchase Rifompicin, Ehambitol and Septromycin (Injectable), drugs that should have been made available as part of the National TB programme. Being poor, she could not afford the drugs and had to be referred (by a social worker) to an NGO run shelter for the medicines.

NB: We have two more similar incidences reported for the same hospital and three for TB Hospital, Taleigao about non-availability of drugs and prescription for their purchase issued to the clients.

At GMC, Mrs S (name changed) who was diagnosed and admitted for meningitis was put on drips due to her severe and weak condition. Being HIV positive, improper treatment was meted out to her. Her drips were adjusted for "slower speed" to maintain as minimal contact as possible. On 13.07.2004 following her discharge, it was reported by a social worker that the scalp vein used to administer drips was still intact on her forearm. The social worker then referred the case to a care home for PLHIV were she was promptly attended to.

In October 2002, a commercial sex worker was referred to the STD Clinic, Baina (located in the red light area) for diagnosis and treatment. She was accompanied to the clinic by a peer educator from one of the local NGOs at 11.00pm. At the doctor was not present, they decided to await his arrival. The doctor (male) did not turn up that day and was also reported as being regularly absent from his duties during official working hours. As a result of this, the sex worker had to be referred to a private doctor to seek timely treatment for her worsening condition.

As a result of regular absenteeism and discrimination against sex workers at the STD clinic, an NGO working in the area established a free medical services clinic for the sex workers and the community.

In May 2004, Ajay, a 6yr old orphan staying in a care home for children was taken to GMC after a bout of severe coughing. The doctors diagnosed him as having TB. On his discharge, the doctors gave him a prescription for the purchase of Rifompicin and Ehambitol. When he along with the "guardian" went to the pharmacy to collect the drugs,

they were informed that the stock was over and that they would have to purchase the drugs themselves. The caretaker of the children shelter than had to seek donations to purchase the required drugs for Ajay.

On 02.09.2002, Mr John Gonsalves was admitted to the Goa Medical College with complaints of vomiting, fever and blurred vision. On developing breathing problems, he was transferred to the intensive care unit of the hospital. Due to non-availability of a ventilator (all machines were in use), he was kept on hold. The doctors than told the parents to hire a ventilator from a private hospital. When the ventilator was brought, the doctors declined to use it and preferred to opt for artificial respiration with the help of a hand manned pump that was inserted through the larynx. This continued on for approximately 16- 18 hrs after which he was put on a ventilator on the 4th of Sept. Also during the time he was in GMC, the doctors told the family to conduct a series of expensive tests that were not available at the GMC or in Goa. Costs to transport and test samples of Cerebro spinal fluid (CSF) and another to tests various microorganism had to be borne by the family. This not only resulted in additional expenses but also in delayed diagnosis to discern the cause of infection and to seek timely treatment. His final report stating cause of infection due to Enthrovirus arrived only after his death on 11.09.2002.
Additional costs borne by parents for services that were unavailable, insufficient infrastructure to deal with intensive care cases, lack of proper testing facilities resulting in delay in diagnosis of cause of infection.

In September 2003, Ms PD a person living with HIV who was prescribed ARV (anti-retrovirals) was required to do a CD4 test to determine her CD4 cell count prior to her commencing therapy. GMC being the only place providing CD4 facilities in Goa at a subsidised rate of Rs 500.00 she was shocked to discover that the machine was not working (had not been working for the past one month). As it was imperative for her to commence ARV due to her deteriorating condition, she went to Bangalore to do the test where she had to pay Rs 1800.00. In the following year January-February 2003, she accompanied two other persons to GMC to do the CD4 test only to find out that the machine was still not repaired.
Non availability and lack of concern to repair essential equipment resulting in outside investigations.

RECOMMENDATIONS

1. All essential drugs to be stocked at all government hospitals and to be provided free of charge.
2. The government should provide free ARV therapy to persons living with HIV.
3. The GMC should purchase another CT scan .
4. All hospital equipment should be serviced regularly to avoid breakdown. Other essential testing equipment and sophisticated labs have to be incorporated into the current hospital set-up so as to negate the need for sending samples for testing out of state.
5. The number of beds in the intensive care unit to be doubled. The district hospitals at Hospicio, Margao should be improved and provided with increased facilities so as to avaoid over dependency on the GMC.
6. Taking into account the various National Health programmes being implemented, all drugs should be made available free and regular stock monitoring ensured.
7. The facilities at the PHC's have to be improved. Despite having a good health care system, the PHC are understaffed, have no doctors and lack the basic amenities.
8. Prompt treatment to be given to all persons irrespective of their HIV status.
9. ***Universal precaution kits be made available in all hospitals for health care workers.***

Cases of denial of basic health care in Madhya Pradesh

Health for all by 2000, health as a basic right seems to be mere a slogan when we look at the status of health at the village level. Even elementary, primary health-care is not available. On the basis of the protocol prepared at the national level, we have documented these cases from Barwani district of denial of basic health care.

Women's health care

Case No 1-

M is a 30 year women residing in A village of B district. She was persuaded by Anganwadi worker to undergo Laparoscopic Tubectomy (LTT) operation. She has 8 children and went to the camp only get a checkup regarding fitness to undergo the LTT operation. But in the camp she was not only told that she is fit to undergo LTT operation but also was immediately operated **even though she had been 3 months pregnant** and she had specifically told then that she has missed her cycle for 3 months (on 4/5/04). There was no kit for testing pregnancy and no ultrasound machine in the camp. She was also discharged the same day.

In her village there are few more women who have had children after LTT operation and the entire village is now afraid to undergo an LTT operation.

TYPE OF DENIAL:

1. Gross negligence by the health staff.
2. Non availability of the essential simple test required for detection of pregnancy.

CONSEQUENCES OF DENIAL

Extreme financial Loss on account of bringing up a 9th Child.

Case No-2

The only family planning service that is mostly provided in the PHC is tubectomy. It is generally conducted in overcrowded camps held occasionally by the government at the PHCs. The main aim of doctors and ANMs in these camps is to fulfill the set target and therefore the operations are often done insensitively and in unhygienic conditions. No attempt is made to explain to the women what is being done to them. Often women from the interior villages are forced to walk long distances to get home the same day.

In one of these types of camps, Ms. M, a 30 year old women from K village, went to the family planning camp held at So PHC in So block. After her operation, which was conducted in overcrowded conditions, she returned home the same day. A week later she went to the PHC to get the stitches removed and returned home the same day. Two days later she developed severe abdominal pain and was admitted to the civil hospital in Al. Here she was diagnosed with tetanus and was also told that treatment will not be possible in that hospital and she would have to be taken elsewhere. Since the family did not have the money for further expenses they took her back home where she died three days later.

Here is a case of gross negligence by the government health facility and reflects the obsession of its personnel to fulfill their agenda and targets rather than provide quality health services. Also there is denial of health care and extreme insensitivity when she was detected to have developed. Tetanus, they simply referred her case abdicating themselves of all moral responsibility of a heath care provider.

TYPE OF DENIAL-

1. Negligence of the health staff leading to the deadly Tetanus to a patient.
2. Non–availability of the treatment for tetanus in a civil hospital.
3. Unavailability of transport facility to refer the patient to higher facility.

CONSEQUENCES OF DENIAL

Death

Communicable diseases-

Case no 3-

M 23 years is a old of D village of B district. He was suffering from body ache. fever and blood in sputum. He was treated for 9 months for T.B. by private doctors and incurred large amount of expenditure but no improvement occurred. He was referred to B district hospital. where again he was put on anti-T.B. treatment without any sputum examination and referred to PHC, S for collecting medicines where all his investigations were again got done from private hospital. He paid money to the government doctor and he was given T B treatment for 6 months. All this while his symptoms did not change at all. He is a poor man but incurred a total expenditure of Rs. 26,000 in 2 years. He has mortgaged his 3 acre land & pawned all his wife's jewellery to pay for his medical treatment. He visited 8 doctors (Pvt and Govt.) in all but now he has no money left and no will to fight with the health bureaucracy.

TYPE OF DENIAL:

1. Patient referred outside for doing basic investigations.
2. Medicines not available & he was asked to replace the medicines used for the patient during his stay in the hospital.
3. The Health Department was insensitive.

● CONSEQUENCES OF DENIAL

Extreme financial loss and risk from a killer disease.

Case no 4

H is a 45 year old man of village L (J) having problem of cough with blood in sputum. Initially treated at PHC & later referred CHC where he was diagnosed as patient of TB on the basis of sputum and X-ray examination. He was given anti-T.B. medicines for 1 month, but thereafter had to discontinue the treatment because of non availability of medicines in the CHC. For next 1month he visited the CHC a number of occasions but did not get the medicines, Since his symptoms became worst he visited a number of private hospitals in Gujarat, He had to sell off his wife's jewellery, his goats; mortgaged his land. The high expenditure of private treatment broke his back. Left with no money, he again came back to CHC, P. But here again he was refused treatment saying he has no problem.

TYPE OF DENIAL:

1. Medicines not available even at CHC for TB.
2. Negligence of the health staff.

● CONSEQUENCES OF DENIAL

Extreme financial Loss and risk to life due to lack of treatment.

Child health problems-

Case no 5-

R is two and half years old child of Mr. V of village D of a block of Badwani district,M.P. He had fever & vomiting for which he was taken to a private doctor for two days. Later because of no improvement, he was taken to G PHC where after treatment of 2-3 days he developed dropping of the left eyelid (pitosis). He was referred to CHC, P where was treated by the doctor for 5 days, By this time the child had developed rigidity of limbs, and the doctor gave eye drops & ointment for rigid mussels for massage. He even took treatment from Jan Swasthya Rakshak of P block, He was finally referred to Badwani District hospital. Here no proper treatment was given to the child even though he

remained there for 8 days. Since condition of his eye worsened, he was asked to get admitted to the eye ward. Child was taken to eye department again;The eye doctor without treating him referred him back to the Pediatric department. He was again kept in the Pediatric department for 6 days & his both eyes became infected. When his father protested he was referred to a private eye doctor.
From the prescription of private eye doctor (Part of case record) it is clear that the child had developed complete paralysis of all the mussels of both eyes (complete opthalmoplegia) and very little could be done to save his eye sight.
After seeing the prescription of private eye doctor the hospital instead of treating him, immediately discharged the child.The unfortunate child became blind for life due to continued denial of health services at the all levels (Jan swasthya Rakshak, PHC.CHC.District hospital)

TYPE OF DENIAL:

1. Continued denial of health services at the all levels (Jan swasthya Rakshak. PHC.CHC.District hospital) for a serious eye condition.
2. Negligence of the health staff.

CONSEQUENCES OF DENIAL

1. Permanent damage leading to a major handicap of blindness
2. Moderate financial loss.

Case no 6-

K is a 3 year old child of village J, The child was suffering from diarrhea, vomiting, was taken to the MPW who gave ORS but since condition of child worsened, he was taken to the PHC where the doctor administered saline, He was referred to bigger PHC where the child was given injections & medicines which had to be purchased, Later the child was referred to Civil hospital B in a serious condition. No ambulance was available at that time. The father spent a lot of time in arranging money for the private vehicle to take him to B, The child died on the way to B.

TYPE OF DENIAL

1. Non availability of the essential treatment of diarrhea and it's complications.
2. Non availability ambulance

GENERAL EMERGENCIES-

Case no 7-

M is 25 years man of village S, was bitten by a rabid dog, He went to nearest PHC R, which did not have any Anti Rabies vaccine, He was asked to purchase vaccine from the market. But due to lack of money he couldn't do so. Having been denied this life saving, essential treatment at PHC level he went to the District hospital R where only two doses of injection were administered and he was asked to purchase the rest from market. M died after few months leaving behind two children, widowed wife & old parents.

TYPE OF DENIAL:

1. Life saving, essential medicine for dog bite not available at PHC and even at the district hospital.
3. Negligence of the health staff.

CONSEQUENCES OF DENIAL

Death

Chronic illness-

Case No 8-

Mr. R was a resident of village R. near district headquarter D in Jharkhand state. In May 2002 Dr. J. the cardiologist in Ranchi diagnosed him as a case of ischaemic heart disease due to high BP. He was taking prescribed medicines regularly since then. In second week of January 2004 he complained fever and vomiting which persisted for nearly two months in spite of treatments by doctors of D and R. Finally some disease related to kidneys was detected by Dr. A.K S of D. His son decided to seek treatment for him at Indore in CHL Apollo hospital. He approached Dr. NJ, Gastro -entomologist in CHL Apollo Hospital at the evening of 12th March 2004. After scrutinizing all the previous medical records the doctor told him to discontinue all the medicines prescribed by Dr. S.C.J (Cardiologist), because according to him Mr. R was not having any heart disease. Dr. J also told him to undergo some investigations the next morning. Accordingly Mr. R went again to the hospital at 8 am on 13th march for investigation prescribed by Dr. J. After the investigations the doctor advised him to get admitted into the hospital because he was having a bleeding oesophageal ulcer and his kidney had stated failing. He was advised to undergo dialysis and accordingly did so in the Apollo Hospital on 14th March. After the dialysis though his blood pressure showed a fall it was not monitored hourly, Relatives got restless as the patient seemed to be sinking. After about three hours, the patient was checked properly on repeated requests by the relatives. It was discovered that his BP has gone down very much and his heart has developed a complication (atrial fibrillation). He was treated for this complication, shifted to the ICU but his BP was not monitored hourly, nor was any treatment given for this very low BP (80/60 mm of Hg) bordering on shock. No cardiologist visited him till his death on 15th March morning despite his critical heart condition since 14th March evening.

He walked into the hospital at 10.30am on 13th March and was dead within 48 hours i.e. in the morning of 15th March 2004.

TYPE OF DENIAL: – Gross negligence in a tertiary care hospital
CONSEQUENCES OF DENIAL -Death

Case no-9

M. Suffering from TB for the last 3 years. Registered in the govt. hospital at A. However, not cured due to lack of regular supply of medicines. He has spent Rs. 2000e , so far and sold his goat. Now can not spend more as he is very poor.

TYPE OF DENIAL:

1. Life saving, essential anti-TB not regularly available at PHC and even at the district hospital.

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MADHYA PRADESH

Undernutrition and Starvation Deaths

An Inquiry

An investigation of undernutrition and suspected starvation deaths in a few selected villages of Barwani district in Madhya Pradesh, a chronically drought-prone region, has thrown up a number of issues impinging on the concepts, methods and processes used for measuring of malnutrition and starvation.

Barwani district in western Madhya Pradesh is one of the less developed districts of the state, with a large tribal population. This district with a total population of 10.8 lakhs (2001 Census) has a tribal population of about 65 per cent. The district has suffered the effects of severe drought during the last three years, which is a part of the larger scenario of failure of rains, which have affected many regions of western India. The SATHI team of CEHAT has been collaborating with a people's organisation, Jagrit Adivasi Dalit Sangathan, a broad based health committee, Jan Swasthya Samiti and an NGO, Ashagram Trust in Barwani to develop a health initiative. Given the prevailing drought situation, these local organisations with inputs from CEHAT carried out an investigation of undernutrition in selected villages of Pati and Barwani blocks and conducted a survey of deaths in a few selected villages.

The study involved a survey of undernutrition among one to five-year old children; a study of undernutrition among adults; an assessment of suspected increase in death rates; and verbal autopsy to ascertain the causes of deaths occurring during a three-month period.

Given the context of lowered food intake, the first step was a survey of nutritional status of children. The first stage of this survey was completed by 'swasthya sathis' (community health workers, all women), in 25 hamlets of nine villages in Pati block. The hamlets were basically those where swasthya sathis were based and hence it was a convenience sample. This survey covered all children in these hamlets who could be contacted (1,663 children) in the age range of 1 to 5 years. The swasthya sathis were given a brief training in the use of the 'mid arm circumference tape' and were shown how to record the findings for each child on a specially prepared record sheet. This was necessary because all of the swasthya sathis are non-literate and could not write, but could record the status of each child (red, yellow or green) on the coloured record sheet. They measured the mid arm circumference of children and all those falling in the red zone, i e, with mid arm circumference less than 12.5 cm were classified as malnourished. The results when collected and analysed, showed that 1,260 (75.7 per cent) children were malnourished. However, it was felt that this was a comparatively less sensitive method, and a more accurate estimation of the grade of undernutrition was needed. Therefore certain hamlets were selected from Pati and Barwani blocks for a weight-for age survey. These hamlets were randomly selected from clusters where there were ongoing activities of local organisations involved in the Jan Swasthya Samiti. In this way 10 hamlets from Pati and nine hamlets from Barwani block were selected. All the children in these 19 hamlets – a total of 712 children between age 1 to 5 years – were weighed, their age in months was obtained and nutritional status determined based on weight-for-age. This included recording of age in months, measurement of weight, recording of presence of edema and skin/hair changes and taking a brief dietary history. The standard IAP criterion – weight of the child being less than 80 per cent of the expected weight – was used to define undernutrition.

The analysis of this data has yielded the results in Table 1. Some 84 per cent of the children in these villages were found to be malnourished and nearly 22 per cent were found to be suffering from severe malnutrition. It should be noted that these severely malnourished children are at significant risk of succumbing to fatal infections if malnutrition is not corrected. For comparison, Table 2 gives the nutritional status of children in tribal areas of MP as per NNMB survey, 2000.

This data from National Nutrition Monitoring Bureau (NNMB) *Diet and Nutritional Status of Tribal Population Report on First Repeat Survey* is according to Gomez classification and hence has a higher cutoff point for normalcy (>90 per cent expected weight for age) which results in this extremely high prevalence of malnutrition (92 per cent). Here it may be noted that if we use the Gomez classification, about 98 per cent children in the Barwani sample would be classified as malnourished.

However the figures for severe undernutrition found in Barwani district (22 per cent) seem comparable to the figures found for the general tribal population of Madhya Pradesh according to NNMB (20.4 per cent). Here the cut-off points in both classification systems are the same, i e, <60 per cent of expected body weight, and hence the proportions are directly comparable.

Table 3 shows detailed agewise analysis of nutritional status of under-five children, however it is a sub sample of 311 children in five villages of Pati block which have been analysed in detail. Severe undernutrition was found to be commonest among the recently weaned (12-23 months) group – as high as 42.1 per cent – and less common in higher age groups.

Undernutrition among Adults

Adults were also examined for undernutrition in selected villages as part of the study. Adult undernutrition was assessed based on the Body Mass Index (BMI) or (weight in kg/height in metres) with the following standard classification.

BMI Analysis	Grade of Undernutrition
BMI <16	III degree CED*
BMI 16-17	II degree CED
BMI 17-18.5	I degree CED
BMI 18.5 to 20	Low normal
BMI 20 to 25	Normal
BMI >25	Overweight

* Chronic Energy Deficiency.

132 adults (above age 18) were examined in two villages for weight and height and their BMI was calculted. The findings were in Tables 4 and 5.

According to the findings, 63 per cent of adults were undernourished, 15 per cent adults had a BMI of less than 16 which is indicative of chronic hunger/energy deficiency and severe undernutrition, which can contribute to the development of life-threatening illnesses. Undernutrition among men seems to be more (73 per cent) than women (54 per cent). Severe undernutrition among men (18 per cent) is also somewhat greater than among women (12 per cent).

According to the NNMB data collected from the tribal areas of Madhya Pradesh in general, 49 per cent of the adults are undernourished and 8 per cent are severely undernourished. As against the findings in the Barwani study, the NNMB data shows slightly greater prevalence of undernutrition among women in MP (50 per cent) as compared to men (47 per cent). Severe undernutrition too is greater among women (9 per cent) than men (6 per cent).

Severe undernutrition in Barwani in adults (15 per cent) is double that of tribal areas of Madhya Pradesh in general (7.9 per cent), at the same time overall adult undernutrition is significantly greater here (63 per cent) than the NNMB data (49 per cent). Undernutrition in men at Barwani (73 per cent) seems to be much worse than MP tribals in general (47 per cent) and severe undernutrition among men in Barwani (12 per cent) is double that of NNMB data (6.3 per cent). On the other hand the prevalence of undernutrition in women seems to be comparable in Barwani and tribal areas of MP (54 per cent and 50 per cent respectively), while severe undernutrition is again somewhat higher in Barwani (12 per cent) than the MP tribal population (9.3 per cent). Overall tribal areas in MP do not score well on nutrition parameters, but the drought situation prevailing in Barwani seems to have taken an additional toll and may be responsible for the higher level of undernutrition.

Suspected Increase in Death Rates

Anecdotal reports were received about unusually high death rates in certain villages. Three villages in one cluster, from where there had been some reports of suspected starvation deaths, were taken up for investigation of all the deaths that had taken place in the last one year. The families of the deceased were visited, the date/month of death were recorded for all deaths in the past one year. In all, 70 deaths during the last year were documented in these three villages. To confirm the time span of these deaths and in order not to miss any deaths, an attempt was made to compare this data with the mortality records maintained by the ANM. However this additional corroborative data could not be obtained from two of the three villages as the local health authorities refused to cooperate in giving this information. Therefore the actual number of deaths is actually likely to be higher than what we could document.

Local calendar, local festivals, phases of the moon and local market days were used to ascertain the date of death in case of all deaths in the last three months. The exact number of deaths in these three months was used for the calculation of death rates, as this being a short recall period, the date of deaths could be assessed fairly accurately. This data, based on the population of the village and concerning three month's span was extrapolated for a population of 1,000 and a span of a year and the death rates were calculated. It was found that the three monthly death rate of Semli village was 3.5 deaths per 1,000 population, of Verwada it was 2.65 and of Sipahiduwali it was 5.33 deaths per 1,000 population. This brings the annual rate of death per 1,000 population in these villages to 14, 10.6 and 21.3 respectively. The total annual death rate in these three areas combined was 14.15.

The average death rate in the three villages during these three months (14.15 deaths per 1,000 population per year) is somewhat higher than the crude death rate of MP (11 deaths per 1,000 population per year, SRS). However, given the small population base and time period in this sample, it was not considered possible to draw definitive conclusions from this information.

Use of Verbal Autopsy

It was felt that more definitive investigation of the cause of all deaths occurring in these villages in the recent period was required in order to ascertain whether these were starvation deaths. This exercise was also considered essential to develop a methodology to study and diagnose starvation deaths. It was decided to conduct a verbal autopsy (VA) on each death occurring in the selected villages during the last three months. This meant a detailed investigation of the symptoms and signs, bodily appearance, history of food intake, family food supply and other relevant factors in case of each death.

Although a standardised verbal autopsy questionnaire for childhood deaths, standardised by WHO along with John Hopkins School and London School of Hygiene and Tropical Medicine is available, such was not the case with the VA questionnaire for adults. So taking a general-purpose VA questionnaire from an article in *WHO Bulletin* as the basis, a modified VA form was prepared which could take care of 'starvation related deaths'. Questions relating to food intake and family food supply were added to this questionnaire. This was done based on suggestions from C S Kapse (head of department forensic medicine, D Y Patil Medical College, Pune), Veena Shatrughna (jt director, National Institute of Nutrition, Hyderabad), and H H Trivedi (ex-professor, department of medicine, M G Medical College, Bhopal) who gave their detailed and valuable inputs to modify this questionnaire and also agreed to be the expert panelists for analysing the results. The VA questionnaire had the following major sections. (1) Personal identification details. (2) Family food supply related information including irrigated and non-irrigated land owned, state of the harvests, wages earned and ongoing government relief work,

Table 1: Undernutrition in Pati and Badwani

Grade	Criteria (Per Cent)	Total	Percentage
Normal	>80	114	16
Mild to moderate undernutrition			
I	71-80	442	62.1
II	61-71		
Severe undernutrition			
III	51-60	156	21.9
IV	50<		
Total		712	100

Pati and Badwani block combined, Total 19 hamlets, 712 children (IAP classification).

Table 2: Nutritional Status of 1-5 Year Old Children in Tribal Areas
(Gomez classification)

Nutritional Grades	Madhya Pradesh - Tribal N = 1514
Normal	8.1
Mild	25.8
Moderate	45.6
Severe	20.4

categorywise status of food items being consumed by the family. (3) Individual dietary history during the week and the month before death. Calorific value of each food item consumed was calculated in order to analyse this data. (4) Unnatural food consumption patterns such as begging or borrowing food, consumption of unusual foods such as leaves of plants, forest tubers, etc. (5) Signs and symptoms during the last illness, as well as any medical records and prescriptions. (6) Physical appearance at the time of death.

Establishing the case of death – at the end of the questionnaire there were sections to record (a) immediate cause of death; (b) underlying cause of death; and (c) contributory cause of death. This diagnosis was to be made by each panelist based on the findings of the Verbal Autopsy. For this the complete sets of copies of all the filled questionnaires were sent to each of the three panelists for analysis. Their opinion about immediate, underlying and contributory causes of death were taken and collated.

A drawback noticed in the process was that the currently available verbal autopsy questionnaires are quite medicalised. Although good quality training was imparted regarding it's administration, and the help of locally available doctors was taken wherever necessary, it was felt that a qualified doctor would have been better suited for the job. This again brings us into the realm of over-medicalising an essentially social problem. Not only that 'death related to starvation' almost never appears in the death certificate of a doctor certifying a death, but even undernutrition seldom appears as an underlying cause. To add to this we could not obtain any clear guidelines about how to define a starvation death, or the parameters to certify such a death (see discussion). A tool less medical in nature, and one that can be administered with minimal training is definitely needed. Our modified verbal autopsy form might be seen as one step in the direction of developing such a tool.

All the deaths (19 deaths), which occurred during March 2001 to May 2001, in the villages of Semli, Sipahiduwali and Verwada were investigated. These villages were purposively selected, where local activists suspected an unusually large number of deaths. Six deaths during the six months prior to this period (September 2000 to February 2001), which were strongly suspected to be starvation deaths were also analysed. Thus a total of 25 deaths were investigated, seven of which were children, and 18 were adults.

The questionnaire was translated into Hindi. Bhausaheb Aher who administered the questionnaire and Amulya Nidhi who assisted him (both MSWs) were both trained and acquainted with the medical phrases and clinical conditions that appear in the questionnaire. This was pre-tested, by investigating the deaths of five children and four adults in these villages, and then finalised for use. Both the questionnaires were used to investigate all the deaths in the selected three villages – Semli, Sipahiduwali and Verwada.

So far the verbal autopsy forms for all the adult deaths have been analysed (18 deaths). The completed forms were sent to all three panelists who gave their independent opinions, which were then compiled in a table. If at least two of the three panelists stated starvation or malnutrition as the underlying cause of death, this was taken as the probable underlying cause of death. A similar definition was used for a probable contributory cause of death. Among the 18 adult deaths, in case of three adult deaths, starvation was identified as the probable underlying cause of death. Apart from these, in an additional three deaths, starvation or undernutrition has been identified as the probable contributory cause of death.

Some of the many issues, which emerged in the course of this study are:

(A) Though the phenomenon of starvation is widely discussed and reported, we could not find a very clear definition of starvation and especially no clear definition of a 'starvation death'. However some indicators which were pointed out by Veena Shatrughna and which helped to initially guide us when we were grouping for some working definitions, were as follows: a dietary intake in adults of less than 500 kcal per day is starvation (NIN report on drought in Gujarat); doubling of the proportion of adults with a BMI of less than 16, compared to the baseline, is indicative of starvation; and consumption of abnormal or unusual foods (forest leaves/tubers/wild fruits not usually eaten, etc) is indicative of starvation. However, the first two of these criteria seemed problematic when we started actually applying them to the situation. The third seems useful but may not be a sufficient criterion in itself.

The NIN criteria of starvation (mentioned in passing in its report on drought and malnutrition in Gujarat) of 'less than 500 kcal intake per day' seems inadequate. Those having such low consumption levels would definitely be starving. But what about those adults consuming between 500 and 1,400 kcal per day? They are consuming below the amount required for basal metabolic functions, and considering the additional fact that they would be doing some physical activities to obtain food, they would be continuously and

Table 4: Nutritional Data for All Adults (BMI) in Two Villages

BMI Analysis	No	Percentage	Grade of Undernutrition
All Adults (132)			
BMI <16	20	15	III degree CED*
BMI 16-17	19	14	II degree CED
BMI 17-18.5	45	34	I degree CED
BMI 18.5 to 20	26	20	Low normal
BMI 20 to 25	21	16	Normal
BMI >25	01	01	Overweight
Total	132	100	
Females (65)			
BMI <16	8	12	III degree CED*
BMI 16-17	7	11	II degree CED
BMI 17-18.5	20	31	I degree CED
BMI 18.5 to 20	15	23	Low normal
BMI 20 to 25	14	22	Normal
BMI >25	01	02	Overweight
Total	65	100	
Males (67)			
BMI <16	12	18	III degree CED*
BMI 16-17	12	18	II degree CED
BMI 17-18.5	25	37	I degree CED
BMI 18.5 to 20	12	18	Low normal
BMI 20 to 25	06	09	Normal
BMI >25	00	00	Overweight
Total	67	100	

* CED - Chronic energy deficiency.

Adults with BMI below 18.5 (undernourished) → 84 (63 per cent).

Adults with BMI below 16 (severe undernutrition) → 20 (15 per cent).

Women with BMI below 18.5 (undernourished) → 35 (54 per cent).

Women with BMI below 16 (severe undernutrition) → 8 (12 per cent).

Men with BMI below 18.5 → (undernourished) 49 (73 per cent).

Men with BMI below 16 (severe undernutrition) → 12 (18 per cent).

Table 3: Agewise Analysis of Nutritional Status of Under-Five Children in Pati Block

Age (Months)	Normal	Mild/Mod Maln	Severe Maln	Total
12 to 23	7 (9.2)	37 (48.6)	32 (42.1)	76
24 to 35	5 (8.3)	38 (63.3)	17 (28.3)	60
36 to 47	11 (13.7)	59 (73.7)	10 (12.5)	80
48 to 60	14 (14.7)	63 (66.3)	18 (18.9)	95
Total	37 (11.8)	197 (63.3)	77 (24.7)	311

Percentages in parentheses.

perhaps rapidly losing body weight (probably muscle mass since fat reserves would be long gone). This is clearly an unsustainable situation. Given the fact that continuing such a low level of dietary intake will in the course of time inevitably lead to fatal results, what distinguishes this from starvation?

There seems little sense in talking of the 'baseline' for a community that is already chronically undernourished. If statewise 9 per cent tribal adults have a BMI <16, then why should 'doubling' of this to 18 per cent be a criteria for starvation? By this criterion, worse-off states would have a higher cut-off point for starvation! If at all we have to make a comparison, should it not be with a general standard rather than with a 'baseline' of an already unacceptably poor nutritional status? In this context we can refer to the criteria laid down in the WHO expert committee report on Anthropometry (WHO TRS 854, 1995) related to classifying low BMI as a public health problem:

Low prevalence	5-9 per cent population with BMI <18.5
Medium prevalence	10-19 per cent population with BMI <18.5
High prevalence (serious situation)	20-39 per cent population with BMI <18.5
Very high prevalence (critical situation)	> = 40 per cent population with BMI <18.5

By this classification, the situation in MP tribal areas in general is already 'critical' (49 per cent population with BMI <18.5) and the situation in Barwani can only be called 'supercritical' (63 per cent population with BMI <18.5)!

(B) Starvation emerges more and more as a public health problem requiring community diagnosis. In this sense starvation deaths differ from classical 'disease related mortality'. The diagnosis of a death due to tuberculosis might be considered an individual diagnosis. But the diagnosis of a 'starvation death' cannot be just an individual diagnosis; we have to document the circumstances prevailing in the family and community along with the individual to reach such a conclusion, for the simple reason that starvation is a deeply social phenomenon. In fact, looking at the scale and depth of malnutrition in tribal and rural areas of our country, making individual diagnosis of 'starvation deaths' may seem almost incidental to the main issue. These deaths, though tragic and extremely unfortunate especially since they could have been so easily prevented, are just the tip of the iceberg of a situation of near universal undernutrition in rural and tribal areas. However, the paradox is that the government can ignore or downplay the fact that hundreds of millions of children and adults lead lives of severe, lifelong undernutrition since it does not provoke any public outcry. But a few starvation deaths reported in the press make the entire government machinery go into overdrive to 'deny' such an event and take some emergency measures. Even civil society and middle class opinion which starts wringing hands at the mention of starvation deaths, remains impervious to the implications of findings such as NIN data according to which around 90 per cent of children in rural areas are undernourished! So what do we do – focus on the near universal community undernutrition/starvation or on the few starvation deaths? One emerges as the main problem from a public health perspective while the other is an emergency with the advocacy impact of moving public opinion and the government system. Can we develop an approach to adequately understand and document both?

(C) Generally prevalent 'baseline' malnutrition, gradually worsening severe malnutrition and starvation merge with each other along a seamless continuum. In a community which is used to barely subsistence intake, three years of drought reduce this further and then some families start eating once a day, some individuals get to eat only once in two days... where exactly is the dividing line between malnutrition and starvation? When exactly does the situation change from 'a chronic problem' to 'an alarming situation'? Our figures for severe malnutrition in Barwani (22 per cent) are only minimally higher than the NIN figures for severe malnutrition in tribal areas of MP (20.4 per cent). One interpretation could be that the drought-induced situation in Barwani is close to 'normal' - after hearing of our results of 84 per cent malnutrition, one official in Barwani rather cynically said, if this malnutrition thing is so common, isn't it 'normal'?

Or do we interpret this as a silent yet alarmingly widespread situation of chronic severe undernutrition, with drought as an additional aggravating factor, a last straw which breaks the camel's back and leads to obvious deaths?

In summary, there seems to be an urgent need to be able to utilise the wealth of existing data on widespread malnutrition for effective advocacy, to enable people to access the right to food security. At the same time, there is a specific value of documenting starvation, or a state of extremely reduced food intake which in due course is incompatible with life, both because it is a humanitarian emergency and because it may help to shake an otherwise complacent state and civil society into some action. The challenge is to develop an approach, which has both breadth and depth, which views malnutrition and

Table 5: Comparative Table of Undernutrition in Selected Villages of Barwani

BMI Analysis	Proportion of Malnourished Females	Proportion of Malnourished Males	Percentage of Men and Women Together
1 BMI <16 CED III degree	12	18	15
2 BMI <18.5 CED all degrees	54	73	63

Table 6: NNMB Nutritional Data for All Adults (BMI), Madhya Pradesh (Tribal)

BMI Analysis	Proportion Out of			Grade of Undernutrition
	3,209 Females	2,788 Males	All Adults	
BMI <16	9.3	6.3	7.9	III degree CED*
BMI 16-17	12.4	10	11.3	II degree CED
BMI 17-18.5	28.4	30.9	29.6	I degree CED
BMI 18.5 to 20	24.4	28.2	26.2	Low normal
BMI 20 to 25	24.2	23.1	23.7	Normal
BMI >25	1.3	1.5	1.4	Overweight
Total	100	100	100	

* CED - Chronic energy deficiency.
Source: NNMB Technical Report No 19.

Table 7: Comparative Table of Undernutrition: MP Tribal Areas and Barwani

BMI Analysis		Madhya Pradesh Tribal Areas (Per Cent of Persons)	Barwani Villages (Per Cent of Persons)
BMI <16	Females	9.3	12
	Males	6.3	18
	Pooled	7.9	15
BMI <18.5	Females	50.1	54
	Males	47.2	73
	Pooled	48.8	63

starvation as public health problems with a social dimension, and to wield such a tool effectively to establish the entitlement of all for basic food security. EPW

[The study was undertaken by the SATHI team at the Centre for Health and Allied Themes (CEHAT). Bhausaheb Aher has been involved in collecting data and conducting interviews for this study as part of his block placement with CEHAT. Abhay Shukla, Amulya Nidhi and Amita Pitre of the SATHI team have participated in various aspects of design and analysis. Activists of Jagrit Adivasi Dalit Sangathan and Ashagram Trust, Barwani contributed in various ways during all stages of the study.]

JHARKHAND

Vision 2010

Chasing Mirages

Dazzled by the east Asian economic 'miracle', the newly created state of Jharkhand has drawn up a Vision 2010 document for development that seeks to turn it into another Singapore. However, the document lacks clarity and commitment and also suffers from skewed priorities that will severely impede the state's progress towards the goals of growth and poverty eradication.

NITYA RAO

Jharkhand, created as an independent state in November 2000, has produced Vision 2010 – a statement of policy directions for the new state. Former chief minister Babulal Marandi had identified increasing socio-economic disparities with, more than 56.8 per cent of the population living below poverty line (as against 36 per cent for India in 1996-97), lack of road connectivity in more than 60 per cent of the villages, 54 per cent literacy rate (42 per cent in the tribal sub-plan area that includes 112 out of 221 blocks in Jharkhand, spread in 11 districts out of 22) and 85 per cent of villages having no electricity, as the key problems confronting the state, along with the challenge of extremism.

Marandi, in the last several months, had seemed increasingly attracted by the 'Asian strategy' for development, particularly that adopted by Singapore. Along with an 11-member team, he undertook a tour of Singapore, Malaysia and Thailand in December 2002 [Prasad 2002b]. Thereafter he proposed a trip for Jharkhand legislators to China and south-east Asia: "Legislators will be sent to foreign countries to observe the developments there to change their mindset" [IANS 2003]. These trips have been funded from the state's exigency fund, meant for emergency purposes [Prasad 2002b].

Turning Jharkhand into another Singapore is indeed a commendable objective, but perhaps it is time to reflect on the key ingredients of Singapore's success and ask whether these are reflected in the actions or even in Jharkhand's vision document. What have been the measures taken to counter the human costs in terms of displacement and shrinking access to natural resources that would accompany a process of rapid growth? With many thousands starving to death or dying of diarrhoea and malaria, the answer sadly is predictable.

I discuss briefly in this paper the key elements of the east Asian 'miracle', and then point towards the lack of both clarity and commitment in the Vision 2010 document as well as in the actions of the state government, in terms of these key elements.

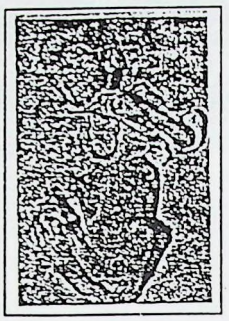
Development Strategies in Asia

Remarking on Singapore's achievements in the introduction to his lecture at the Institute of Southeast Asian Studies in Singapore, Amartya Sen said, "This country's success in economic development as well as in building a vibrant and harmonious multicultural society has been exceptional" (1999:3). The success of the region lies not just in enhancing the productivity of international trade, but rather in its emphasis on basic education as a prime mover of change as well as conscious measures for cultural integration of the Malays, Chinese and Tamils [Seen-Kong 1983]. The new features of the 'Asian strategy' included the wide dissemination of basic economic entitlements through land reform, education and training, essential medical facilities and credit that allowed for a wider sharing of social opportunities, thus leading to the participation of a majority of the people in the process of economic expansion and social change.

While poverty still prevailed, this strategy led to an expansion of human capabilities, facilitated economic and industrial expansion by improving people's productive capacities, while at the same time leading to an improvement in the quality of life. Even the World Bank, with its focus on the 'market' to boost growth, has acknowledged the role of state-led public action, particularly education, in leading to 'the Asian economic miracle' (1993).[1] It has admitted that these are the only economies that have "high growth and declining inequality" [ibid:3].

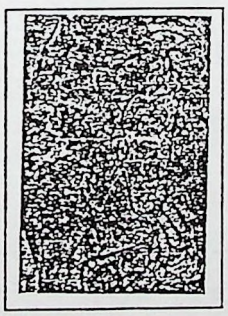
In the case of Singapore, in the decade of 1972-82, poverty declined from 31 per cent to 10 per cent, in India from 54 per cent to 43 per cent. During this period, the Singapore government had to demonstrate to its people that the benefits of growth would be shared. Attempts to reduce inequalities in basic wealth were an important component of this development strategy. Thus, workers' cooperatives were formed to give workers a stake in the economy, such as the 'fairprice supermarket cooperative' with over 2,40,000 members, 'comfort taxis', and many others. Similarly, a massive public housing programme was undertaken. The National Wages Council was set up in 1972 with representation from both the government and trade unions to keep the inter-industry wage structure stable. By the early 1980s, provision of child care services was expanded to enable women to participate equally in the economy [Phongpaichit 1988]. The building of a merit-based and competent civil service as well as improving relations between business and the state (including encouragement to small and medium enterprises) assisted the rapid economic growth and demographic transition.

By the mid-1980s, 5 per cent of GNP was allocated to education, a bulk of it for basic education. Universal, high quality basic education helped close gender gaps in education. In the late 1990s, an increase in income inequalities has become visible. Higher incomes are clearly linked to higher education; therefore, in order to stabilise income inequalities, there may now be a need for the state to intervene in maintaining equal educational opportunities at the



".....क्योंकि भूख आग है"

विदिशा, शिवपुरी और गुना जिलों के ग्रामों में भूख और कुपोषण से हुई मौतों पर एक संक्षिप्त रिर्पोट



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एक बात .....

अत्यधिक मातृ एवं शिशु मृत्यु दर तथा कुपोषण की विकराल स्थिति के लिए कुख्यात मध्य प्रदेश "भूख – कुपोषण – बीमारी" से हुई मौतों के कारण एक बार पुनः कलंकित हुआ है। पिछले 2–3 माह के दौरान मौत का जो तांडव विदिशा, शिवपुरी और गुना जिलों ने देखा गया वह आधुनिकता का दम भरने वाले किसी भी समाज को कलंकित करने के लिए पर्याप्त है। एक तरफ तो आम गरीबजनों पर पड़ी यह विपदा, वहीं दूसरी और लोगों की मौत के कारणों पर बेशर्म राजनैतिक बहसें व बेहूदा टिप्पणियां हमारे राजनैतिक तंत्र मे लिप्त जनों की हृदयहीनता को प्रदर्शित करती हैं। राजनैतिक हलकों में इंसानी मौतों पर जारी लगातार आरोप – प्रत्यारोप और एयरकंडीशनरों में बैठ कर की जातीं भूख पर बहसें किस तरह की सभ्यता को प्रदर्शित करतीं हैं यह बताना जरूरी नहीं।

विकेन्द्रीकरण और ग्राम स्वराज की शहनाई की धुनों पर दुनिया भर में थिरकती सरकार के मंत्रीगण कब तक भ्रम के बीजों से मतदान की फसल उगाकर काटते रहेंगें ? एक तरफ ये है तो दूसरी तरफ वे धर्मवीर भी हैं कि जिनके लिए इंसान की जान से बढ़कर गाय की जान है। विकराल सूखे से गांवो में कई गायें बेमौत मर रहीं हैं। जरा पूछा जाना चाहिए इन गौ– रक्षकों से कि इन्होनें कितने टन चारा गायों के लिए गांवो में पहुंचाया ?

विश्व खाद्य कार्यक्रम द्वारा संचालित एक रिसर्च की रिर्पोट मध्य प्रदेश को सर्वाधिकार खाद्यान्न असुरक्षित राज्य घोषित करती है लेकिन म.प्र. सरकार यहां अब भी भूख से और कुपोषण से मौतों का होना नहीं स्वीकारती। यह सच भी है कि जब तक सरकार न स्वीकारे तब तक न तो सूखा है और न ही भूख से मौतें । और तो और वे सरकरी चिकित्सक अपने साढ़े पांच साला चिकित्सकीय ज्ञान का शानदार प्रर्दशन करते हुए कहते हैं कि मृत्यु कुपोषण से नहीं बीमारी से हुई हैं। शायद चिकित्सा विज्ञान कि किताबों से कुपोषण और बीमारियों के आपसी संबंधो वाले पाठ नदारद हो गए हैं।

यह कितना दिलचस्प है कि मध्य प्रदेश मे सालाना 1.6 करोड़ टन खाद्यान्न का उत्पादन होता है। राष्ट्रीय बफर स्टॉक मे करीब 90 लाख टन खाद्यान्न म.प्र. से ही जाता है। इस प्रकार प्रति व्यक्ति प्रतिदिन 473.33 ग्राम अनाज उपलब्ध है, जबकि आई.सी.एम.आर. के मुताबिक प्रतिदिन सिर्फ 420 ग्राम अनाज ही प्रति व्यक्ति के लिए काफी है। हमारे प्रदेश में प्रतिदिन प्रति व्यक्ति 32 ग्राम दालें उपलब्ध हैं जबकि राष्ट्रीय औसत 22 ग्राम का है। इतने पर भी जो सरकार अपनी जनता को दो जून की दाल रोटी तक मुहैया न करा सकी तो जनता कब तक और क्या – क्या सहती रहेगी ? इस पर हम सभी को तुरन्त ही कुछ सोच कर पहल करना आवश्यक है क्योंकी भूख धुआं नहीं बल्कि आग है।

विदिशा

विदिशा जिले के गंजबासौदा के ग्राम नाहरिया, खूजूरी, लहधरा और लमनिया में भूख और कुपोषण से हुई मौतों का जायजा लेने के लिए म.प्र. भारत ज्ञान विज्ञान समिति का एक दल दिनांक 13 नवम्बर 2002 को सूखा प्रभावित क्षेत्र में पहुंचा। म.प्र. भा.ज्ञा. वि.स. के साथ–साथ इस दल में एक्शन–एड के साथी भी शामिल थे। प्रभावित क्षेत्रों में रवाना होने से पर्व गंजबासौदा के अस्पताल में चिकित्सकों से आपदा से उपजी स्थिति का जायजा लिया गया। गंजबासौदा का यह अस्पताल रैफरल सेंटर है। यहां के इन्चार्ज चिकित्सा अधिकारी डॉ. वत्सल ने मृतकों की संख्या एवं उनकी मृत्यु के कारणों के बारे में जानकारी दी। जिसका ब्यौरा निम्न है।

- दिनांक 7.8.02 – 28.8.02 तक नहारिया में 5 लोगों की मृत्यु।
- दिनांक 30.9.02 – 25.9.02 तक खूजरी में 6 लोगों की मृत्यु।
- दिनांक 21.10.02 – 24.10.02 तक लमानिया में 2 लोगों की मृत्यु।
- दिनांक 23.10.02 – 25.10.02 तक लहधरा में 2 लोगों की मृत्यु।
- दिनांक 20.9.02 – 5.11.02 तक भिलायार में 9 लोगों की मृत्यु (जहां स्वास्थ्य उपकेन्द्र है)
- दिनांक 6.11.02 को ग्राम कंजना में 1 मृत्यु।
- चिकित्सकों के अनुसार मरने वालो में ज्यादातर बच्चे और बुजुर्ग थे।

मृत्यु का कारण चिकित्सकों के अनुसार भुखमरी नहीं, कुपोषण भी नहीं लेकिन टी.बी. और न्यूमोनिया जैसी बीमारियां थी। कुछ इक्का–दुक्का मामलो में ही कुपोषण मौत के लिए जिम्मेदार बना।

> मौतें तो बीमारी से हुई लेकिन उसे जबरदस्ती कुपोषण से हुई मौतें बताया जा रहा है – एक चिकित्सक (रैफरल सेंटर गंजबासौदा)

अस्पताल के रिकार्ड के अनुसार दिनांक 11.11.02 तक 41 मरीज अस्पताल में दाखिला ले चुके थे जिनमें से ज्यादातर बच्चे थे।

लगभग डेढ़ लाख की आबादी पर यहां मात्र 1 चिकित्सक है।

प्राथमिक स्वास्थ्य केन्द्रों/उपकेन्द्रों की संख्या भी बहुत कम है।

गंजवासौदा से आगे उदयपुर के साहवा की लिधेरा पंचायत के ग्रामीणों से हमने बातचीत की। इस पंचायत में लिधेरा, शंकरगढ़, पधार तथा नहारिया गांव आते हैं। इस पंचायत की कुल जनसंख्या 1500–2000 के मध्य है। नहारिया गांव जहां 5 लोगों की मृत्यु हुई वहां कुल 46 परिवार हैं जिनमें 250–300 के बीच सहरिया आदिवासी रहते हैं। यह गांव पूरा सहरिया आदिवासियों का है। यहां की सरपंच श्रीमती गौतमीबाई पत्नी श्री मुन्नालाल है। गौतमीबाई भी गरीबी और सूखे की मार से किस कदर प्रभावित है इस बात का अनुमान सिर्फ इससे ही लगाया जा सकता है कि उनका एक बेटा अत्यधिक कुपोषित था। वह अचानक एक दिन तीव्र रूप से कांपने लगा, सांस लेने में उसे परेशानी हो रही थी, उसके मुंह से झाग आने लगे और वह जोर जोर से खांसने लगा। आसपास कोई स्वास्थ्य केन्द्र नहीं होने के कारण उसे उदयपुर की डिस्पेन्सरी

में ले जाने के लिए लोग बस स्टेण्ड पर बस का इतजार कर रहे थे तभी उस लड़के ने दम तोड़ दिया। इसी प्रकार के मिलते जुलते लक्षणों से और कुछ ने भूख से इस गांव में दम तोड़ा। यहां एक लड़का, 3 लड़कियां तथा 1 आदमी की मृत्यु हुई। पिछले तीन माह से डाक्टर की तो बात ही छोड़ दें कोई ए.एन.एम./एम.पी. डब्ल्यू भी गांव में नहीं आया।

सरपंच ने बताया कि पिछले वर्षो में पंचायत के फंड से स्टापडेन बनवाया; फ्लेरिंग करवाई तथा विद्यालय हेतु कमरा बनवाया है। इसके अतिरिक्त सूखे से निपटने के लिए सरकार ने पंचायत को कोई सहायता या निर्देश नहीं दिये हैं। इस गांव में शिक्षा गारंटी योजना का स्कूल 1998 से संचालित है। यहां 70 बच्चे हैं। लेकिन उनकी उपस्थिति बहुत कम रहती है। दोपहर के भोजन में यहां गेहूं बांटा जाता है। जो कभी कभी व कन तोल कर दिया जाता है।

"समा ने बदला समां" – भंवरी बाई (ग्रामीण महिला, नहरिया)

अलग–अलग व समूह में ग्रामीणों से बातचीत करने पर पता चला कि इस क्षेत्र में पत्थर की कई खदानें हैं। इनमें पिछले 35 वर्षो से ग्रामीण पत्थर तोड़ने का काम किया करते थे। जिससे वे प्रतिदिन 50–100 रूपये तक कमा लिया करते थे। तीन माह पूर्व अचानक खदानों को बंद कर दिया गया। जैसे तैसे ग्रामीणों ने कु[redacted] दिन निकाले फिर गेहूं के अभाव में घास के बीज जिसे 'समा' कहा जाता है उसका दलिया व रोटियां खाने लगे। समा में कोई भी पोषक तत्व नहीं होते तथा यह नुकसान भी पहुंचाता है। धीरे–धीरे ग्रामीणों के शरीर में रोगों से लड़ने की क्षमता कम होती गई और उनकी मृत्यु होने लगी। चूंकि बच्चे और बुजुर्ग ज्यादा संवेदनशील होते हैं। अतः वे ज्यादा तादाद में मरने लगे।

बारिश न होने से इस क्षेत्र में पिछले वर्षों से वैसे ही सूखे की स्थिति बनी हुई है। लेकिन सूखा राहत हेतु कोई पहल या प्रयास नहीं किये गये।

इतनी बड़ी दुर्घटनाओं के बाद भी आज तक सहायता कार्यों का कोई स्पष्ट खाका नहीं है। लोग काम तो कर रहे हैं। सड़क पर गड्ढे खोद रहे हैं। जिसके एवज में उन्हें दिन भर का 10 किलो अनाज (गेहूँ) मिल रहा है। लेकिन यह कब तक मिलेगा कोई पता नहीं। इस प्रकार सरकार द्वारा जो काम के बदले अनाज कार्यक्रम प्रारंभ किया गया है वह बहुत ही असंरचनात्मक है। उन ग्रामीणों व ग्राम स्तर के पंचायत कर्मियों आदि को नहीं मालूम कि रोड बनाने के बाद, क्या कोई और काम मिल पायेगा ?

बीमार, कुपोषित और दुर्बल ग्रामीणों का कहना था कि जब हमारे शरीर में इतनी क्षमता ही न बची [redacted] कोई काम कर सकें तो काम के बदले अनाज कार्यक्रम किस काम का। पहले हमें इस लायक तो कर दो कि काम करने के लिए उठकर जा सकें। एक ग्रामीण ने खांसते हुए कहा।

ग्रामीणों ने बताया कि पिछले 15 दिनों से यहां बाहरी लोगों की, अधिकारियों की आवक बढ़ गई है। कुछ डाक्टर भी आए खूब सारी दवाएं दे गये। कह गए दूध से खाना इन्हें पर हमारे पास तो साफ पानी भी नहीं दूध कहां से लायेंगे। सूखे की मार पशुओं पर भी पड़ी है। तमाम पशुओं की मृत्यु हो गई कुछ बचे हैं। वे अब दूध नहीं दे रहे हैं।

हमें दवाईयां नहीं रोजाना एवं अच्छा खाना चाहिए" – बाबूराम (टी.बी. से पीड़ित ग्राम नहारिया)

ग्रामीणों से चर्चा के दौरान मालूम पड़ा कि सबसे ज्यादा दुर्गती इन गांवों में केन्द्र सरकार की खाद्य एवं सामाजिक सुरक्षा योजनाओं की है। सुप्रीम कोर्ट के कई आदेशों के बावजूद इन ग्रामीणों को किसी भी

योजना के बारे में कुछ पता नहीं है और कोई योजना यहां स्पष्ट तौर पर चल भी नहीं रही। ग्रामीणों ने बताया कि मात्र 4–5 दिन पहले सिर्फ 40–50 लोगों को कुछ कार्ड बांटे गऐ और कहा गया कि इन पर सस्ता अनाज मिलेगा। इससे पूर्व, गांव के 4–5 लोगों के पास ही कार्ड थे। लेकिन उन कार्ड से क्या करना है कब कहां और कितना अनाज मिलेगा यह कोई नहीं जानता।

यहां के आसपास के गांवों में भी कोई आंगनबाड़ी नहीं है। अभी 8 दिन पहले जल्दबाजी में नहारिया गांव में ही एक आंगनबाड़ी खोलकर उस पर 8 बोरी अनाज रखवाया गया जो अब वितरित हो रहा है।

पहली बार में ही स्पष्ट तौर पर यह देखा जा सकता है कि लगभग सारी महिलाएं और सारे बच्चे तीव्रतम रूप से कुपोषित है।

गरीबी की रेखा से नीचे (बी.पी.एल.) के लोगों को उचित तौर पर सर्वेक्षित नहीं किया गया। जो थोड़े सम्पन्न हैं। वे इस सूची में आकर इसका लाभ ले रहे हैं। वास्तविक गरीब इसमें लिए ही नहीं गये हैं।

पिछले 8 अगस्त से शुरू हुआ मौतों का सिलसिला अब तक इन क्षेत्रों में 20 से ज्यादा लोगों की जान ले चुका है। जिनमें 5 वर्ष से कम आयु के 8 बच्चे और 60 वर्ष से अधिक आयु के 5 व्यक्ति शामिल हैं।

एक और पंचायत जिसका नाम मूंदरी है का दौरा इस दल ने किया। इस पंचायत में तीन गांव आते हैं। देहलवारा, खजूरी एवं नूरपुरा। इस पंचायत की जनसंख्या लगभग 1500 है। यहां के सरपंच श्री अखय सिंह ने बताया कि इस गांव (खजूरी) में 7 लोगों की मृत्यु हुई। सरकारी भाषा में बोलते हुए सरपंच ने इन मौतों का कारण भूख और कुपोषण नहीं बल्कि बीमारी ही बताया। इन सात मृतकों में 3 बुजुर्ग थे तथा 3 बच्चे एवं 1 युवा भी इस दौरान काल के मुंह में समा गया।

यहां के ग्रामीणों ने भी वही स्थिति बयां की जो नहारिया गांव के लोगों ने बताई थी। पत्थर की खदान चूंकि वन परिक्षेत्र में आती थी इसलिए वन विभाग ने इसे बंद करवा दिया वो भी बिना किसी पूर्व सूचना के। इस कारण अचानक गांव वालों पर विपदा आ गई।

जिन लोगों की मृत्यु हुई उनमें लगभग एक से ही लक्षण उभरे थे। एक तो कई दिनों से भोजन में तीव्र अनियमितताएं थी फिर लोगों को बुखार आया, उल्टी हुई और उनकी मृत्यु हो गई।

इस पंचायत में भी सरकारी योजनाओं की लगभग वही स्थिति है जो पूर्व की पंचायत में बयां की गई है। यहां 104 लोगों को नीला कार्ड एवं 6 लोगों को पीला कार्ड राशन के लिए दिये गये हैं। लेकिन राशन की दुकान गांव से बहुत दूर है जो कभी–कभी ही खुलती है जिस पर हमेशा राशन नहीं रहता एवं दुकानदार भी नहीं देना चाहता ऐसा ग्रामीणों ने बताया।

यहां के ग्रामीण भी काम के बदले अनाज कार्यक्रम की स्थिरता को लेकर आशंकित हैं। सरकार द्वारा उन्हें अभी तक ऐसा कोई स्पष्ट आश्वासन नहीं दिया गया कि यह कार्यक्रम सतत रूप से चलाया जाता रहेगा।

मुझे जहर की गोली दे दो कोई –(एक वृद्धा रोते हुए, ग्राम खजूरी)

शिवपुरी

शिवपुरी ज़िले का पोहरी ब्लॉक जो ज़िला केन्द्र से 32 कि.मी. दूर है, यहां भी सहरिया आदिवासियों के जीवन पर बन आई है। खाद्य सामग्री की अनुपलब्ध मे अपने जीवन के अस्तित्व को बनाए रखने के लिए ललटेना (एक विषैला जंगली फल), कंदमूल और समा खाने को विवश हैं। जिसके कारण पिछले एक माह में ही 50 से ज़्यादा लोग काल के गाल में समा गए हैं। यहाँ भी सूखे की स्थिति पिछले 3 वर्षों से बनी हुई है।

> सूखा तो तब ही माना जाएगा जब यह सरकार के मुखश्री से घोषित होगा – एक सरकारी कर्मचारी (छर्च गांव में राहत कार्य के दौरान)

म.प्र. भारत ज्ञान विज्ञान समिति, एक्शन–एड, संभव संस्था एवं सी.आर.एस. के प्रतिनिधियों ने सम्मिलित तौर पर 20 नवंबर–02 को शिवपुरी के पोहरी ब्लॉक के छर्च गांव का दौरा किया जो भुखमरी से हुई सर्वाधिक मौतों के कारण चर्चा में हैं।

पोहरी ब्लॉक से 35 कि.मी. दूर छर्च गांव आदिवासी बहुल है जहां सहरिया आदिवासियों के साथ–साथ अनुसूचित जाति और पिछड़ा वर्ग व कुछ सामान्य वर्ग के लोगों के भी घर हैं। इस गांव में इन सभी जातिगत वर्गों के बीच आर्थिक आधार पर अन्तर स्पष्ट नज़र आता है।

यह संयुक्त दल सर्वप्रथम बिलौआ पंचायत के मोहरा गांव में गया। यह छर्च से 16 कि.मी. पहले है। यहां से छर्च का रास्ता असहनीय तौर पर खराब है। यहां के स्थानीय ग्रामीणों ने चर्चा के दौरान बताया कि पिछले 3 वर्षों से बारिश न होने के कारण भयंकर सूखा है। यहाँ क कई लोगों के पास यद्यपि अपनी ज़मीने हैं लेकिन उन पर कोई फ़सल पैदा नहीं हो पा रही है।

पंचायत की ओर से एवं ग्राम स्वराज की बैठकों में इस भयंकर स्थिति पर कोई बातचीत नही की जाती क्योंकि सरकार की ओर से न तो कोई सहायता है और न ही पंचायतों को कोई निर्देश।

पिछले 3–4 माह से ग्रामीण यहां बेलपत्र, बेर तथा आंवले की छाल खाकर गुज़ारा कर रहे हैं। यहाँ तक कि पिछले 3–4 वर्षों से पीने के पानी की स्थिति गंभीर बनी हुई है। लोगों ने अपने पालतू पशुओं को उनके ही हाल पर छोड़ दिया है। कई पशु इस दौरान काल का ग्रास बन चुके हैं।

> "हमारे घर को ढूँढ़ लो बर्तन देख लो अगर खाने को कुछ मिल जाए। अभी खन्ती खोदने पर जो गेहूँ मिला है वही है। इससे पहले हम बेर का मिरचन (चूरा) और ललटेना (एक जहरीली वनस्पति) खाकर ही गुज़ार रहे थे।" – एक ग्रामीण

यहां के निवासियों और पंचायतकर्मियों का कहना था कि इस क्षेत्र में सूखे का अहसास पिछले अगस्त माह में ही हो गया था लेकिन सरकार और प्रशासन तो मौतों के इन्तज़ार में थे।

गाँव के लोग जंगल से एक ख़ास प्रकार की लकड़ी काट कर लाते हैं। जिसे "च्यारो" कहा जाता है। इस लकड़ी से ग्रामीण डलिया बनाकर उसे बाज़ार में बेचते हैं। लेकिन अब च्यारी भी नहीं मिलती क्योंकि वर्षा न होने के कारण उसकी पैदावार भी प्रभावित हुई है।

बिलौआ गांव में राहत कार्यो को लेकर बहुत विवाद की स्थिति बन रही है। क्योंकि सरकार द्वारा लगभग पिछले 15 दिनों से राहत कार्य शुरू किए हैं। लेकिन ये योजनाबद्ध ढंग से नहीं चल पा रहे हैं। मसलन काम के बदले अनाज कार्यक्रम जो प्रारंभ किया गया है। उसके अन्तर्गत ग्रामीणों को खन्ती खोदने का कार्य दिया गया है। दिन भर (सुबह 7.00 बजे से शाम के 5 बजे तक) कार्य करने के बाद उन्हें 10 किलो

गेहूं दिया जाता है या 8 किलो गेहूं के साथ 10 रुपये दिए जाते हैं।

खन्ती खोदने के कार्य में पूरा परिवार (लगभग 4–5 व्यक्ति) लगे तो दिन भर में एक खन्ती खोद पाते हैं। इस प्रकार पूरे परिवार को दिन भर काम करने पर 10 किलो अनाज मिल पाता है। इस प्रकार प्रत्येक के हिस्से में लगभग 2 या 2 1/2 किलो अनाज पड़ता है। इस पर भी यह कि जो कुशवाहा वर्ग के लोग हैं उन्हें काम देने में प्राथमिकता दी जाती है। सहरिया आदिवासियों को कोई तवज्जो नहीं दी जा रही।

हमने बिलउआ, मोहरा, बासरिया और बंसोड गांवों के लोगों से सम्मिलित तौर पर बातचीत की। इन सभी का एक मत से यह कहना था जो राहत कार्य चलाया जा रहा है वह गैर योजनाबद्ध ढंग से, असमानता युक्त तथा अपूर्ण हैं।

खाद्य सुरक्षा योजनाओं की स्थिति अंदर के गांवों में क्रमशः एक सी है। लोगों को कतई नहीं मालूम कि कौन–कौन सी योजनाएं हैं उनके क्या–क्या लाभ हैं तथा उनके लाभार्थी कौन–कौन हो सकते हैं।

लोगों का कहना है कि शासन की दुकान हफ्ते में एक या दो बार ही खुलती है। यहाँ चावल 7 रु. कि., गेहूं 5 रु. कि. तथा शक्कर 13 रु./कि मिलती है। लेकिन यह हमेशा उपलब्ध नहीं रहते।

> हमारे पास राशन की दुकान से अनाज ख़रीदने को एक भी पैसा नहीं – एक ग्रामीण (ग्राम मोहरा)

वृद्धावस्था पेंशन योजना क्या है ? मातृत्व कल्याण योजना क्या है ? राष्ट्रीय परिवार लाभ योजना क्या है ? ग्रामीणों को कुछ नहीं मालूम उन्होंने कभी इन योजनाओं के नाम नहीं सुने।

बिलऊआ गांव में मात्र 4 लोग बी.पी.एल. सूची में शामिल किए गए हैं। पहले गांव के ग़रीब लोग मूँगफली खोद कर कुछ कमा लिया करते थे। लेकिन सूखे के कारण फसल चौपट है।

गांवों में न तो आंगनवाड़ी है और न ही उचित तौर पर दोपहर का भोजन वितरित किया जा रहा है। विद्यालयों में अनाज 2–4 दिन ही वितरित किया जाता है वह भी कम तोला जाता है।

छर्च के सरपंच अमरजीत कुशवाहा और उपसरपंच लक्ष्मी नारायण भार्गव ने बताया कि मौतें बीमारी से हुई हैं और राहत कार्य पूर्णतः चल रहा है। मुख्यमंत्री का दो दिवस पूर्व ही यहां दौरा हुआ था इसलिए यहां राहत कार्य तेज़ी से चलता दिखाई देता है। साथ ही ग्रामीणों को भारी–भारी आश्वासन भी दिए गए हैं कि राहत कार्य बन्द नहीं होगा लगातार काम के बदले अनाज कार्यक्रम चलता रहेगा।

यहाँ गांव की राशन की दुकानो पर न तो सर्वोच्च न्यायालय के आदेश के पोस्टर लगे हैं। और ना ही लोगों को इस बाबत् कुछ मालूम हीं है।

इन गांवों में स्वास्थ्य सुविधाओं की उपलब्धता न के बराबर हैं। 2–3 माह में भूलवश एक आध ए.एन.एम. यहां बच्चों के टीके लगाने आ जाती है। जन स्वास्थ्य रक्षक नामक स्वास्थ्य कार्यकर्ता का तो कोई अस्तित्व ही नहीं है। जनसंख्या के अनुरूप चिकित्सा सुविधाओं का न होना लोगों के मरने का मुख्य कारण बन रहा है।

> लोगों को काम के बदले अनाज कार्यक्रम में प्रति व्यक्ति लगभग 2, ² 1/2 किलो अनाज (गेहूं) मिल पा रहा है। कोई सरकार से पूछे कि रोटी को को क्या पानी में घोल कर खाएँ ? – एक ग्रामीण, रामताल "छर्च"

गुना

विदिशा और शिवपुरी से लगातार आ रही मौत की खबरों ने वैसे ही प्रदेश को शर्मसार किया था, कुछ दिनों बाद गुना ज़िले से भी कुपोषण, निमोनिया, उल्टी दस्त और बुख़ार से होती जा रही मौतों की ख़बरें आने लगीं गुना ज़िले के गढ़लागिर्द, डांगदेवरी गांव और ईसागढ़ ब्लॉक के जमडेरा गांव में कई लोग मौत के मुंह में समा गए।

म.प्र. भारत ज्ञान विज्ञान समिति, एक्शन–एड के दल ने 21 नवंबर के गुना के ऊनरी ब्लॉक के नानी गांव का दौरा किया। यद्यपि इस गांव से किसी भी मौत की कोई ख़बर न अख़बारों में छपी थी न हीं स्थानीय प्रशासन को इसकी जानकारी थी। लेकिन अकस्मात दौरे से ज्ञात हुआ कि दीपावली से अब तक इस गांव के 5 लोग जिनमें बुजुर्ग और बच्चे हैं मौत के मुंह में विभिन्न बीमारियों और कुपोषण से चले गए।

पूर्व वर्णित अन्य गांवों की तरह ही इस गांव की स्थिति थी। लोग पिछले 2–3 माह से समा की रोटी, आंवला तथा बेलपत्र पर गुज़ारा कर रहे थे। लगभग 10–15 दिवस पूर्व ही यहां राहत कार्य प्रारंभ हुआ है।

राहत कार्य की यह स्थिति (सांवनी गांव में) है कि 4 दिन किसी गांव के लोगों को फिर 4 दिन किसी अन्य गांव के लोगों को राहत कार्य किया जाता है।

राहत कार्य के अन्तर्गत सांवनी गांव में तालाब निर्माण का कार्य चल रहा है। यह कार्य पिछले 10–15 दिनों से ही शुरू हुआ है। यह कार्य सिंचाई विभाग के द्वारा करवाया जा रहा है। ठेके पर कार्य करने की मनाही के बावजूद लोगों से ठेके पर ही काम लिया जा रहा है। इसके एवज़ में उन्हें बमुश्किल 2 या 2 1/2 किलों अनाज प्रति परिवार प्रतिदिन पड़ रहा है। जबकि प्रावधान 10 किलो अनाज का है। ग्रामीण जो कार्य में संलग्न थे उनमें से कोई भी ठेके पर कार्य करने को तैयार नहीं था। लेकिन मजबूरी में उन्हें यह कार्य करना पड़ रहा है।

नानी गांव के ग्रामीणों ने अंत्योदय योजना के कार्ड दिखाए जो लगभग 2 वर्ष पहले बने हैं लेकिन कई कार्ड्स पर कोई राशन नहीं दिया गया है और कई कार्डस पर 2 से 8 माह तक ही अनाज मिला है।

राष्ट्रीय वृद्धावस्था पेंशन योजना की कई पासबुक ग्रामीणों ने दिखाई जो पूर्णतः खाली थी या कई में 2 या 4 माह तक 150/– पेंशन मिली थी। ग्रामीणों ने बताया कि उन्हें बैंक से वापस कर दिया जाता है यह कह कर कि उनके लिए राशि सरकार ने नहीं भेजी हैं।

इस गांव की जनसंख्या 394 है यहां कोई भी स्वास्थ्य की सुविधा उपलब्ध नहीं है। लगभग 9 कि.मी. दूर अमरी के स्वास्थ्य केन्द्र है। जहां तक जाना बड़ा दुरुह है।

इस गांव में जिन 5 लोगों की मृत्यु हुई वे भी उल्टी, दस्त बुख़ार और कुपोषण से ही मारे गए।

ऊनरी गांव जो गुना से 15 कि.मी. पहले है वहां की राशन की दुकान पर इस दल ने बातचीत की। यह राशन की दुकान 8 पंचायतों में अनाज की सप्लाई करती है। यहां सरकार की ओर से विभिन्न योजनाओं हेतु अनाज कम उपलब्ध करवाया जाता है। ऐसा दुकान मालिक ने बताया।

जैसे गरीबी की रेखा से नीचे के लोगों के लिए यहां 438.60 क्विंटल अनाज की जरूरत है। लेकिन मात्र 100 क्विंटल अनाज ही सरकार की ओर से दिया जा रहा है।

मध्यान्ह भोजन हेतु अनाज 42 विद्यालयों में जा रहा है। इस हेतु 70 क्विंटल अनाज आता है लेकिन

कई स्कूलों से अनाज उठाने कोई नहीं आता।

गुना के मुख्य कार्यपालन अधिकारी श्री मनीष सिंह और कलेक्टर श्रीमती नीलम से भी इस दल ने बातचीत की।

उन्होंने बताया कि प्रत्येक पंचायत के लिए लगभग 1–3 लाख रुपए प्रदान किया जाना तय किया है। यह भी सुनिश्चित करने के प्रयास किए गए हैं कि काम के बदले अनाज कार्यक्रम हर 5 कि.मी. के दायरे में चलें सूखा प्रभावित क्षेत्रों की पहचान मैपिंग के आधार पर की जा रही है। कलेक्टर ने बताया कि केन्द्र सरकार की तरफ से

> "कुछ मौतें और कुपोषण तो हमेशा ही रहता है हम उसे इतनी गंभीरता से नहीं लेते" – कलेक्टर, गुना

राज्य सरकार को अनाज कम ही उपलब्ध करवाया गया है। कलेक्टर ने कहा कि अगली फरवरी (2003) तक लगभग 75000 लोगों को काम दिया जाएगा।

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अनुशंसाएँ

1. सर्वप्रथम, अत्यधिक कुपोषित और बीमारजनों को बिना काम की शर्त के पोषक आहार उपलब्ध करवाया जाये।

2. प्रदेश के कई जिले जहां पिछले तीन वर्षों से पर्याप्त बारिश नहीं हुई है सरकार द्वारा उन्हें सूखा प्रभावित घोषित किया जाये।

3. सूखा प्रभावित क्षेत्रों में सतत रूप से काम के बदले अनाज कार्यक्रम चलाया जाये। इस कार्यक्रम में सभी वर्गों को समान रूप से अवसर दिये जाये।

4. म.प्र. के सभी गांवों में कुपोषण के स्तर का उचित सर्वेक्षण करवा कर उससे निपटने हेतु तुरंत पहल की जाए।

5. विदिशा, शिवपुरी एवं गुना में भूख–कुपोषण–बीमारी से हुई मौतों की उच्चस्तरीय जांच करवाई जाए। उच्च समिति में शासकीय अधिकारियों के साथ–साथ पंचायत प्रतिनिधियों, गैर सरकारी संगठनों व समीनीयजनों को भी सम्मिलित किया जाए।

6. खाद्य एवं सामाजिक सुरक्षा हेतु केन्द्र सरकार की योजनाओं के क्रियान्वयन में पाई जा रही विकृतियों को तत्काल प्रभाव से दूर किया जाए। क्योंकि योजनाओं की वर्तमान स्थिति उच्चतम न्यायालय के आदेश की सरासर अवमानना है।

7. सर्वोच्च न्यायालय के द्वारा केन्द्र सरकार की खाद्य सुरक्षा संबंधी योजनाओं पर दिये गये आदेश के पोस्टर राशन की दुकानों, स्कूलों व अन्य विभागों पर लगाएं जाएं एवं इस हेतु ग्रामीणजनों को जागृत किया जाये।

8. हर गाँव में तत्काल प्रभाव से आवश्यक स्वास्थ्य सुविधाएँ मुहैया करवाई जाएं।

9. अनाज भंडारणों में उपलब्ध अनाज एवं वर्तमान वितरण हेतु प्रदान किये जा रहे अनाज की मात्रा का स्पष्ट तौर पर खुलासा किया जा रहे। वितरण में आ रही अड़चनों को तत्काल प्रभाव से दूर किया जाए।

10. गंजबासौदा में पत्थर की खदानों के अचानक बंद होने के स्पष्ट कारण बताए जाएँ। यदि संभव हो तो खदानें एक सोसायटी बनाकर उसे लीज पर दे दी जाएँ, ग्रामीणों की भी ऐसी ही इच्छा है।

11. गरीबी की रेखा से नीचे रहने वालों की सूची को वास्तविकता के आधार पर पुनर्निधारण किया जाये।

4. भू अधिकार एवं खाद्य सुरक्षाः इस कार्यशाला का मुख्य चिंतन कृषि मजदूरों, भूमिहीनों एवं महिलाओं को लेकर है। मुख्य मुद्दे इस प्रकार हैंः– कृषि सुधारों का महत्व एवं उक्त मुद्दे की पुनःप्रतिष्ठा, भूमि हदबंदी एवं भूमि वितरण, महिलाओं के भू–अधिकार तथा भू–अधिकार एवं खाद्य सुरक्षा का संबंध। इस कार्यशाला के संदर्भ व्यक्तिगण मुख्यतः उत्तरप्रदेश भूमि सुधार एवं श्रम अधिकार अभियान समिति, एन. एफ.एफ.पी.एफ.डब्ल्यू. तथा एकता परिषद से होंगे। संयोजकः– कोमा (एन.एफ.एफ. पी.एफ. डब्ल्यू.)।

5. बच्चों का भोजन अधिकारः गांवों (बल्कि घरों में) से लेकर दिल्ली में सत्ता केंद्रों तक सभी स्तरों पर, बच्चों के भोजन अधिकार के आग्रह को मुखरित करने के तरीकों पर चर्चा हेतु यह कार्यशाला आयोजित है। इस चुनौती को बच्चों में व्याप्त कुपोषण, व्यापक गरीबी, लिंग भेद तथा बच्चों का राजनैतिक सीमांतीकरण आदि के ढांचागत संदर्भों में जोड़कर देखने की कोशिश की जाएगी। बच्चों के भोजन अधिकार को राज्य संरक्षण के हाल के प्रयासों, जैसे कि सार्वजनिक मध्याह्न भोजन एवं आय.सी.डी.एस. सेवाओं से उत्पन्न अनुभवों को उजागर किया जाएगा। इन कार्यशाला से आगामी कार्ययोजनाओं के ठोस सुझावों एवं इसके विस्तार एवं मजबूती हेतु व्यावहारिक विचारों के आने की उम्मीद होगी। संदर्भ व्यक्तिगण : एस श्रीधर (बोरीक्डा–केयर), शांता सिन्हा (एम.वी. फाउंडेशन), बी.जी.वी.एस., मध्यप्रदेश। संयोजकः ज्यां द्रेज (दिल्ली स्कूल ऑफ इकॉनोमिक्स) तथा वंदना प्रसाद (जन स्वास्थ्य अभियान)।

6. दलित दृष्टिकोणः इस कार्यशाला में भोजन एवं काम का अधिकार को आर्थिक एवं सामाजिक हक हेतु जारी दलित संघर्षो के संदर्भ में विचार केंद्र में रखने की कोशिश होगी। संदर्भ व्यक्तिगणः अली अनवर, यामिनी चौधरी एवं मुकुल शर्मा (दलित मानवाधिकार का राष्ट्रीय अभियान, एन.सी.डी.एच.आर.)। संयोजकः अशोक भारती (नेशनल कांफ्रेंस ऑफ दलित आर्गेनाइजेशन्स)।

7. मूल प्रजातिक (आदिवासी) समाजों का दृष्टिकोणः इस कार्यशाला का आधार बिंदु यह है कि 'विकेंद्रित एवं टिकाऊ मापदंडों पर आधारित भोजन एवं आजीविका के हक हेतु हमारे संघर्षो में मूल प्रजाति के समाजों का दृष्टिकोण भी शामिल किया जाना आवश्यक है। मुद्दे पर समग्र विचार, इलीना सेन द्वारा प्रस्तुत एवं इसके पश्चात संक्षिप्त अवधारणात्मक प्रस्तुतियां निम्नलिखित होंगी– "जंगल आधारित खाद्य सुरक्षा प्रणालियां" (कलावती एवं इकवाल), "चारजानियां–एक सामुदायिक व्यवस्था" (मुकाऊराम कुंजम), "पुरा आदिवासी समूहों में खाद्य सुरक्षा" (गंगाराम पैकरा) "मूल प्रजातिक व्यवस्थाओं के लिए संभावित खतरे" (घनश्याम), "मूल प्रजातिक समाजों में महिलाओं की भूमिका" (वासवी), "स्थानीय बाजारों की भूमिका" (सुरेश साहू) तथा "आदिवासी समाज में भोजन की राजनैतिक अर्थव्यवस्था" (अर्चना प्रसाद), आदिवासियों

की भोजन की रामरया (श्रमिक आदिवासी संगठन, म.प्र.) आदिवासियों में कुपोषण से मुकाबले हेतु प्रयास – एक अनुभव (म.प्र. विज्ञान सभा)। भविष्य योजना पर खुली बहस। संयोजकः इलीना सेन (रूपांतर)।

8. अकाल एवं जीवनरक्षाः यह कार्यशाला हाल ही में देश के विभिन्न भागों में हुए अकाल–इसका प्रभाव, राज्य की जवाबदारी तथा जीवन रक्षा हेतु लोक संघर्ष आदि पर विचार हेतु आयोजित है। विशिष्ट मुद्दे इस प्रकार हैंः अकाल से बचाव एवं अकाल सहायता में राज्य की भूमिका; अकाल संहिता/अधिनियम की जांच–पड़ताल; संकटग्रस्त समूहों पर अकाल का असर; भुखमरी की स्थिति का मूल्यांकन; अकाल की स्थिति में लोक अभियान आदि। संयोजकः मानस रंजन (लोक अधिकार नेटवर्क, बाडमेर) तथा प्रीति ओझा (अकाल संघर्ष समिति, राजस्थान)।

9. महिलाओं का दृष्टिकोणः सरोजनी (सामा, दिल्ली) द्वारा "भोजन एवं काम का अधिकार विषय में महिलाओं का दृष्टिकोण" पर प्रारंभिक प्रस्तुति होगी। केस स्टडीःबारां (राजस्थान) एवं श्योपुर (म.प्र.) की सहरिया महिलाएं। बी.जी.वी.एस. (उड़ीसा), विजयपंडा आदिवासी मुक्ति संगठन तथा एकता परिषद की प्रस्तुतियां खुली बहस एवं भविष्य के लिए कार्ययोजना। संयोजकः आशा मिश्र (बी.जी.व्ही.एस.)।

10. भोजन एवं काम का अधिकार हेतु कानूनी कार्यवाहीः भोजन एवं काम का अधिकार हेतु कानूनी कदम के हाल के अनुभव (विशेष तौर पर 'पी.यू.सी.एल. विरुद्ध भारत संघ एवं अन्य' के संदर्भ में) पर प्रारंभिक प्रस्तुति (ह्यूमन राइट्स लॉ नेटवर्क)।

11. सीमांत जन एवं राज्य की जवाबदारीः हर्ष मंदर की प्रारंभिक प्रस्तुति। सीमांज जन, विकलांक जन, आवारा बच्चे, शहरी क्षेत्र के आवासहीन, विधवाएं एवं एकल महिलाएं, बंधुआ मजदूर, कलंकित व्यवसायों में शामिल दलित, कुष्ठ रोगी, पुरा आदिवासी के भोजनाधिकार के संबंध में सर्वोच्च न्यायालय के हाल के आदेश पर चर्चा। संदीप पांडेय द्वारा नीत अंतिम चर्चा "संकटग्रस्त समूहों के लिए सार्वजनिक खाद्य एवं सामाजिक सुरक्षा–संभावनाएं"। संयोजकः हर्ष मंदर एवं संजीव पांडे।

12. भोजन का अधिकार एवं सूचना का अधिकारः सूचना के अधिकार का सामान्य महत्त्व एवं भोजन तथा काम के अधिकार से इसके जुड़ाव पर प्रारंभिक प्रस्तुति एवं खुली चर्चा। हाल के अनुभवों तथा संघर्षो की प्रस्तुतिः– राजस्थान में सहायता कार्यों में व्याप्त भ्रष्टाचार उन्मूलन हेतु एम.के.एस.एस. का कार्य, शहरी पी.डी.एस. पर 'परिवर्तन' का कार्य, ग्रामीण पी.डी.एस. एवं घूरा–वापसी हेतु 'जागरुक नागरिक मंच' का कार्य तथा पंचायतों में भ्रष्टाचार के विरुद्ध भारवां समूह का अभियान। संभावित भविष्य योजना पर खुली बहस। संयोजकः निखिल डे (मजदूर किसान शक्ति संगठन) तथा अरविंद (परिवर्तन)।

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- अकाल एवं उसके बाद का जीवन
  संयोजक : प्रीति

दोपहर 1 से 2 बजे तक : भोजन
दोपहर 2 से 3 बजे तक : विश्राम

दोपहर 3 से शाम 6 बजे तक : समानान्तर कार्यशालाएं

- महिलाओं के परिप्रेक्ष्य में भोजन का अधिकार
  संयोजक – आशा मिश्र
- भोजन और काम का अधिकार हेतु कानूनी कार्यवाही
  संयोजक : अपर्णा
- वंचित वर्ग एवं राज्य की जिम्मेदारी
  संयोजक : हर्ष मंदर, शीला, विनोद, गंगाराम, कमल, राजेन्द्र, शमशुन, निशा
  एक व्यक्ति मैला ढोने वाले समुदाय से
  एक व्यक्ति : सहरिया जनजाति से
- भोजन का अधिकार एवं सूचना का अधिकार
  संयोजक : निखिल MKKS

रात 7 से 8 बजे तक: खुला सत्र–दूसरे दिन की समानान्तर कार्यशालाओं की रिपोर्टों का प्रस्तुतिकरण

रात 8:30 से 9:30 बजे तक : भोजन

रात 9:30 बजे से : सांस्कृतिक कार्यक्रम
संयोजक : संजय अग्रवाल

<u>तीसरा दिन</u> : रविवार, 13 जून 2004

सुबह 8 से 10 बजे तक : समापन सत्र

सुबह 10:30 से : रैली: इकबाल मैदान से नीलम पार्क तक

दोपहर 1 बजे आगरभा: नीलम पार्क

भोजन एवं काम का अधिकार विषय पर राष्ट्रीय गोष्ठी

(भोपाल, 11–13 जून)

कार्यशालाओं का संक्षिप्त विवरण

1. काम एवं आजीविका का अधिकार: इस कार्यशाला का मुख्य उद्देश्य है 'जीने जीने योग्य वृत्ति हेतु काम' जिसमें रोजगार सुनिश्चितता अधिनियम भी शामिल है। विशिष्ट मुद्दे इस प्रकार हैं: महाराष्ट्र सरकार का रोजगार सुनिश्चितता अधिनियम एवं हाल के वर्षों में इसकी अनदेखी, पिछले साल सजग नागरिकों द्वारा तैयार किए गए प्रारूप अधिनियम की प्रस्तुति; 'धन उपलब्ध नहीं' वाले तर्क का जवाब कैसे दें, राजस्थान में रोजगार सुनिश्चितता अधिनियम हेतु जारी अभियान की प्रस्तुति तथा नयी केन्द्रीय सरकार 'शीघ्र ही राष्ट्रीय रोजगार सुनिश्चितता अधिनियम' के वायदे के संदर्भ में कार्ययोजना पर विमर्श। संदर्भ व्यक्तिगण : सुभाष भटनागर (एन.सी.सी. एल.), निखिल डे (एम.के.एस.एस.), सुभाष लोमटे (एन.सी.सी.आर.डब्ल्यू.), अनुराधा तलवार (जे.एस.के.) संयोजक शिराज (काश्तकारी संगठन)।
2. सार्वजनिक वितरण प्रणाली (पी.डी.एस.) : इस कार्यशाला का मुख्य उद्देश्य है, हाल के वर्षों में पी.डी.एस. व्यवस्था को हटाने की प्रक्रिया एवं इसकी बहाली के प्रयास। विशिष्ट मुद्दे इस प्रकार हैं: पी.डी.एस. हटाने के दुष्प्रभाव, पी.डी.एस. के वैकल्पिक मॉडल। शुरूआती प्रस्तुति किरण मोघे (पी.डी.एस. को हटाने की प्रक्रिया) एवं एम.पी. परमेश्वरन (पी.डी.एस. व्यवस्था में सामुदायिक सहभागिता) द्वारा की जाएगी। पी.डी.एस. संबंधित जमीनी संघर्ष के अनुभव: परिवर्तन (दिल्ली), डेक्कन डेवलपमेन्ट सोसायटी (आंध्रप्रदेश), जन स्वास्थ्य अभियान (म.प्र.), राशन कृति समिति (महाराष्ट्र), अखिल भारतीय जनवादी महिला संगठन, संभावित कार्ययोजना पर विमर्श। संयोजक:–अमित सेनगुप्त (जन स्वास्थ्य अभियान), उल्का महाजन (एन.ए.पी.एम., महाराष्ट्र) एवं अजय खरे (म.प्र. विज्ञान सभा)।
3. खाद्य उत्पादन, कृषि एवं व्यापार: इस कार्यशाला में हाल में भारतीय कृषि, खाद्य उत्पादन एवं व्यापार में हुए परिवर्तन एवं भोजन का जनाधिकार पर इसके प्रभावों के बारे में चर्चा होगी। विशिष्ट चर्चा में शामिल मुद्दे इस प्रकार हैं: कृषि पर संकट, जैविकीय परिवर्तन युक्त फसलें तथा विश्व व्यापार संगठन के नियमों का भोजन के अधिकार पर प्रभाव। संदर्भ व्यक्तिगण:– सुमन सहाय (जीन कैम्पेन), ए. तायल (ग्रीनपीस), के. अशोक राव (एन.सी.ओ.ए.–सी.पी.एस.यू.), जया मेहता (संदर्भ, इंदौर) एवं एस.पी. शुक्ला (संभावित) संयोजक: दिनेश एबरोल (आल इंडिया पीपुल्स साइंस नेटवर्क)।

कार्यक्रम

'भूख से मुक्ति और काम का अधिकार' पर राष्ट्रीय–सम्मेलन

11 से 13 जून 2004
गांधी भवन, भोपाल

प्रथम दिन : शुक्रवार, दिनांक 11 जून 2004

प्रातः 8 से 10 बजे तक : पंजीकरण

सुबह 10 से दोप. 1 बजे तक: उद्घाटन सत्र

संचालन	:	आशा मिश्र
गीत	:	म.प्र. भारत ज्ञान विज्ञान समिति के समूह की प्रस्तुति
स्वागत भाषण	:	डॉ. नुसरत बानो रूही, अध्यक्ष म.प्र. राज्य आयोजन समिति
वक्ता	:	कविता श्रीवास्तव, कॉलिन गॉन्साल्विस एवं पॉल [illegible]
गीत	:	आनंद पाणिनी द्वारा
वक्ता	:	डॉ. एम.पी. परमेश्वरन, वृंदा करात, अरुणा रॉय
गीत	:	म.प्र. भारत ज्ञान विज्ञान समिति के समूह द्वारा
[illegible]		[illegible]

दोपहर 1 से 2 बजे तक : भोजन
दोपहर 2 से 3 बजे तक : विश्राम

दोपहर 3 से शाम 6 बजे तक : समानान्तर कार्यशालाएं

- काम का अधिकार एवं आजीविका
  संयोजक–शीराज़
- सार्वजनिक वितरण प्रणाली
  संयोजक– डॉ. अमित सेन गुप्ता और डॉ. अजय खरे
- कृषि एवं व्यापार
  संयोजक : डॉ. दिनेश अब्रोल
- भू–अधिकार और खाद्य सार्वभौमिकता
  संयोजक : रोमा

शाम 6 से रात 8 बजे तक : सांस्कृतिक समूह द्वारा भोपाल में विभिन्न स्थानों पर प्रदर्शन

रात 8 से 9 बजे तक : भोजन

रात 9 बजे से : सांस्कृतिक कार्यक्रम
संयोजक– संजय अग्रवाल

शाम 6 से रात 10 बजे तक भूख से मुक्ति अभियान के सांगठनिक पक्ष पर चर्चा होगी। सम्मेलन में हिस्सेदारी कर रहे प्रत्येक संगठन से अनुरोध है कि उनका एक प्रतिनिधि इस चर्चा में जरूर शामिल हों।

दूसरा दिन : शनिवार, 12 जून 2004

सुबह 8:30 से 9:15 बजे तक : खुला सत्र
प्रथम दिन आयोजित समानान्तर कार्यशालाओं की रिपोर्टों का प्रस्तुतिकरण

सुबह 9:30 से दोपहर 12:30 बजे तक : समानान्तर कार्यशालाएं

- बच्चों को भोजन का अधिकार
  संयोजक: डॉ. जॉन ड्रीज़ एवं डॉ. वन्दना प्रसाद
- [illegible] परिप्रेक्ष्य में भोजन का अधिकार
  संयोजक : अशोक भारती
- आदिवासी परिप्रेक्ष्य में भोजन का अधिकार
  संयोजक : डॉ. इलिना सेन

राष्ट्रीय स्तरीय आयोजन संगठन

1. जन आंदोलनों का राष्ट्रीय समन्वय (NAPM)
2. भारत ज्ञान विज्ञान समिति (BGVS)
3. जन स्वास्थ्य अभियान (JSA)
4. अखिल भारतीय जनवादी महिला समिति (AIDWA)
5. नेशनल फेडरेशन ऑफ इंडियन वुमेन (NFIW)
6. राष्ट्रीय दलित मानव अधिकार अभियान (NCDHR)
7. ह्यूमन राईट्स लॉ दलित आर्गनाइजेशन (NACDOR)
8. नेशनल कैम्पेन फॉर वर्कर्स (NCCRW)
9. पिपुल यूनियन फॉर सिविल लिबर्टिज (PUCL)
10. सूचना का अधिकार का राष्ट्रीय अभियान (NCPRT)

मध्यप्रदेश राज्य आयोजन समिति

1. अखिल भारतीय जनवादी महिला समिति (म.प्र.)
2. नेशनल फेडरेशन ऑफ इंडियन वूमेन (म.प्र.)
3. समता
4. संगिनी
5. एकता परिषद
6. म.प्र. भारत ज्ञान विज्ञान समिति
7. म.प्र. विज्ञान सभा
8. जन स्वास्थ्य अभियान
9. जन संघर्ष मोर्चा
10. सांस्कृतिक मोर्चा
11. जनवादी लेखक संघ
12. प्रगतिशील लेखक संघ
13. तुलिका संवाद
14. एकलव्य
15. सेहत
16. निराश्रित पेंशन भोगी महिला संगठन
17. गैस पीड़ित महिला उद्योग संगठन
18. म.प्र. वॉलन्टरी हेल्थ एसोशिएसन
19. सीटू
20. एटक
21. संदर्भ दस्तावेजीकरण, इन्दौर
22. पापुल्स रिसर्च सोसायटी
23. दलित आदिवासी जागृति संगठन
24. समाज प्रगति सहयोग देवास
25. इन्सानी बिरादरी
26. समावेश
27. गांधी भवन ट्रस्ट
28. ग्राम सेवा समिति, होशंगाबाद
29. अभिव्यक्ति राज्य संसाधन केन्द्र, भोपाल
30. गैस पीड़ित सहयोग संघर्ष समिति

मुद्रक: प्रियंका ऑफसेट, प्रेस कॉम्पलेक्स, भोपाल. फोन: 2555789

'भूख से मुक्ति और काम का अधिकार' पर राष्ट्रीय-सम्मेलन

11 से 13 जून 2004

कार्यक्रम एवं अवधारणा

कार्यक्रम स्थल
गांधी भवन, भोपाल, मध्यप्रदेश
मध्यप्रदेश राज्य आयोजन समिति
ई–8/4, त्रिलंगा, भोपाल. फोन : 5294378

स्वश्री जीवन सेवा गारंटी योजना के अंतर्गत मिलने वाली स्वास्थ्य सेवाओं के अध्ययन पर

रपट

जन स्वास्थ्य अभियान, म.प्र.

संयोजन कार्यालय : मध्यप्रदेश विज्ञान सभा
9-ए, सिविल लाईन्स, प्रोफेसर्स कालोनी, भोपाल
फोन : 2738481, फैक्स : 2660352

स्वस्थ जीवन सेवा गारंटी योजना के अन्तर्गत मिलने वाली स्वास्थ्य सेवाओं के अध्ययन पर एक रिपोर्ट

स्वस्थ जीवन सेवा गारंटी योजना, म.प्र. राज्य सरकार द्वारा 11 जुलाई 2001 को प्रदेश में शुरू की गई थी। स्वास्थ्य रहना हर व्यक्ति का मूलभूत अधिकार है। इसलिये स्वास्थ्य के लिये मूलभूत सुविधायें प्रदाय करना राज्य सरकार की जिम्मेदारी है।

स्वास्थ्य जीवन सेवा गारंटी योजना के तहत — जिला स्तर पर — जिला स्तरीय स्वास्थ्य एक्शन समिति का गठन हुआ तथा ग्रामीण स्तर पर — ग्राम स्वास्थ्य समिति बनायी गई जो कि गॉव में स्वास्थ्य के कार्यक्रम को क्रियान्वयन करने में मदद करेगी।

योजना का मुख्य उद्देश्य यह थे कि विकेन्द्रीकरण कर, जिला स्वास्थ्य और ग्रामीण स्वास्थ्य समिति द्वारा समाज में स्वास्थ्य के काम कराये जाये। जिसमें इस बात पर जोर दिया गया है कि गॉव में स्वास्थ्य की मूलभूत सुविधायें पहुँचाने के लिये हरएक गॉव में एक ट्रेंड दाई व एक जन स्वास्थ्य रक्षक का होना आवश्यक है। साथ ही साथ ग्रामीण स्वास्थ्य समिति आगनबाड़ी सहायकाओं से सहयोगात्मक सम्पर्क कर, स्वास्थ्य सेवाओं और सरकारी स्वास्थ्य कार्यक्रमों को प्रदाय करने में मदद करें।

राज्य सरकार ने इस योजना को एक निश्चित समय सीमा में पूर्ण करने का वादा जनता से किया था। जिसके अन्तर्गत :–

- जून 2002 तक हर गॉव में एक जन स्वास्थ्य रक्षक
- जून 2002 तक हर गॉव में एक प्रशिक्षित दाई
- पूर्ण टीकाकरण की सुविधा
- गर्भवती महिला की प्रसव पूर्व तीन बार जॉच
- शिशु, तीन साल तक के बच्चे, गर्भवती महिला व धात्री महिला के लिये पोषण आहार की उपलब्धता
- कूड़ा–कर्कट व खराब पानी के निकासी संबंधी स्वच्छता कार्यक्रम शामिल है।

सरकार द्वारा चलाई जा रही स्वस्थ जीवन सेवा गारंटी योजना के उद्देश्यों को कितना पाया जा सका है। इसका अध्ययन पश्चिम मध्यप्रदेश के कुछ जिलों में सेहत संस्था इन्दौर, सम्पर्क झाबुआ, म.प्र.वालेन्ट्री हेल्थ एसोसियेशन इन्दौर, जन विकास केन्द्र पालदा, इन्दौर द्वारा किया गया।

सर्वेक्षण विधि

- एक ब्लाक से तीन प्राथमिक स्वास्थ्य केन्द्र चुने गये। जिसमें पश्चिम मध्यप्रदेश इन्दौर संभाग के अन्तर्गत चार जिले – बड़वानी, झाबुआ, खरगौन और इन्दौर के सेन्धवा, पेटलावद, बालवाड़ा व इन्दौर के प्राथमिक स्वास्थ्य केन्दों पर सर्वे किया गया।

- प्राथमिक स्वास्थ्य केन्द्र के तहत आने वाले वे दो गॉव यह ध्यान में रखते हुये चुने गये कि एक गॉव प्राथमिक स्वास्थ्य केन्द्र के नजदीक हो और दूसरा प्राथमिक स्वास्थ्य केन्द्र से दूर हो।

इस तरह से ब्लाकों की स्थिति

1. सेन्धवा
   - बलवाड़ा प्राथमिक स्वास्थ्य केन्द्र के दो गॉव देवली और चीचापाठा
   - गावली प्राथमिक स्वास्थ्य केन्द्र के दो गॉव गावडा और आवलदी
   - धनौरा प्राथमिक स्वास्थ्य केन्द्र के दो गॉव बालखेड़ा और झिरी झामली

2. झाबुआ
   - वैकल्दा प्राथमिक स्वास्थ्य केन्द्र के दो गॉव कोटरा और सलारपाठा
   - सारंगी प्राथमिक स्वास्थ्य केन्द्र के दो गॉव दौलतपुरा और गामड़ी
   - रामपुरिया प्राथमिक स्वास्थ्य केन्द्र के दो गॉव सौरपथ और सागरिया

3. खरगौन
   - बालवाड़ा प्राथमिक स्वास्थ्य केन्द्र के दो गॉव मुख्यतारा और झाबर

4. इन्दौर
   - पालदा प्राथमिक स्वास्थ्य केन्द्र के दो गॉव पालदा और कुमारभट्टी

इस तरह 8 प्राथमिक स्वास्थ्य केन्द्र के 16 गॉवों का चयन कर पायलट स्टडी की गई।

- प्रत्येक गॉव में से ऐसे दस घर चुने गये जहॉ पर पिछले एक साल में बच्चे का जन्म हुआ था। इस प्रकार 16 गॉवों की 141 महिलाओं की मौखिक जानकारी सर्वे प्रपत्र के माध्यम से ली गई।

- प्रत्येक गॉव के 15 से 30 महिला व पुरूष समूह के साथ समूह चर्चा कर सर्वे प्रपत्र प्रश्नावली द्वारा जानकारी इकट्ठा की गई

- गॉव के मुख्य स्त्रोत व्यक्ति जैसे सरपंच, दाई, जन स्वास्थ्य रक्षक, आंगनवाडी सेविका से मौखिक जानकारी सर्वे प्रपत्र के माध्यम से ली गई तथा उनकी स्वस्थ जीवन सेवा गारंटी योजना के बारे में राय क्या है ?

स्वस्थ जीवन रोधा गारंटी योजना की जानकारी को त्रिस्तरीय समीक्षा की गई

प्राथमिक स्वास्थ्य केन्द्र स्तर पर	ग्रामीण स्तर पर	व्यक्तिगत स्तर पर
डॉक्टर से उपलब्ध जानकारी	आगनवाड़ी सेविका, दाई सरपंच व स्वास्थ्य रक्षक से उपलब्ध जानकारी	व्यक्तिगत स्तर पर हर गॉव की महिलाओं से सवाद कर
प्राथमिक स्वास्थ्य केन्द्र से उपलब्ध आंकडे	ग्राम में समूह चर्चा	

उपलब्ध जानकारी को रिपोर्ट में प्रस्तुत किया गया है।

1. योजना की जानकारी के सम्बन्ध में

ग्रामीण स्तर पर

	जानकारी है	जानकारी नहीं है	कोई उत्तर नहीं	प्रतिशत जानकारी है
सरपंच	सभी को जानाकरी	–	–	100 प्रतिशत
आगनवाड़ी	8	6	2	50 प्रतिशत
समूह चर्चा के बाद	11	2	1	80 प्रतिशत

व्यक्तिगत स्तर	03	134	4	2.12 प्रतिशत

यहॉ पर आंकड़े यह बात साफ करते हैं कि उपर से नीचे तक योजना की जानकारी मात्र पहुँचाने में कितना अन्तर आता है। (वह भी महिलाओं के स्तर पर नगन्य है)

2. स्वास्थ्य समिति गठन करने के सम्बन्ध में

	समिति है	समिति नहीं है	प्रतिशत समिति है
सरपंच	15	1	93.75
समूह चर्चा	11	2	78.57

3. ग्राम स्वास्थ्य समिति की सदस्य संख्या को लेकर

ग्राम समिति में कुल सदस्य 12 जिसमें एक तिहाई महिला बहुमत व रिर्जवेशन अ.ज./ अ.ज.ज./ओ.बी.सी. शासन के नियमों के अनुसार गठित करना चाहिये।

सदस्य संख्या	पूर्ण	अपूर्ण (10 से कम संख्या)	प्रतिशत पूर्ण गठन
समूह चर्चा	2	8	14.28

4. समिति की नियमित बैठक होती है

बैठक	हाँ	नहीं	प्रतिशत हाँ
सरपंच	5	9	35.71
समूह चर्चा	3	7	21.42

➢ स्वास्थ्य समिति के गठन का कार्य लगभग सभी गाँवों में पूर्ण हो चुका है लेकिन इसकी कार्यप्रणाली को लेकर कर काफी अनियमिताये व अधूरापन देखने को मिलता है। जिसके कारण असफलता दिखाई पड़ती है।

5. स्वास्थ्य समिति द्वारा किये गये कार्य की समीक्षा

सरपंच :

पोषण आहार व टीकाकरण के कार्यक्रम में अन्तर आया पर कुछ ही सुधार हुआ है।

समूह चर्चा :

मात्र तीन गाँवों में पिछले एक साल में टीकाकरण साफ सफाई कार्यक्रम को लेकर सुधार हुआ है।

11 गाँवों में कोई सुधार नहीं हुआ। मतलब **78.57 प्रतिशत असफलता।**

पानी के निकास के लिये गठनबंध सुविधा किसी गाँव में नहीं न कोई शौचालय बनाई गई है। मतलब पूर्ण असफलता।

समिति के गठन व बैठक व कार्यप्रणाली की प्रक्रिया मात्र खानापूर्ति प्रतीत होती है।

6. जन स्वास्थ्य रक्षक

प्राथमिक स्वास्थ्य केन्द्र के स्तर पर

प्राथमिक स्वास्थ्य केन्द्र	अन्तर्गत आने वाले गाँवों की संख्या	प्रशिक्षित जन स्वाथ्य रक्षक	प्रशिक्षित दाई
वैकल्दा	48	18	20
सारंगी	51	43	51
रानपुरिया	23	11	23
वालवडा	74	26	16
पाल्दा	11	—	—

➢ आंकडे साफ कहते है कि मात्र एक प्राथमिक स्वास्थ्य केन्द्र को छोड़कर अभी तक ट्रेनिंग का काय्र पूर्ण नहीं हुआ है।

7. ग्रामीण स्तर पर

स्वास्थ्य रक्षक	प्रशिक्षित जन स्वास्थ्य रक्षक	नहीं	प्रशिक्षण चल रहा है	
सरपंच	4	8	—	28.57
समूह चर्चा	3	9	2	21.42

अ. जन स्वास्थ्य रक्षक का प्रशिक्षण का कार्य और ग्रामीण स्तर पर उपलब्धता सरकार के स्तर पर 50 प्रतिशत, ग्रामीण स्तर पर 29 प्रतिशत गॉव में उपलब्धता के हिसाब से मात्र 21.42 प्रतिशत रह जाती हैं।

ब. प्रशिक्षित दाई प्रशिक्षण

➢ प्राथमिक स्वास्थ्य केन्द्र स्तर पर — 110/196 = 56.12 प्रतिशत

ग्रामीण स्तर पर

दाई	प्रशिक्षण	प्रशिक्षण चालू है	नहीं	प्रतिशत
समूह चर्चा	5	1	8	56.12
सरपंच	4	1	8	31.71

दाई प्रशिक्षण कार्य का कार्य जन स्वास्थ्य रक्षक प्रशिक्षण से बेहतर चल रहा है। पर कार्य की समीक्षा करें तो

➢ व्यक्तिगत स्तर वर

प्रसव का स्थान

जचकी की जगह	कुल	प्रतिशत
घर	137	97.16
अस्पताल	4	2.83

जचकी के दौरान प्रशिक्षित दाई की उपस्थिति

उपस्थिति	कुल	प्रतिशत
हाँ	46	33.57
नहीं	91	66.42

जचकी के दौरान दाई किट का उपयोग प्रशिक्षित दाई द्वारा

उपयोग	कुल	प्रतिशत
हाँ	38	26.95
नहीं	97	68.99
कोई उत्तर नहीं	6	4.25
समूह चर्चा	415	80

ग्रामीण इलाको में आज भी जचकी का काम घर पर होता है। इसलिये प्रशिक्षित दाई के [illegible] नहीं जा सकता है। प्रशिक्षण का काम भी पूर्ण नही है। प्रशिक्षण 56 प्रतिशत है पर दाई की उपलब्धता के हिसाब से 31.71 प्रतिशत है।

पारंपरिक दाई ट्रेनिंग का सवाल माता के स्वास्थ्य से जुड़ा हुआ है, आंकड़े यह बात तो साफ करते है की दाई प्रशिक्षण का कार्य धीमी गति से चल रहा है तथा पूर्ण नहीं है पर साथ में यह भी यह सुनिश्चित भी करना होगा कि प्रशिक्षण के बाद जचकी के दौरान दाई की उपस्थिति व दाई किट का उपयोग होता है या नहीं।

8. पूर्ण टीकाकरण व पोषण आहार

व्यक्तिगत स्तर पर

➢ गर्भावस्था के दौरान टीकाकरण

टीकाकरण	कुल	प्रतिशत
हाँ	76	53.90
नहीं	62	43.97
कोई उत्तर नही	03	2.12

➢ आंगनबाड़ी से गर्भवती महिलाओं को मिलने वाला पोषण आहार

पोषण आहार	कुल	प्रतिशत
मिलता है	38	26.95
नहीं मिलता है	94	66.66
कोई उत्तर नही	09	6.38

➢ आयरन व फोलिक एसिड गोलियों का वितरण

वितरण	कुल	प्रतिशत
1–30 तक	19	30.64
31–60 तक	18	29.32
60 से उपर	25	40.02

➢ गर्भावस्था के दौरान ए.एन.एम. द्वारा जाँच

जाँच	कुल	
एक बार		
दो बार		
तीन बार		

9. टीकाकरण की स्थिति बच्चों में

➢ बच्चों को 6 महिने पूर्व होने पर जाँच पर कितने टीके लगे

	कुल	प्रतिशत
हाँ	58	41.13
नहीं	74	52.48
कोई उत्तर नही	09	6.38

- आंगनबाडी में पंजीकृत बच्चों की संख्या 30 से तो अधिक है लेकिन पलायन की प्रवृत्ति है। पोषण आहार वितरण व खिलाने के लिये बच्चों को बुलाकर लाना पड़ता है। पंजीकृत गर्भवती महिलाओं व धात्री महिलायें के भी इरादे ऐसे ही है।

आंगनबाडी सहायिका मानती है कि जागृति व ज्ञान के अभाव के कारण पलायन की प्रवृत्ति।

- स्वस्थ जीवन सेवा गारंटी योजना के तहत पूर्ण टीकाकरण की सुविधा, गर्भवती महिला को प्रसव पूर्व तीन बार जाँच, शिशु, तीन साल तक के बच्चे, गर्भवती महिला व धात्री महिला के लिये पोषण आहार की उपलब्धता सभी के लिये सुनिश्चित हो।

कुछ अच्छी बातें तो सर्वेक्षण के दौरान निकालकर आयी –

1. जहाँ सरकार द्वारा पूर्णरूप से कार्य हुआ है वहाँ की स्थिति खराब है।
झादुआ में सम्पर्क संस्था द्वारा दाईयों को ट्रेनिंग दी गई है। जिन पर संस्था द्वारा निगरानी की जाती है। इससे टीकाकरण और जच्चा की सेवाओं में सुधार हुआ है।

प्रतिक्रिया

1. तीन गॉव में ए.एन.एम. द्वारा गॉव का दौरा किया जाता है।
2. तीन गॉव में एक साल में टीकारण साफ सफाई कार्यक्रम को लेकर सुधार हुआ।
3. ट्रेनिंग के बाद दाई के काम में सुधार आया आत्मविश्वास में वृद्धि हुई और डिलेवरी भी करवायी है।
4. स्वास्थ्य समिति द्वारा स्वास्थ्य कार्यक्रमों को निगरानी करने का तरीका यह कि समिति के सदस्य स्वास्थ्य कार्यक्रमों में स्वयं भागीदारी करते है।

पायलट स्टडी में स्वस्थ सेवा गारंटी योजना के उद्देश्यों में जो मूलभूत सुविधाये जनता को मिलनी चाहिये वह अपर्याप्त है।

STATUS OF PUBLIC HEALTH SERVICES IN BARWANI DISTRICT OF MADHYA PRADESH

STUDY REPORT[1]

2003 – 2004

By

Jan Swasthya Samiti, Barwani / Sendhwa

Jan Swasthya Abhiyan, Madhya Pradesh

[1] This investigation was done by Jan Swasthya Samiti for Jan Swasthya Abhiyan to document the situation of public health services. The study was done in collaboration with the organizations of JSA, MP, which includes Centre for Enquiry into Health and Allied Themes (CEHAT) Indore, Ashagram Trust (AT), Jagrit Adivasi Dalit Sangathan (JADS) and Adivasi Mukti Sangathan (AMS).

ACKNOWLEDGEMENT

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The Samiti acknowledge individuals. M.S.W students from Barwani school of social work, Ashagram trust, CEHAT, Indore, who have extended their support towards this endeavor. We are thankful to Dr Abhay Shukla for his invaluable inputs. The Samiti recognises the contribution of Mr. Laxminarayan Sohner and Mr. Vijay for publication of this report. Kajal and Anand have done the Hindi translation of the summary report.

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EXECUTIVE SUMMARY

Status of Public health services in Barwani district of Madhya Pradesh

PHCs in Barwani district:

- There is a shortfall of 15 PHCs in the district! One PHC is serving an average population of more than 29000 instead of 20,000.
- None of the PHCs fulfill the 2-6 beds norm; all PHCs have less number of beds and 8 out of 31 (26 %) have no admission facilities.
- 11 out of the 31 PHCs (36 %) building are in very bad condition.
- 15 out of 31 PHCs (48 %) do not have normal delivery facilities and 13 (42%) PHCs do not even have a delivery room.
- Out of 31 PHCs, 8 PHCs do not have connection of electric supply. In 40 % PHC the fans and the tube lights are not working. Not a single PHC had a generator backup.
- 6 (19%) PHCs did not have any source of water. 13 (41%) PHCs have water supply by hand pump and most of these run dry in summer months. Only 12 (42 %) of the PHCs had facility for running water.
- 26 PHCs (84%) do not have ambulance facilities. Only 5 PHCs (16%) had an ambulance facility and even in these 5 PHCs the drivers do not reside in PHCs.
- 13% PHCs are running without regular doctors. Only 3 PHCs had lady doctor. In 70 % percent of the PHC LHVs and MPWs were not posted.
- In 29 % of PHCs, doctors were not available in scheduled timings. Even for other staff in 20 % PHCs, staffs are not present at scheduled timings.

CHCs in Barwani district

- The district has less than half of the required number of CHCs. Instead of 1 CHC per 80,000 population the district has 1 CHC for 1,84,612 population.
- None of the CHCs fulfill the 30-bed norm; all CHCs have 10 beds or less.
- 40% CHCs do not have running water facility.
- There is no functioning Operation Theatre in 60% CHCs; certain CHCs do not even have a delivery room
- 80% of the CHCs have no specialists, the single CHC with specialists has only half of those required
- Only one CHC has a female doctor
- In 40% CHCs, doctors are not present during scheduled timings
- 80% CHCs do not have neonatal resuscitation equipment or ECG machine; 40% do not have oxygen cylinder, incubator or adequate operation equipment
- None of the CHCs provide services for caesarean delivery.
- 40% CHCs do not provide treatment to severely anemic women or children with severe respiratory / gastrointestinal infections: 60% do not have STD clinics.

District Hospital in Barwani district

- When admitted, some patients have to lie on floor and even in corridors. This was observed especially in Pediatric and orthopedic wards. Similar conditions exist in Mahila Hospital also where most of patients were seen to be lying on the floor.
- The water facility in the hospital is erratic and unhygienic. The district hospital has only one water tank but the water is likely to be contaminated as it is situated beside the septic tank.
- Only one ambulance in the District Hospital is in good condition.
- Many patients have to purchase medicines such as drugs/syrups/saline from private medical stores.

ROGI KALYAN SAMITI of Barwani District Hospital (Data for 2002-2003)

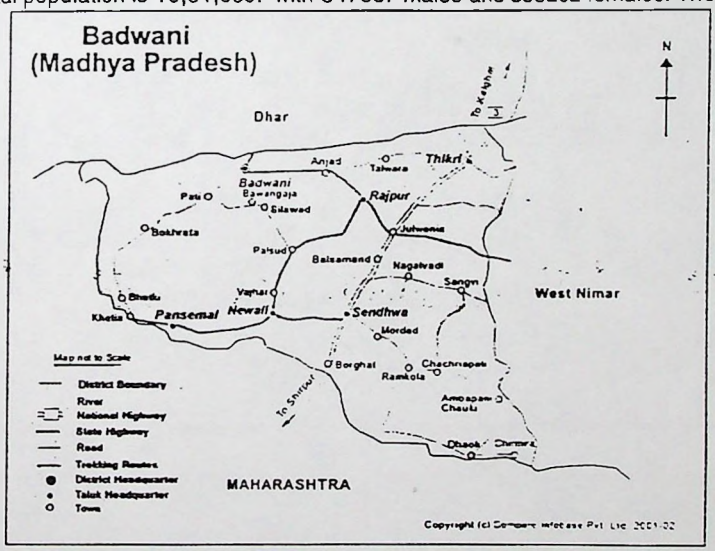
- RKS is not utilising almost 25 % of its collection even though the hospital is seriously lacking in many of the essential services due to lack of funds.
- 75% of the total money collected by RKS is earned from general patients. However, **only 11% of the total expenditure is spent on services** for general patients.
- Out of the total expenditure of Rs 15,26,201/- the major expenditure of (81.3%) RKS has been incurred on **items not related directly to patient services** like new installation of AC, coolers, grass cutter and water pump for lawn, building repair, electric expense of CMHO office and for salary of staff employed by RKS.

INTRODUCTION:

Madhya Pradesh is located at the geographical centre of India with **Bhopal** as the capital. It shares its borders with five states, viz. Maharashtra, Gujarat, Rajasthan, Uttar Pradesh and Chhattishgarh. Erstwhile Madhya Pradesh was the largest Indian state in terms of area (spread over 443,000 sq. kms), and had accounted for 14% of India's land mass. According to 2001 census, Madhya Pradesh had a population of 60,385,118(male 314,568,73. female 28,928,245). The population sex ratio number of females per 1000 males was 920 in 2001. The state, has the highest population of Schedule Tribes (23% of the country) outside northeastern states. The literacy rate of the state is 64.11%. It is one of the most economically backward states with more than 42 percent population living below the poverty line (NCAER 2002) It is also one of the low literacy states in the country. Most of the villages in the state do not have an all season approach road. Tribal regions are mostly in hilly areas, where people have to walk nearly 15-20 Kilometers to get basic services.

In the western region of Madhya Pradesh, Barwani is one of the less developed districts. Ninety percent tribal population, mainly by Barelas, Bhilalas, and the Bhils, inhabits it.

According to 2001 Census the total population is 10,81,039. with 547837 males and 533202 females. The female literacy is 19.01% and the male literacy is 36.77%. Barwani district has 7 development blocks, 714 villages, 383 Gram Panchayat and 1121 AWW. The maternal mortality rate is 5 per 1000. In terms of health facilities it has 1 district hospital, 5 Community Health Centre (CHC), 31 Primary Health Centres (PHCs), 235 sub centers (SCs). At the village level, ANM/MPW are deputed to provide basic health services to people.



The declaration of Alma-Ata Conference in 1978, setting the goal of Health for All by 2000 AD has ushered in a new philosophy of equity, the new primary health care approach. The National Health Plan (1983) proposed reorganization of primary health centres on the basis of one PHC for every 30000 rural population in the plains, and one PHC for every 20000 population in hilly, tribal and backward areas for more effective coverage.

Health problems like tuberculosis and Malaria in tribal communities are compounded by difficult terrain, mutual disbelief and mistrust between the community and health workers and non-availability of essential/life saving medicines in the area. Poor child and maternal health status, prevalence of infectious and diseases are common causes of early deaths in this area and the state has to improve the situation by improving its health services accepting an appropriate developmental plans and by co-operation with social and voluntary organisations.

Madhya Pradesh Government has given a Guarantee to provide all basic Health services through Swastha Jeevan Seva Guarantee Yojna, which was initiated in the year 2001. But over 2 years after the implementation of the Yojna, the failure of the public health services in several districts of Madhya Pradesh

continues to be a stark reality. This prompted the Jan Swasthya Samiti to initiate an investigation of Public Health Services in Barwani district.

OBJECTIVES:

1. To assess the level and limitations regarding availability of the health care services in the government health facilities.
2. To recommend improvements in organisation and delivery of public health care services

METHODOLOGY:

Sample selection:

The data was collected from all the 5 Community Health Centers (CHCs), all the 31 Primary Health Centres (PHCs), and the District Hospital from Barwani District.

Sources of Information Gathering:

1. The data was collected using the M.P. government checklist, which is used to monitor the public health services. We decided to use the government checklist so as to demonstrate how the public health services are functioning even according to their own guidelines. The checklist for CHC had 131 parameters and PHCs had 65 parameters. A similar checklist was used for the Civil Hospital with 152 parameters.
2. All the checklists were filled, observed and crosschecked with interviews from doctors, other staff, patients and villagers.
3. Beside the checklist, observation was also done to substantiate the data gathered by checklist.

The data was collected from doctors and other staff present at the health care facilities. The data was collected between mid July to September 2003.

In the following sections, we would be presenting the findings of the data collected from PHC, CHCs and district hospitals.

REPORT CARD OF PRIMARY HEALTH CENTRES

- There is a shortfall of 15 PHCs in the district! One PHC is serving an average population of more than 29000 instead of 20,000.
- None of the PHCs fulfill the 2-6 beds norm; all PHCs have less number of beds and 8 out of 31 (26 %) have no admission facilities.
- 11 out of the 31 PHCs (36 %) building are in very bad condition.
- 15 out of 31 PHCs (48 %) do not have normal delivery facilities and 13 (42%) PHCs do not even have a delivery room.
- Out of 31 PHCs, 8 PHCs do not have connection of electric supply. In 40 % PHC the fans and the tube lights are not working. Not a single PHC had a generator backup.
- 6 (19%) PHCs did not have any source of water. 13 (41%) PHCs have water supply by hand pump and most of these run dry in summer months. Only 12 (42 %) of the PHCs had facility for running water.
- 26 PHCs (84%) do not have ambulance facilities. Only 5 PHCs (16%) had an ambulance facility and even in these 5 PHCs the drivers do not reside in PHCs.
- 13% PHCs are running without regular doctors. Only 3 PHCs had lady doctor. In 70 % percent of the PHC LHVs and MPWs were not posted.
- In 29 % of PHCs, doctors were not available in scheduled timings. Even for other staff in 20 % PHCs, staffs are not present at scheduled timings.

Findings of the PHCs:

1. Adequacy of PHC:

A PHC is supposed to serve an area of 30000 population in plains and to 20000 population in remote and tribal areas. Our area of study, Badwani district is a tribal area and thus a single PHC is supposed to serve 20000 rural population. According to 2001 census, the district had 9,23,063 rural population (Provisional Population Total, Directorate of Census Operations, Census of India 2001, MP). So according to the population criteria the district should have 46 PHCs but in reality the district have 31 PHCs. It means a shortfall of 15 PHCs in a district! Thus in effect a PHC in the district is serving an average population of more than 29000 instead of 20,000.

2. Infrastructure arrangements:

2.1 Condition of building:

Of the 31 PHCs, 24 PHCs had their own building, whereas the rest 7 PHC are situated either in donated place (2), place given by Gram Panchayat (2), rented place (1) and in subcentre (2). As shown in the table below physical conditions of 11 PHCs are very bad.

Name of block	% of government building		% of non government building		Total PHC in the block
	Satisfactory condition	Bad condition	Satisfactory condition	Bad condition	
Pati	66.7 (2)	33.1 (1)	0.0	0.0	3
Badwani	100.0 (3)	0.0	100.0 (1)	0.0	4
Rajpur	33.1 (1)	66.7 (2)	66.7 (2)	33.1 (1)	6
Newali	50.0 (1)	50.0 (1)	0.0	0.0	2
Pansemal	100.0 (4)	0.0	0.0	0.0	4
Sendhwa	28.6 (2)	71.4 (5)	0.0	0.0	7
Thikri	100.0 (2)	0.0	66.7 (2)	33.1 (1)	5
TOTAL of PHCs	15	9	5	2	31

(Figures in parenthesis indicate number of PHCs.)

In Rosar PHC the entire roof leaks. PHCs of Ojhar, Balwadi, Julwania, Dhawli, Warla and Sendhwa have very bad leaking roofs and water easily gets into the building and damages the walls, doors and windows, furniture, medical equipments and medicines. Leaking roofs affects other conditions of the building like electricity. A large number of the PHCs have new buildings under construction since long and the PHCs are being carried out from the old dilapidated buildings eg Julwania, Nagalwadi, ojhar,etc

2.2 Furniture:

As per norm every PHC is required to have admission facilities of minimum 4 to 6 beds. Our observation show that in large number of PHCs there are 1-2 beds and in some PHCs there is not even a single bed available and it is interesting to note that patients have to bring their own beds in case they want admission in Balwadi or Dhauli PHC. In some of the PHCs there are no wards but beds are there in corridor and in other PHCs there are wards but no beds. In Balwari PHC there is ward but no beds are there whereas in Nagalwadi even though beds are there no ward is there.

Those PHCs that have beds do not have clean and adequate linen like cushions, pillows and bed sheets for example in Dhanora and Rosar PHC. Either they are torn and in bad condition or they are extremely dirty and have not been washed for a long time which is the condition in Jhopali, Chachriya, Nagalwadi. Dawana, warla PHC.

Some PHCs lack basic furniture like chairs, tables and benches, examination tables etc. Lack of basic furniture hampers efficient performance of the medical staff. In many PHC patients had to stand while they wait for their turn to meet the doctor. Many PHCs did not have almirah which is needed to store medicines, linens, bandages, injections and equipments etc. In many of the PHCs medicines were either left on shelves or dumped on the floor or tied in bundles using clothes. Proper storage is essential for maintaining the efficacy of medicines and injections. In Chachriya the medicines are not stored properly in absence of almirah. In most of these PHCs the drugs supplied are without cover.

2.3 Delivery Room:

Forty two percent PHC (13) did not have a delivery room, and of the rest 18 PHC where there is a delivery room, delivery facility is not available in 6 PHCs for all 24 hours and in another 2 PHCs it is not available at all. No delivery facility in Balwari, Moida, rakhi Bajurg, Bandha Bajurg, Chatley PHC.

This non-availability of basic health service like delivery needs to be seen in the light that charges for normal delivery in private hospital vary from Rs 300 to Rs 1000 depending on the capacity of the individual to pay.

2.4 Indoor facility:

PHC by its norm is supposed to have admission facility. The study show that in 8 PHCs (26%) there is no indoor facility and only outpatient facility is available.

2.5 Electricity:

Out of 31 PHCs, 8 PHCs have power cable connected but the supply has not been connected at the time of data collection e.g. Rosar, Moida, Dhanora, Chchariya etc. Even the PHCs with power connections have very erratic power supply (4-6 hours per day). The electricity wiring is also very bad. For patient examination and carrying our other routine activities availability of adequate light is very important. Unfortunately in all the PHCs it was observed that in many rooms have dim lights. In 40 % PHC the fans and the tube lights are in non working order. For sterilization, kerosene stoves are used by many PHCs by which one can only boil needles, syringes and metal equipments, but a large number of items need dry heat like gauze, cotton, plastic items etc. that cannot be heated in absence of electricity. Certain vaccines like polio vaccine, anti-rabies vaccine and certain essential injections and reagents need continuous refrigeration to maintain their potency. Even the ice packs for cold chain maintenance are required to be refrigerated, to carry polio vaccine into far of villages. Lack of electricity even in presence of a refrigerator, hampers the vaccination programmes.

Despite a poor erratic supply not a single PHC has a generator backup. Probably government has never thought of providing modern equipments like auto analyzer, auto-claves etc. to the rural areas.

2.6 Water supply:

As evident from the table below 6 PHCs did not have any source of water (e.g. Dhauli,Talwara, Bajurg). Thirteen PHCs have water supply by hand pump and most of these run dry in summer months. In Talwara Deb water has to be fetched from more than half a kilometer away from the PHC. Only 42 percent of the PHCs had facility for running water. As explained earlier, absence of water hampers cleanliness of the facility. Therefore it is not surprising that our survey found that cleaning is unsatisfactory in 12 PHCs (39%).

Source of water	No of PHC	Percent
No water Facility	6	19.4
Tap	12	38.7
Hand pump	13	41.9
Total	31	100.0

2.7 Toilet:

Most of the PHCs, did not have a functioning toilet facility!

3. Ambulance:

Only 5 PHCs (16%) had an ambulance facility and even in these 5 PHCs the drivers do not reside in the PHCs and take some time to reach the hospital in case of emergency loosing vital minutes in case of emergency. In the absence of some basic emergency facilities at PHCs at least ambulance can be handy during emergency cases, and proper transportation facility can be life saving. The charges for ambulance is Rs. 4.00 per kilometers, but in some places double the amount are being unofficially charged.

However, in most PHCs the patients have to hire private taxis at very high cost if they are available, and if they are not available or too expensive then in case of emergencies the patients' relatives becomes helpless and many patients die because of lack of transportation facility. For instance, in Sendhwa block there is only one ambulance attached to the Sendhwa PHC, which has to cater the needs of 6 other PHC of the block which do not have any ambulance.

Case Study 1:

A clear example of 'denial of health care' is from Jhirijamli village of Sendhwa block of Barwani district, where Nawalsingh, a poor adivasi, was residing with his family of 6 members. In the night of 23rd June his son Kuwarsingh had a severe problem of vomiting and loose motions. Next day the MPW gave him an ORS packet.

When no improvement was observed in the child's condition, it was suggested that he be taken to Dhanora PHC, where the MO treated him. But, after sometime bleeding started from inside the mouth and nose of the child. At another doctor's suggestion, Nawalsingh had to shift his child to Sendhwa PHC. Due to lack of money he had to bring the critically sick child by a brick loaded truck just because Dhanora PHC didn't have ambulance for this emergency situation.

Even in Sendhwa hospital, he had to purchase injections and syringes worth over hundred rupees. Afterwards when the condition became more serious, it was suggested that he take the child to Barwani district hospital. But Nawalsingh, a poor adivasi, did not have money for the transport and further treatment, and ultimately decided to come back to home. On the way back home the child died.

This case study demonstrates how a PHC is not able to provide essential health services, not even an ambulance in an emergency condition, to save the life of an ill child.

4. Adequacy of staff:

A PHC as per norms is to have a medical officer in charge, two sector supervisors - one male and female, a staff nurse, a laboratory technician, a compounder cum pharmacist and a dresser, a watchman and atleast one another class IV staff.

Type of personnel	% of PHCs
Doctor	87.1
Compounder	16.0
Staff nurse	18.7
Others	30.7
No staff	1.3

As evident from the above table, 87 percent PHCs have a doctor but what is significant to note is that 13% PHCs did not have doctors! For instance, Palsud and Roisar PHC do not have any doctor. In Moida and Dhanora PHC, the doctor comes sometimes. Only 3 PHCs had lady doctor. The presence of compounder and staff nurse is also very inadequate. In only around 30 percent of the PHCs, LHVs and MPWs were found. One PHC (Inderpur) from Rajpur did not have any staff!

Functioning: Survey has shown that doctor stay in the Head quarter (HQ) in only 15 PHCs and in other 16 (52%) PHCs the doctor do not stay at the PHC. It is important for a PHC doctor to stay at the HQ in order to attend to emergency cases. As evident from the table below in around 29 percent of PHCs, doctors were not available in scheduled timings. Even for other staff in around 20 percent PHCs, staffs are not present at scheduled timings.

Availability of service providers	% of PHCs
Doctor available in scheduled timing	71 (22)
Other staff available in scheduled timing	80.6 (25)

Figures in parenthesis indicates number of PHCs.

5. Residence facility:

For doctor: Out of 31 PHC, 23 PHCs have residential facilities for doctors, but even these are very badly maintained and as a result doctors don't stay there. It was found that doctor's residences are occupied by other staff. For instance, iIn Mohda and Julvania they are occupied by compounders and dressers.

For Staff: Out of 31 PHC, only 13 provides staff-quarters, 18 PHCs don't have any staff quarters. Therefore LHVs, dresser and compounders working for 8-12 hours in a particular PHC are without a residence and had to stay in rented accommodation.

6. Required Equipments:

The PHCs were surveyed for basic and essential instruments and equipments. These included stethoscope, B.P. apparatus, weighing machine, basic surgical instruments like scalpel, forceps etc., microscope and oxygen cylinder. These equipments are either basic diagnostic tools even for routine and emergency diagnosis or very essential equipments for conducting lab investigation or providing emergency care. Out of 31 PHCs surveyed, 14 PHCs lacked essential supplies, and did not have more than 4 of these items. In Rosar PHC, paper pin instead of needles is used for making blood slides. It is shock to find that in a PHC needles are not available!

Case Study 2: Surgical Emergency:

Dhadgo is a 90 year old man of Kunjari village of Niwali block in Barwani district. Sometime ago he was not being able to pass urine and was suffering from acute urinary retention. Due to this problem he was taken to Sendhwa PHC for treatment, where Dr. Prajapati checked him and referred to Karuna Hospital (Private) by saying that he is not able to give him treatment here. Urinary retention is an acute surgical emergency and is simply treated by catherisation, which means a tube has to be inserted to drain the urine from the urinary bladder. This simple facility should be available at the PHC level.

In this emergency condition, the family had to take Dhadgo to Karuna Hospital where the doctor was surprised that catherisation which is easy treatment, but was not given to this old man. Hence the person had to suffer and had to spend Rs. 1200/- on treatment, which could have been freely available.

7. Laboratory facilities:

One can find a mismatch between laboratory facilities, required instruments and human power. In some PHCs there are labs equipped with microscope but there are no lab technicians and in others there are lab technicians but no microscopes are there e.g. Moida, Rosar, Bhandara, Bajurg which do not have lab technicians. In many PHCs there are microscope and lab technicians but in absence of reagents even basic routine tests like blood, urine and sputum examination cannot be done.

8. Type of services available (selected services):

Type of service	% of PHCs
Immunization	87.1
ANC/PNC clinic held	83.9
Referred new born cases treated	64.5
Treatment of communicable disease	61.3
Treatment of respiratory cases	58.1
Treatment of malaria	77.4
Laparoscope's	48.4
Female sterilization	54.8

As evident from the above table, none of the above essential services were available in all the PHCs. Immunization services are available in 87 percent PHCs, though there is much scope to doubt whether all the doses of immunization is provided to the children. If one goes by NFHS-2 data, complete coverage in the state has come down from the earlier NFHS survey, the above figure seems doubtful. Many child deaths happen due to respiratory problems, and one of the major barriers for seeking treatment is unavailability of services. This is evident from this situational analysis of Badwani district, where only 58 percent PHCs are found treating respiratory cases. Little more than 61 percent PHCs were found to treat communicable diseases. Even treatment of common illnesses like malaria is not available in more than 22 percent of the PHCs. Sterilisation services, which is very much emphasised in public health facilities that too was not found inadequate in many PHCs, then one can imagine what can be the case for other services. Sterilisation services were mostly provided through camps.

NATIONAL PROGRAMMES:

Malaria Control is a National Programme but in most PHCs there is no provision for testing of malaria parasite e.g. Julwania PHC. In many PHCs even though slides are prepared, patients do not receive the reports or the appropriate follow up treatment.

COMMUNITY HEALTH CENTRES

Report card on CHCs in Barwani district

- The district has less than half the required number of CHCs. Instead of 1 CHC per 80,000 population the district has 1 CHC for 1,84,612 population.
- None of the CHCs fulfill the 30 beds norm, all CHCs have 10 beds or less.
- 40% CHCs do not have running water facility.
- There is no functioning Operation Theatre in 60% CHCs; certain CHCs do not even have a delivery room.
- 80% of the CHCs have no specialists, the single CHC with specialists has only half of those required.
- Only one CHC has a female doctor.
- In 40% CHCs, doctors are not present during scheduled timings.
- 80% CHCs do not have neonatal resuscitation equipment or ECG machine; 40% do not have oxygen cylinder, incubator or adequate operation equipment.
- None of the CHCs provide services for caesarean delivery.

Forty percent CHCs do not provide treatment to severely anemic women or children with severe respiratory / gastrointestinal infections; 60% do not have STD clinics.

1.Adequacy of CHCs:

The CHCs is conceived as a 30 bed secondary referral centre and the norm expected is 1 CHC per block of 1 lakh population and for tribal areas is one CHC per 80000 population. At present Badwani district has 5 CHCs for a rural population of 9,23,063 (Provisional Population Totals, Rural-urban distribution, Census of India 2001, Directorate of Census Operations, MP), which means instead of 1 CHC per 80,000 population (as per tribal area norm) it has 1 CHC for 1,84,612 population approximately. A shortfall of 4 CHCs! Two blocks, Sendhwa and Badwani do not have any CHC. This shortage of CHCs in the district results in inadequacy of referrals services.

2. Infrastructure arrangements:

CHCs of the district are all situated in government owned building but none of the CHCs have 30 beds according to CHC norm. Only Rajpur and Pansemal CHC have 10 beds and the CHC at Pati has only 3 beds! Also 2 CHCs (Pati and Thikri) does not have the required furniture that a CHC is supposed to have. In absence of required furniture, drugs and other medical instruments gets damaged.

2.1 Electricity:

Uninterrupted supply of electricity is an important requirement for any medical facility. One CHC (Thikri) at the time of survey did not have electricity. In absence of electricity, drugs, and vaccines gets wasted and loses its potency, it also affects the cold chain and can become fatal in cases of operations. Even in CHCs where electricity is available, the wiring conditions are in bad shape. Alternative electric facility is available in only one CHC (Rajpur).

2.2 Water supply:
Three CHCs have facility for running water (i.e. tap) and for the rest two CHCs (Newali and Thikri), water is stored in a earthen pot. But any facility with inpatient facility should have running tap water, bathing facility and toilets. Even maintaining minimum cleanliness would be difficult to maintain in absence of such water supply.

2.3 Delivery room:
Maternal death is very high in our country. It is quite unfortunate to find that the CHC in Pati did not have a delivery room. Most of the villages in the district do not have trained birth attendants even, and therefore for delivery many women had to take recourse to untrained traditional birth attendants. In 4 CHCs, delivery room is present but it is in bad shape. It was observed that in Pansemal and Rajpur CHCs the delivery room is flooded with water during rains, and therefore become impossible to perform safe deliveries.

2.4 Operation theatre (OT):
There is no OT in 3 CHCs of the 5 CHCs in the district. It was observed that only stitching of wounds is done in OT, and due to lack of equipment, operations are not done and patients are referred to District hospital.

2.5 Ambulance facility:
All the CHCs had an ambulance, but during emergency people are not able to avail this facility due to variety of reasons like unavailability of drivers. According to the Rogi Kalyan Samiti norms people have to pay Rs 4 per kilometer but interaction with people show that most of the people are illegally charged more than that.
Vehicle for supervision: None of the CHCs had a vehicle for supervision, which in turns affects effective monitoring of extension/outreach work of the CHC.

3. Adequacy of staff:
Medical staff strength including availability of specialists at each CHC is important indicators of its provision of quality care. Of the CHCs studied, most did have medical officers but were found lacking in case of specialists. The norm is that each CHC should have 4 specialists - surgery, obstetrics and gynaecology, general medicine and paediatrics. Of the 5 CHCs only one CHC (Rajpur) had specialists that too only one surgeon and paediatrician. Only one CHC had a female doctor. Presence of female doctors assumes importance as women find it comfortable to share their health problems with female doctors especially related to their reproductive problems.

In terms of other staff, all the CHCs had a computer operator (though some CHC don't have computer!), compounder, technician, radiographist and other 4th class staff. Two CHC did not have Block Extension Educator (BEE) and clerk and one CHC did not have staff nurse. Absence of BEE means that supervision and monitoring of extension workers are not done, which might mean no or less than required extension services.

4. Residence facility:
The checklist only had one question that is whether the doctor stays at head quarters. It was found that doctors of all the 5 CHCs stay at the head quarters.

5.Functioning:
Though the study found that the CHCs were open for full time, in 2 CHCs (Pati and Newali) doctors are not present during scheduled timings. Also based on observation and with discussion with patients and villagers it was found that beside regular timings doctors hesitate to come to hospitals to attend serious cases and many of them are engaged in private practice during scheduled timings. This unavailability of doctors in health care facilities poses serious problems to patients in times of emergency in accessing health care.

6. Required Equipments:

As evident from the table below, all the CHCs were found to have BP apparatus, microscope and X-ray machine. Weighing machines were found in 4 CHCs. In Pati CHC, x-ray facilities is available only once a week, in Rajpur 3 days in a week. Only Rajpur CHC had a ECG machine. Newali and Thikri were found to have operation equipments but do not have a surgeon or an OT. There is thus a great mismatch of equipments, facilities and human power. This mismatch forces people to seek medical care from private providers. All the CHC had some of the equipments required for the cold chain, but none of them had all the required (as per the checklist) instruments.

Required Instruments	No of CHC	
	Yes	No
BP apparatus	5	0
Microscope	5	0
X-Ray machine	5	0
ECG machine	1	4
Weighing machine	4	1
Operation equipments	3	2
Equipments for cold chain	5	0
Neo-natal Equipments		
Resuscitation	1	4
Neonatal warmer	3	2
Incubator	3	2
Oxygen cylinder	3	2

Even life saving instrument like oxygen cylinder is absent in 2 CHCs (Pati and Rajpur). Important life saving neonatal instruments like resuscitation, neonatal warmer and incubator is present in only one CHC (Rajpur). No wonder neonatal mortality is high in Madhya Pradesh (According to NFHS - 2 MP, neonatal mortality is as high as 54.9 for 4 year period preceding the survey). Certain CHCs were found unable to even perform a basic investigation such as estimation of Hemoglobin.

7. Type of services available (selected list):

As evident from the table below, the services available as per the norms of a CHC are quite inadequate. None of the CHCs provide services for caesarian delivery, which is an emergency service. Many maternal deaths take place due to obstructed labour and these lives can be saved with timely interventions and quality services.

Type of service	No of CHCs in which it is available
Caesarian delivery	0
Treatment of severe anemic pregnant women	3
Serious respiratory and diarrhea cases	3
ANC and PNC clinic	5
Immunization services	5
Laparoscope's	4
Female sterilization	1
Non scalpel sterilization	1
Cuts	4
STD clinic	2

Though the data gathered show that all the CHCs organise ANC and PNC clinic but there is a large scope of doubt about the range of services that are provided as ANC and PNC services.

As far as contraception services are concerned sterilisation services are available only in camps. It is reported that sterilisation follow-ups are done. CuT insertion services are available in 4 CHCs. All the CHCs reported that temporary methods of family planning are available. It was also observed that in most of the CHC,. tubectomy camps were organised merely to achieve the targets and these camps are insensitive to the humane needs of the patients ignoring their basic rights and dignity. The most striking feature of these camps is that the insuffolation procedure (a procedure in key hole surgery where air is filled in abdomen to facilitate key hole surgery) is done using the cycle pump.

According to NFHS -2, more than 40 percent ever-married women in the state were found to suffer from any type of vaginal discharge or with symptoms of urinary tract infections (UTI). Our study found that only 2 CHCs have STD clinic, which is definitely quite inadequate with such a high prevalence of STI/UTI problems.

DISTRICT HOSPITAL (DH)

1. INFRASTRUCTURE:

1.1 Furniture: Even though the hospital has 283 beds due to lack of mattresses some of them are unused and therefore some of the admitted patients have to lie on floor and even in corridors. This is the condition especially in Paediatric and orthopedic wards and also Mahila Hospital where most of patients were seen to be lying on the floor. Condition of beds and general hygienic conditions of '16 Palang ward' are found to be in a bad state.

1.2 Beds Sheet and Linen: It was observed that those patents who are lucky to get a bed have to put up with dirty bed-sheets and pillows which are not washed and are stained with blood and urine.

1.3 Electricity: It was observed that in many of the rooms the fans and lights are not working and the wiring is loose. As Barwani gets very hot during summers it gets difficult for the staff and patients to be comfortable without a fan. Many patients are admitted and kept in the corridors, which have no fans.

1.4 Water: The patients especially the admitted patients need to have clean water for drinking, bathing and toilet. However, the water facility is erratic and unhygenic. The district hospital has only one water tank but the water is contaminated as it is situated beside the septic tank. Patients are thus not able to get safe water for drinking and for other purposes.

1.5 Toilet facility: Though there is toilet attached with most wards they do not have water facility and poses a threat to the overall hygiene of the hospital. The Sulabh Complex built with the money of RKS charges Rs 2/- per day per person and most admitted patients is not able to afford that.

1.6 Waiting facility: District Hospital caters for patients coming from far off places and many patients have to be admitted for long period. There is no proper place for relatives of patients who are admitted. The Ayushmati Bhawan is closed for the last 1 year and the Dhanwantri Dharamshala has broken doors and windows and no beds. In the last 1 year not even a single person has stayed in the Dharamshala. Therefore water, toilet, bathing, food and residential facilities should be available for the relatives of those patients.

2. Ambulances: There are three ambulances in the District Hospital. One is in good condition and used regularly, the 2nd one has breakdowns and goes frequently for repair and the third is not used, as there is no driver. According to people they don't find the service satisfactory, regular and affordable.

3. Availability of drugs: According to the norms, the district hospitals should have all essential drugs including vaccines for dog bite and snakebite. But the study found that patients had to purchase medicines from outside. This information was also corroborated from people who were admitted in the hospital. Many patients said that they have to purchase at least some medicine drugs/syrups/saline from private medical stores.

4. Blood Bank: Though there is a blood bank in the DH, people face difficulty when blood has to be acquired. There is a need for proper monitoring of the services of the blood bank so that it can be optimally used.

5. Diagnostic facilities: Though the DH is found to have facilities for basic diagnosis like a laboratory, X - ray, but patients are charged for the tests that are conducted and most of the time the cost of these tests are very high which a poor patients cannot afford.

Mahila Hospital : "*Prasuti ke nam par pratarna jhel rahi hain mahilain* " Danik Bhaskar 1-102-2003. This news and several other reporting in local dailies highlights the bad state of the Mahila Hospital but little has been done to change the situation.

ROGI KALYAN SAMITI (RKS)

An initiative has been launched in the state under the Rogi Kalyan Samitis, where for the first time effort was undertaken to bring in people's participation in hospital and health centre management and to levy user charges. Today there are 604 hospitals and health centres across Madhya Pradesh that has a RKS (MP-HDR 2002). It was found that RKS is constituted in all the 5 CHCs but it was found that in 1 CHC (Thikri) RKS do not have regular meetings. During one of the Health Dialogue in Pati, it was found that in many PHCs under Pati CHC, RKS have formally not been constituted but staff is still collecting money from patients without proper receipts. opening the way for gross financial irregularities.

ROGI KALYAN SAMITI (RKS), DISTRICT HOSPITAL, BARWANI

- RKS is saving almost 25 % of its collection even though it is seriously lacking in many of the essential services due to lack of funds.
- 75% of the total money collected by RKS was earned from general patients but out of this 11% of the total expenditure was spent on services to general patients.
- Out of the total expenditure of Rs 15,26,201/- the major expenditure of (81.3%) has been incurred on new installation of AC, Coolers and grass cutter and water pump for lawn, Repair, Electric expense of CMHO office, salary of staff employed by RKS.

RKS of DH

As per the information procured from the District Hospital, during the Financial Year 2002-2003, the total income of the RKS was Rs 20,07,762 and the total expenditure was Rs 15,26,201/- and a sum of Rs 4,81,561/- (24%) was saved in that financial year. **RKS is saving almost 25 % of its collection even though it is seriously lacking in many of the essential services due to lack of funds.** It was also gathered that the RKS has a large net saving lying as FDR in the bank amount, which was not disclosed.

On analysis of the accounts it was found that even though Rs 14,96,926 (75% of the total money out of total Rs 20,07,762 collected by RKS)) was earned from general patients but out of this only Rs 2.14.634/- (11% of the total expenditure made by RKS out of the total Rs 15,26,201) was spent on services for general patients.

Earnings of Rs 14,96,926 (75%) from general patients include mainly collections in the form of

- OPD (18.7%), collected @ Rs 2 per patient for case paper
- Indoor (18.3%), collected @ Rs 5 per patient
- Lab (10.2%), collected @ Rs 5-40 per patient
- X-ray (3.1%) @ 20-40 per patient
- Blood Bank (6.4%) collected - @ Rs50-100 per patient
- Sonography (5.4%) @ 100 per patient

Expenditure of Rs 2,14,634/- (11%) on services to general patients included:

- Lab, Blood Bank, Chemicals, ARV (6.3%)
- X-Ray Films (4.0%)
- Blood Collection Exp. (1.9%)
- Eye (1.6)
- Expenses on porridge for women who are admitted in delivery room (0.2%).

Out of the total expenditure of Rs 15,26,201/- the major expenditure of (81.3%) has been incurred on

- New Installations of (Air Conditioners, coolers, grass cutter and water pump for lawn) - 22.3%
- Repair - 12.9%
- Electric expenses for CMHO office - 11.6%
- Salary of staff employed by RKS - 7.8%

It shows that while the District Hospital is lacking in many of the essential services due to lack of funds the money is being spent on non essential repairs, installations etc.

CONCLUSIONS

The investigation report shows that Barwani has a very public health delivery system. Given the fact that the state has a poor health status this lack of public health services becomes a major barrier in improving health status. This poor state of health care services has been documented, published and presented, a number of health dialogues with the Government including Jan Sunwai's were held in Sendhwa and Pati, but yet the Government has been very slow and reluctant in responding to these peoples' initiative to improve public health.

'Health for all', which initially became the target to be achieved by 2000, and also the 'Health Guarantee Scheme' of M.P. Government which guarantees health care, the ground situation of today is very different. The investigation shows that that the public health system is grossly lacking in preparedness to achieve these objectives. Urgent action needs to be taken by the health bureaucracy for achieving these aims and GAURANTEE HEALTH SERVICES.

RECOMMENDATIONS

1. District and Block level **'health coordination committees'** should be formed immediately. These can coordinate the efforts of the public health system and by the voluntary sector in the whole district. It should include representatives of Jan Swasthya Samiti, NGOs, People's organisations and representatives of the Health department at district and block level. These committees may conduct review and planning meetings every two months to monitor improvement in health services.
2. The services should be planned in such a way so as to give **priority to areas which have difficult accessibility,** and have no health facility at all. For example Roisar, Palsud, Bokhrata, Balwadi, Dhauli etc.
3. The outcome of the investigation shows that in Barwani district, there is a shortage of 23 PHCs. Therefore the Health department should ensure to **adequate PHCs in every block.** It should also ensure **at least one CHC per block.** Some of the PHCs like Sendhwa should be upgraded to CHC.
4. All the public hospitals should immediately ensure **regular water supply and power supply** and also ensure **separate toilets and bathing facilities** for men and women. Higher priority needs to be given to waste disposal systems in all health care facilities.
5. All the public hospitals and health centers should have **minimum number of beds** according to the norms.
6. In all hospitals (including PHCs, CHCs), **ambulance with full-time drivers** should be immediately provided so that during emergencies they may be used for referral. The ambulance facility should be made free for the people Below Poverty Line (BPL).
7. At every PHC/CHC/civil hospital a **board giving information about the availability of various services** and rates of services, should be put up.
8. All the primary and community health centers including district hospitals, should have **all essentials drugs including Psychotropic Drugs.** The emergency facilities like **treatment for snakebites and dog bites** should be available in all the hospitals and health centres.
9. All the PHC, CHC and District hospital should **adopt minimum norms of service delivery** and provisioning for it.
10. It is also important that **delivery room should be functional** at PHC level.
11. In all hospitals **basic laboratory set of tests should be provided.** In district hospitals, the laboratory should also be opened along with the OPD timings because people have to go for private laboratories for certain tests. Sonography, X-ray and certain tests facility should be available on all days of the week and timing should be user friendly.
12. The **PHC staffing pattern needs restructuring** to ensure utilization of manpower and better functioning of the facility. PHCs may appoint two or three male/female multi-skilled employees.

13. All vacant posts in the health department should be filled immediately. With regard to this the most important posts are that of the lady doctor, ANM and medical officer.
14. The amount collected from the patients through the Rogi Kalyan Samiti should be made public and displayed in the facility on regular basis. These funds should be used for better patient service by providing enough medicines, disposable syringes, investigation facilities, beds and other facilities etc.
15. Public health system should support community level heath workers (Swasthya Sathis) working in three blocks of Barwani and providing basic health services at village level, by providing them free drugs and referral support.

Report of Expert panelists concerning public hearing held on 4th September 03 at Sendhwa, Madhya Pradesh

The Panel Consisted of Dr. Anant Phadke, CEHAT, Pune. Maharashra, Dr. Sunderraman , Director, State Health Resource Centre, Chattisgarh, Dr. Rahul Sharma, Convenor. B.G.V.S. M.P. (Bhopal).

The panel was quite impressed by the systematic reports presented PHC wise. for 31 PHCs, CHC-wise for 5 CHCs and 1 District hospital. These oral and written submissions indicate that in the eyes of the people, the services offered by the PHCs and CHCs are grossly deficient and of poor quality. The State of buildings, equipment, availability of necessary staff, medicines are unsatisfactory. There was considerable absence of doctors and casual attitude towards care.

Repeatedly we heard evidence that even with slight complications, doctors in these PHCs and CHCs send patients to Civil Hospital, Badwani, when they should have treated them locally itself. Many PHC, CHC doctors and even some nurses have been illegally charging patients in govt. dispensaries themselves.

We listened to the testimonies of some who had lost their children, mostly to diarrhoeal disease and we are constrained to note that in every one of them there was palpable negligence by the concerned staff who referred the case to higher centre without giving the initial treatment which would have been life saving. This kind of referring all sick cases and treating only trivial diseases, that too if possible in their private clinics, is a complete rejection of the spirit of Health for All and the national health policy.

Though they were duly invited by the organizers, unfortunately nobody from the health-officials was present to respond to the issues raised and cases presented by the people. But even in absence of the official explanation, the overall evidence presented by the people, very clearly showed the gross deficiency and poor quality of services in PHCs and CHCs. The government of M.P. through its Swasthya Jeevan Seva Gurantee Yojana has given a 'guarantee' to provide adequate health care to the people. In practice, it seemed conspicuous by its absence.

We were shocked to know that appropriate treatment is not given even in simple cases of diarrhoeas and no treatment is available in some areas for snakebite and dog-bite. Such gross deadly deficiency is a matter of shame when we enter the 21st century.

Our-Recommendations-

1) The CMHO needs to seriously take note of these gross deficiencies and take up remedial measures. A lot of additional attention, funds, human power and above all commitment is needed to provide minimum health services, which we consider as the duty of the govt.

2) The various demands put forth by the Jana Swasthya Samiti by Sendhwa need to be taken seriously.

3) The three cases presented by Rashtriya Satyagrahi Dal, very clearly show gross negligence by the concerned govt. officials. Its very disturbing that despite the follow-up of these three cases by the Rashtriya Satyagrahi Dal, so far, no justice has been done to the victims and no action has been taken against the govt. officials. We strongly recommended that social-political leaders, thinkers. press take up these cases to mobilize public opinion to harness justice in these cases.

4th Sept. 03

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Annexure – I

BLOCK & POPULATION	Sector PHC	Sub-PHC	Villages			A.W.W.
DHB Civil Hospital Anjad (43222)			Acco. to revenue dept.	Acco. to survey	Gram Panchayat	
PATI (CHC) 100000	Bokrata					
	Rosar	24	110	106	45	118
	Gandhawal					
SILAWAD (PHC) 134466	Bhawadi					
	Menimata	34	94	94	52	156
	Talwada Bujurg					
	Palsud					
RAJPUR (CHC) 171026	Julwania	40	98	98	64	256
	Nagalwadi					
	Upla					
	Indrapur					
	Ojhar					
NIWALI (CHC) 85116	Chatli					
	Jogwada	20	76	73	42	117
	Khetia					
PANSEMAL (CHC) 129044	Moyda	26	89	90	39	98
	Bandhara Bujurg					
	Rakhi Bujurg					
	Balwadi					
SENDHWA (PHC) 281824	Jhopali	53	153	153	90	228
	Dhavli					
	Chacharia					
	Warla					
	Dhanora					
	Dawana					
THIKRI (CHC) 136341	Baruphatak	38	94	93	51	148
	Brahman gaon					
	Uchawad					
	Talwada Deb					
2 + 7 = 9	29	235	714	707	383	1121

Comm-87-15

Relevance of Land Reforms for Food Security

Paper presented at National Conference on Food security and Right to work at BHOPAL

India has 70 million tones of surplus food grains in its food stores. Yet 27 percent of its population is facing hunger and acute undernutrition. There are reports of "starvation" deaths from various parts of the country. It is a matter of moral and political concern as the depth of hunger is directly related to mortality rate, life expectancy and work-productivity.

Why are 350 million citizens living in the shadow of hunger amidst plenty? Who are empty bellies and who are over fed and unnecessarily destroy food? Who is responsible for this state of affairs? Lastly what must be done? This small paper tries to answer these questions from the perspective of U.P. Campaign Committee for Land Reform and Labour Rights.

Why the shadow of hunger?

The shadow of hunger is a manifestation of extreme inequalities in people's income and unjust distribution of economic resources in our country. At this juncture availability of food is not the issue, the central issue is the people's capacity to buy it or to produce it for their substance. As per 1991 Agricultural census landless agricultural labour constitute 36.3 per cent households. Of the land owning sections marginal farmers having less than one hector of land, comprise 59.4 per cent of farm holding population owning only 15 per cent of the operated holdings, with average land holding size of 0.39 hectors. The small farmers, having 1.00 to 2.00 hectors of land, comprise 18.8 per cent of the farm holding population, owning 17.4 per cent of the area operated with average holding size of 1.43 hectors. Together marginal and small farmers constitute 78 per cent of the Indian farming population owning 32 per cent of the area operated. Rest 21.8 per cent semi medium, medium and large farmers own 67.6 per cent of the operated area. [illegible] Reforms on Dr[illegible] Rome Institute of Ec[illegible]

Land reform – equitable distribution of land to the tiller – is not a political agenda now. Access to land is privatized. It has become a marketable commodity – only those with enough money have access to it. At the same time, the poor peasants are being lured or sometimes compelled to trade their land as commodity. They then migrate to the cities and become cheap labour for industry. It is by hook or crook the land of the poor peasants is being controlled by the rich. Increase in landless labour and decrease in marginal and small farmers is quite visible. There is a phenomenal growth in the suicide rate of [illegible] and marginal farmers.

Who are empty bellies?

The landless, marginal and small farmers constitute the bulk of below poverty line population. The composition of the poor person consists of 22.5 per cent landless labour. 59.6 per cent marginal holders, 10.3 per cent small holders, 5.3 per cent medium and 2.0 per cent large holders. This clearly indicates that the poverty falls as land owning increases.

Now enough data have been generated which relate the status of undernourished population with the size of the farm household. Among the 223.2 million under nourished persons the share of each category is: agricultural labour 19.1 per cent, marginal farmers 54.6 per cent, small farmers 12.9 per cent, medium 8.4 per cent and large farmers 4.9 per cent. It is also closely associated with the status of calorie, protein and cereal intake. Education and health are also associated with it.

Table One

Nutrition and Poverty Among Agricultural Labour and Farm Household

(1999-2000)

	Agriculture Labour	Farm Households
Population under poverty %	39.7	21.0
Under nourished population %	45.5	26.2
Malnourished population	48.7	28.2
Calorie intake / person / day	1948	2278
Protein intake / person / day / gram	51.9	62.7
Cereal intake / kg / person / year	148.4	161.7

Source – Chand et.al. Impact of Agricultural Trade and Related Reforms on Domestic food security in India: Report of the study done for FAO, Rome Institute of Economic Growth. Delhi. November.

These facts clearly points out the relationship of land holding and food security in our country. People are starving because they do not have land or rights to resources. We firmly believe and reject all those policies, which commodify land. Land is a source of livelihood unless and until people don't have livelihood there is no lasting solution to hunger, under and mal nutrition

Whose Responsibility?

[illegible] of hunger is the direct concern of the state. It is the constitutional responsibility of the state to look after its citizen's [illegible]

citizen's right to work for livelihood. The state is bound with international treaties and commitments. The law of the land also holds state as responsible for creating conducive conditions for food security.

However, the state has not preformed its' duties satisfactorily. It failed miserably in implementing its agenda of land reform. In the absence of economic democracy political democracy is proving counter productive for resolving the problem of hunger. Right from independence Indian state has served the interests of the upper classes. The globalization of Indian economy has rendered the poor section of the population to more venerable conditions. The poor masses have either harmonized themselves with the prevailing conditions or adopting violence means to fulfill their requirements.

What can be done?

We feel the problem of hunger be resolved by the state through institutional methods and agencies. People need to unite for food security. For this national level struggles and mobilization need to incorporate new kind of agrarian reform – not just of land distribution. New agrarian reform needs to distribute land, set up cooperative agro-industries, defend the food sovereignty, right to produce using our own seeds, develop new farming techniques adjusted to the scale of peasant economy and to the equilibrium of the environment, develop new social forms of production in agriculture matched with education and schooling in rural areas. We must oppose corporatizing agriculture and develop new terms of trade favouring landless labour and marginal and small farmers. We must make moves for people centred technology and oppose chemicalization of agricultural land. We must be united to make effective strategies for establishing people's customary rights over natural and common property resources. Natural resources should be treated as sources of livelihood and not as a marketable commodity.

Recently, there is a significant change in the political scenario. Due to the pressure of the people's movement and assertions of deprived people as reflected in the general election 2004, peoples' issues have come up very strongly in the political scenario. Although we have a Right – Centrist Govt. coming to power, but the common minimum programme (CMP) as adopted by the ruling coalition has mentioned the key issues of the deprived sections, including Land Reform. This has created an opportunity for the peoples' organizations and initiatives to strongly emphasize its perspective through democratic struggles & follow up negotiations. An effective strategy has to be evolved to broaden the movement base and also to make it more democratic and secular in the context of class caste & gender relationships.

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Whither Health Rights.....

Issues, Initiatives and Observations

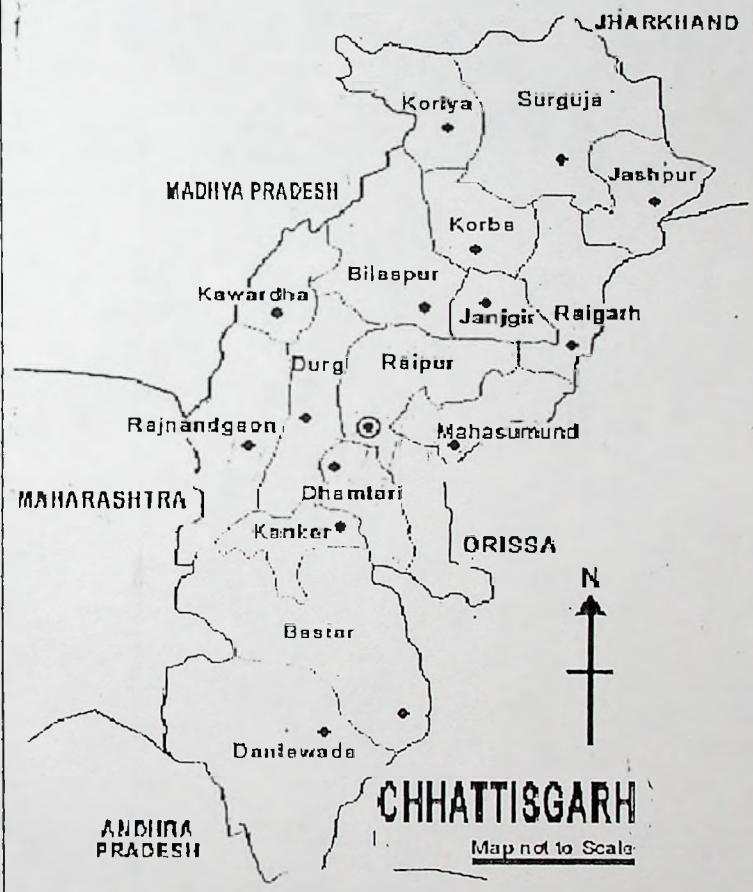
Experiences and Activities during the study on Right to Health Care as part of CHC Fellowship

Fellow: Shalini, Chhattisgarh
Mentor: Dr T Sundararaman

Chhattisgarh-Some Vital Indicators

Indicators	CG		India	
	2000	2003	2000	2003
*IMR Total	79	73	68	64
*IMR Rural	95	85	74	69
*IMR Urban	49	51	44	40
*Birth Rate Total	26.7	25	25.8	25
*Birth Rate Rural	29.2	26.5	27.6	26.6
*Birth Rate Urban	22.8	22.6	20.7	19.9
*Death Rate Total	9.6	8	8.5	8.1
*Death Rate Rural	11.2	9.7	9.3	8.7
*Death Rate Urban	7.1	7.2	6.3	6.1
**Population in million (2001)	20.79			1027
**Population Share (%)	2.02			100
**Decadal Growth Rate during 1991-2001 (%)	18.06			21.34
**Change in decadal growth rate (% points)	-7.67			-2.52
**Female Literacy Rate 2001 (%)	52.4			54.28
**Decadal Rise in Female Literacy (%points)	24.88			15
**Decadal decline in illiterates (no. in million)	2.07			31.96
**Sex Ratio	990		933	
**Popn Density	154		324	
** Tribal Population(%)	34			
***Couple Protection Rate (%)	40.1	39.9	48.1	
***Couple Protection Rate by Spacing		4.5		
***Couple Protection Rate by Sterilisation		35.4		
***Full ANC		12.89		
***Institutional Delivery		21.05		
***Safe Delivery	22.4	42.13	41.9	
***Children Fully Immunized (%)	59.1	57.58	53.3	

Based on *SRS-2002, **Census 2001 and ***IIPS-1999



Existing Health System and Gaps....

- Sub-centers:3818, sanctioned:4693, with own building:1458.
- PHCs: 512, needed by norms: 720, currently sanctioned: 515, with own building & adequate space in 327.
- CHCs:116, needed by norms180, minimum need:130, with adequate infrastructure: 34
- District hospitals:16, with adequate infrastructure : 6
- 2 Govt. Run Medical Colleges
- Facilities provided by Bhilai Steel Plants, mines hospitals, Missionary hospitals/rural centres, NGO/Trade Union Run Hospitals.

State-Civil Society Partnership Efforts At the Community Level—

MITANIN PROGRAMME

"A trained woman health volunteer in every hamlet"

18 days of camp based training and 30 days of on the job training over 18 months. Planned set of preventive and promotive and curative tasks for each Mitanin.

Objectives :

- Increase in health awareness
- INCREASE IN HEALTH SERVICES UTILISATION
- Community basing of disease control programmes and improved outreach of first contact care
- Increased organisation and empowerment of women and increased involvement and capability of panchayats

Seven cardinal features of the Mitanin Programme

1. Woman as health volunteer and hamlet as the unit.
2. Six month long process of selection- by the community but guided by the trained facilitator
3. No honorarium (token compensation for work day loss)
4. Sustained training and support over 18 months by a cadre of trainers .
5. Curative care – supplementary –not central to the programme
6. State-Civil Society Partnership at all levels
7. Parallel improvements in Health facilities to provide referral back up to Mitanins.

Current Status and Observations on Mitanin Programme

Status

- Programme ongoing in all 146 blocks in 3 phases.
- More than 54,000 Mitanins selected.
- Around 20,000 have received 5 rounds of training, further 11000 to reach that stage.
- 23,000 recently got selected and 1st training is going on.
- Programme evaluation completed in 25 blocks.

Observations

- Good Field Support and enthusiasm
- Regular Interventions and Troubleshooting
- Varying Strategies for varying situations-effective coordination established through this
- Mitanins started to respond to various health issues, local initiatives are seen.
- Massive Administrative task: Gaps in training and regular field support, monitoring&reporting,
- Funds flow problems(negligence/corruption), Problems within dept, transfers, issues of political support/commitment, issues of sustainability.
- Local Specific Issues(tribal/remote areas)

Other ongoing approaches on strengthening public health systems:

- Block by block approach on Enhancing Quality of Primary Health Care (EQUIP)-by closing gaps in terms of infrastructure, equipments, manpower, skills and Motivation- launched in 32 blocks.
- GRADED Essential Drug List(EDL) and Standard treatment guidelines (STG)and State drug formulary(SDF) adopted.
- STGs For primary health care doctor, For MPW/ANMs, For health volunteer
- Training of Doctors on the EDL , SDF and STGs. STG trainings for MPWs and CHVs(Mitanins).
- Reform in drug procurement and drug distributions systems
- Purchases only as per essential drug list and quality certification –both GMP and quality testing.
- State Health Resource Centre(SHRC) formed to initiate/support/implement these measures as an offshoot of

These Initiatives Count,

But quite a lot of problems still exist.....

- Denial of health care is prevalent in high degree.
- Discrimination to poor, tribes and marginalised is a burning issue.
- Within a very short period of 3-4 months study, a number of cases with characters of serious denial or negligence identified- Cases of malarial/maternal deaths, denial of treatment in TB, improper measures to address/ control/ manage communicable diseases/epidemic outbreaks, etc...
- lack of proper diagnosis and prescription, improper implementation of programmes, Policy and governance issues, corruption within the department, and many more reasons lead to these situations...
- Without a statewide grassroots peoples movement which is keen on regular advocacy and action, it is difficult to address these issues.
- Political Interventions are also equally important, but.....

Role of State JSA/other groups to address these issues and a brief on initiatives towards this direction

- The coverage of initiatives for PHA-2000 was wide enough in the state and its follow up activities could not be sustained for various reasons including absence of a vibrant state group to lead it. Thus the Jan Swasthya Abhiyan in the state was not functional though some efforts were made to sustain/revive the movement by some individuals/groups.
- As the JSA state group was not functional at the initial stage of the project, establishing individual level contacts to involve possible groups/individuals was a challenge.
- Though a number of NGOs/CBOs work in the state, only a few got focus on grassroots issues with a socio-political understanding. Activities of many are oriented around issues with high funds availability, rather than around burning social issues. Also, coverage of the positive groups is limited to small localities and their immediate priorities vary.
- Now, as a result of constant efforts under this project and with support from many activists/groups who are interested to build up the JSA in the state again, the JSA state group which was stagnant has become reasonably active with added members from new contacts. A number of state/zonal meetings and follow up activities towards raising the issues of denial of health care are going on. So far, more than 10 organisations are actively involved in case identification on denial of health care.

Activities initiated so far under the fellowship in association with JSA on right to health care

- Regular NGO/Activists contacts established and a number of local level meetings held in May, June and July 2004. The Guiding principles and tools on documenting denial of health care and Jan Swasthya Abhiyan has been translated/prepared and widely circulated.
- As a result, a state Jan Swasthya Abhiyan meeting with many new persons/ organisations held on 1st Aug 2004 at Raipur.
- A state JSA working group on right to health care has been formed and it has been decided that the activities will be held in 4 Zones (Sarguja, Korba, Raipur, Bastar) where public seminars would be organised to present the cases/testimonies.
- In august first half, all the 4 zonal meetings were held and regional groups formed. Tendative dates for zonal seminars finalised. Preparatory and review meetings planned. Activities going on in all zones.
- Attended the western region public hearing by NHRC at Bhopal
- Preparations are on to move towards eastern region NHRC hearing to be held at Ranchi on October 11.

Chronology of individual activities

- 15 March-16 April 2004: Initial Orientation at CHC, Bangalore
- By May 15: translation/editing/preparation of tools, guidelines and basic material on denial of health care. The PHA charter (India) also brought out in Hindi as part of this.
- May-August:
  - contacts established with various NGOs (both JSA and others) and individuals. Briefing/orientation of activists done. Met JSA state organisers on regular intervals and briefed them about the progress.
  - Regular follow up with all groups. Repeated visits and meetings wherever it was necessary/possible.
  - Attended Training Workshop of Bharat Gyan Vigyan Samiti community health team, Raebareli, U.P, as a resource person on health centered self-help activities in self help groups. Also covered right to health, right to food and right to health care.
  - Assisted mentor in reviewing the functions and costs of public health facilities.

Chronology of individual activities-2

- Attended review meetings of Mitanin Programme and maintained regular interaction with Mitanins and field functionaries wherever it was possible.
- Attended National Convention on Right to Food Campaign initiatives.
- Organised JSA state meeting, maintain regular interaction with JSA state group members. Prepared meeting proceedings and circulated among member groups.
- Attended all the 4 zonal meetings held in the state on right to health care as a resource person. Sensitised various groups/individuals attended the meeting on right to health and right to health care. Assisted in formation of zonal working groups, plans of action.
- Field Visits to support NGO activists/workers to guide them on case identification and documentation. Regular follow ups maintained.
- Attended Western Region Public Hearing on denial of health care jointly organised by National Human Rights Commission with JSA Support. Also attended JSA national coordination committee meeting representing Chhattisgarh.
- Was invitee to National Consultation on right to health, organised by ActionAid India, as part of drafting their country strategy paper.

Major Learning and Observations During the Study

- **Right to Health/Right to Health Care:** Need of constant alertness- preparations for events like NHRC hearing- challenges of case collection- strengthening media advocacy- need of legislative/executive level lobbying.
- **State and civil society joint initiatives :** SHRC as an example of institution and Mitanin as programme-strategies to sustain/replicate the innovations- political and administrative bottlenecks- Human Resource Issues -need of parallel community level advocacy and action which is not yet taken shape.
- **Right to Food Campaign:** Need of merger/joint action with JSA - importance of community level action along with gaps identification and policy and implemantational interventions with SC support- preparations for organising events.
- **Chhattisgarh NGO Scenario:** need of political education- importance of reorganising groups of conceptually fit people- Jan Swasthya Abhiyan: A network necessary for the time being-How to widen it through Mitanin- advocacy and action.
- **Tribal Health Scenario:** Problems with groups already working on the issue: NGOs, Missionaries(both Christian and Hindu), Health /Forest Depts - Issues of comunalisation- Issues of health services outreach - Issues of Food and Nutrition.

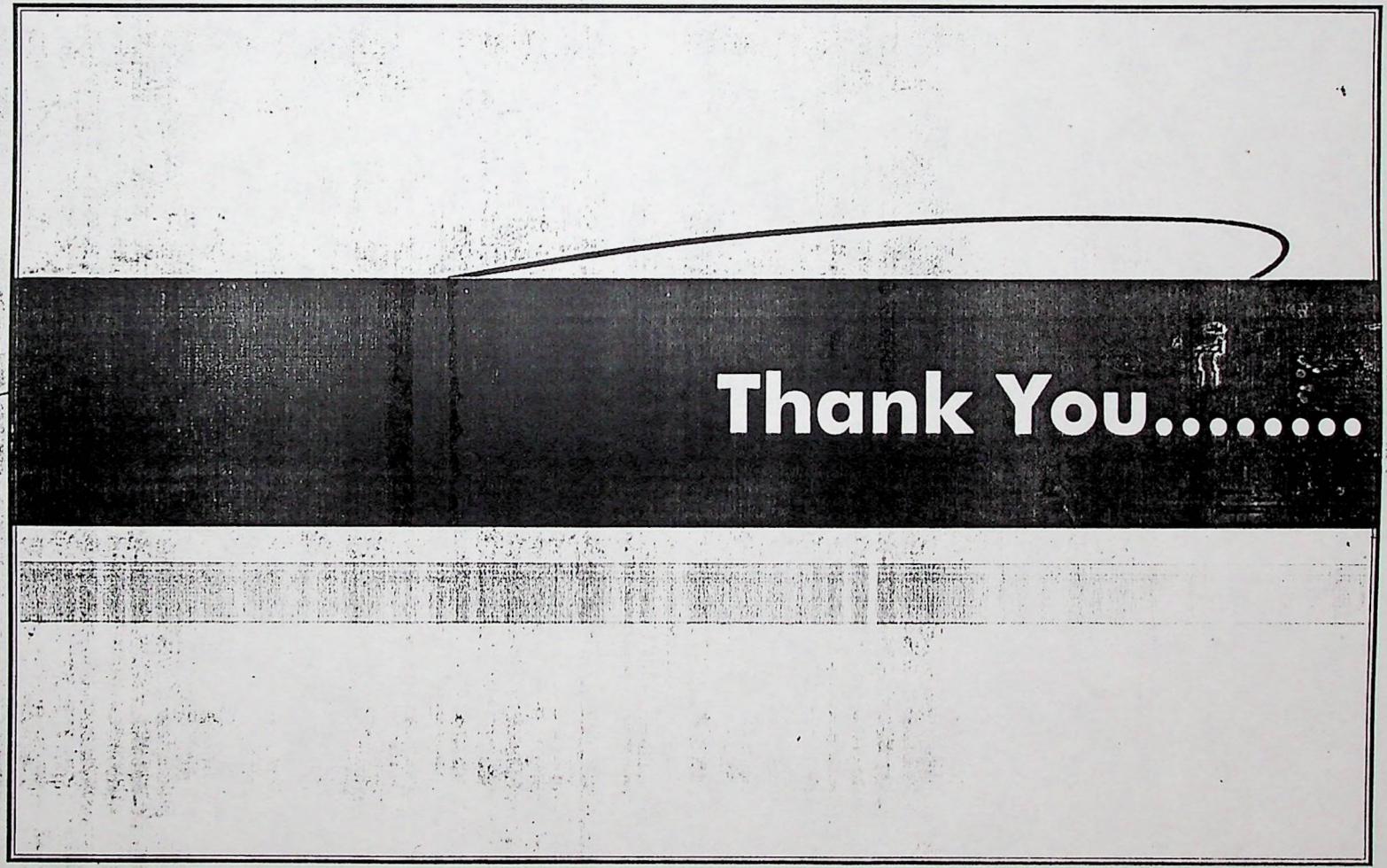
Remaining Activities as part of the study and Future Aspects

- The Project would continue till the eastern region NHRC-JSA public hearing proposed at Ranchi on 11th October, 2004. Following activities would be completed before that:
  - Proposed zonal public seminars on denial of health care in all 4 zones of the state
  - Review and final selection of cases for regional/national hearing
  - Writing and presentation of cases
  - Preparation of final Project Report/Publication.
- After Completion of the tasks under this study, My future focus would be:
  - Active involvement in Jan Swasthya Abhiyan
  - Study and Support the tribal health scenario, with special attention to nutrition aspects. This, I think, is one of the major areas needs attention of community health programmes.

Groups involved in/ Supporting the study

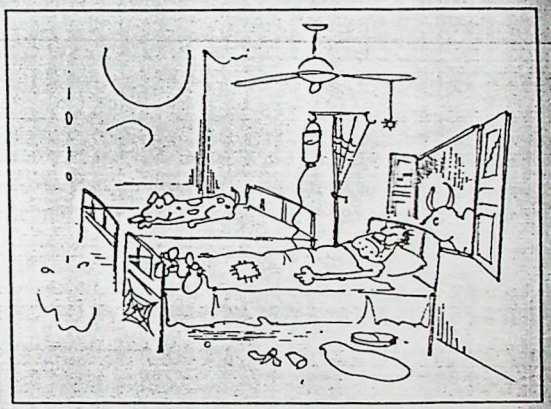
- Abhivyakti SRC, Raipur.
- ActionAid India Koria Initiative, Manedragarh.
- Adivasi Harijan Kalyan Samiti, Bastar.
- Bharat Gyan Vigyan Samiti, Chhattisgarh.
- CART, Raipur.
- Chhattisgarh Kisan Mazdoor Andolan, Sarguja.
- Lok Shakti Samiti, Raigarh.
- Sahyogi Mitra Mandal, Durg.
- SROUT, Raipur and Korba.
- State Health Resource Centre, Chhattisgarh.
- Vanvasi Chetna Ashram, Dantewada.

And other Jan Swasthya Abhiyan member/Supporting Groups in Chhattisgarh.


Thank You.....

STATUS OF PUBLIC HEALTH SERVICES

IN BARWANI DISTRICT OF MADHYA PRADESH



Study Report
Jan Swasthya Samiti, Barwani / Sendhwa
2003 - 2004

Jan Swasthya Abhiyan, Madhya Pradesh

ANNEXURE - I

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STATUS OF PUBLIC HEALTH SERVICES
IN BARWANI DISTRICT OF MADHYA PRADESH

STUDY REPORT

By
Jan Swasthya Samiti, Barwani / Sendhwa

2003 - 2004

Jan Swasthya Abhiyan, Madhya Pradesh
Published by CEHAT

This investigation was done by Jan Swasthya Samiti for Jan Swasthya Abhiyan to document the situation of public health services. The study was done in collaboration with the organizations of JSA, MP, which includes Centre for Enquiry into Health and Allied Themes (CEHAT) Indore, Ashagram Trust (AGT), Jagrit Adivasi Dalit Sangathan (JADS) and Adivasi Mukti Sangathan (AMS).

Acknowledgement

This study has been conducted by Jan Swasthya Abhiyan, Madhya Pradesh. The Jan Swasthya Samiti acknowledges the people of the villages, staff of PHCs, CHCs and District Hospital, Barwani who have responded to the survey. The people have had much belief and conviction that this report would help activate a dialogue between the people and the district health system.

The Samiti acknowledge individuals, M.S.W students from Barwani school of social work, Ashagram trust, CEHAT, Indore, who have extended their support towards this endeavor. We are thankful to Dr Abhay Shukla for his invaluable inputs. The Samiti recognises the contribution of Mr. Laxminarayan Sohner and Mr. Vijay for publication of this report. Kajal and Anand have done the Hindi translation of the summary report.

Coordinated by:
Amulya Nidhi

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Investigation Team:
Main investigator:
Sanjay Tirkey

Field investigators:
Anand Verma
Manish Dixit
Chetan Atre
Hridesh Singh
Pankaj Babu Agrawal

Our Recommendations-

1. The CMHO needs to seriously take note of these gross deficiencies and take up remedial measures. A lot of additional attention, funds, human power and above all commitment is needed to provide minimum health services, which we consider as the duty of the govt.
2. The various demands put forth by the Jana Swasthya Samiti by Sendhwa need to be taken seriously.
3. The three cases presented by Rashtriya Satyagrahi Dal, very clearly show gross negligence by the concerned govt. officials. Its very disturbing that despite the follow-up of these three cases by the Rashtriya Satyagrahi Dal, so far, no justice has been done to the victims and no action has been taken against the govt. officials. We strongly recommended that socio-political leaders, thinkers, press take up these cases to mobilize public opinion to harness justice in these cases.

4th Sept. 03

Report of Expert panelists concerning public hearing held on 4th September 03 at Sendhwa, Madhya Pradesh

The Panel Consisted of Dr. Anant Phadke, CEHAT, Pune, Maharashra, Dr. Sundarraman , Director, State Health Resource Centre, Chattisgarh, Dr. Rahul Sharma, Convenor, B.G.V.S. M.P. (Bhopal).

The panel was quite impressed by the systematic reports presented PHC wise, for 31 PHCs, CHC-wise for 5 CHCs and 1 District hospital. These oral and written submissions indicate that in the eyes of the people, the services offered by the PHCs and CHCs are grossly deficient and of poor quality. The State of buildings, equipment, availability of necessary staff, medicines are unsatisfactory. There was considerable absence of doctors and casual attitude towards care.

Repeatedly we heard evidence that even with slight complications, doctors in these PHCs and CHCs send patients to Civil Hospital, Badwani, when they should have treated them locally itself. Many PHC, CHC doctors and even some nurses have been illegally charging patients in govt. dispensaries themselves.

We listened to the testimonies of some who had lost their children, mostly to diarrhoeal disease and we are constrained to note that in every one of them there was palpable negligence by the concerned staff who referred the case to higher centre without giving the initial treatment which would have been life saving. This kind of referring all sick cases and treating only trivial diseases, that too if possible in their private clinics, is a complete rejection of the spirit of Health for All and the national health policy.

Though they were duly invited by the organizers, unfortunately nobody from the health-officials was present to respond to the issues raised and cases presented by the people. But even in absence of the official explanation, the overall evidence presented by the people, very clearly showed the gross deficiency and poor quality of services in PHCs and CHCs. The government of M.P. through its Swasthya Jeevan Seva Gurantee Yojana has given a 'guarantee' to provide adequate health care to the people. In practice, it seemed conspicuous by its absence.

We were shocked to know that appropriate treatment is not given even in simple cases of diarrhoeas and no treatment is available in some areas for snakebite and dog-bite. Such gross deadly deficiency is a matter of shame when we enter the 21st century.

Status of Public health services in Barwani district of Madhya Pradesh

EXECUTIVE SUMMARY

PHCs in Barwani district:

- There is a shortfall of 15 PHCs in the district! One PHC is serving an average population of more than 29000 instead of 20,000.
- None of the PHCs fulfill the 2-6 beds norm; all PHCs have less number of beds and 8 out of 31 (26 %) have no admission facilities
- 11 out of the 31 PHCs (36 %) building are in very bad condition.
- 15 out of 31 PHCs (48 %) do not have normal delivery facilities and 13 (42%) PHCs do not even have a delivery room.
- Out of 31 PHCs, 8 PHCs do not have connection of electric supply. In 40 % PHC the fans and the tubelights are not working. Not a single PHC had a generator backup.
- 6 (19%) PHCs did not have any source of water. 13 (41%) PHCs have water supply by hand pump and most of these run dry in summer months. Only 12 (42 %) of the PHCs had facility for running water.
- 26 PHCs (84%) do not have ambulance facilities. Only 5 PHCs (16%) had an ambulance facility and even in these 5 PHCs the drivers do not reside in PHCs.
- 13% PHCs are running without regular doctors. Only 3 PHCs had lady doctor. In 70 % percent of the PHC LHVs and MPWs were not posted.
- In 29 % of PHCs, doctors were not available in scheduled timings. Even for other staff in 20 % PHCs, staffs are not present at scheduled timings.

CHCs in Barwani district

- The district has less than half of the required number of CHCs. Instead of 1 CHC per 80,000 population the district has 1 CHC for 1,84,612 population.
- None of the CHCs fulfill the 30-bed norm; all CHCs have 10 beds or less.
- 40% CHCs do not have running water facility.
- There is no functioning Operation Theatre in 60% CHCs; certain CHCs do not even have a delivery room.

- 80% of the CHCs have no specialists, the single CHC with specialists has only half of those required.
- Only one CHC has a female doctor.
- In 40% CHCs, doctors are not present during scheduled timings.
- 80% CHCs do not have neonatal resuscitation equipment or ECG machine; 40% do not have oxygen cylinder, incubator or adequate operation equipment.
- None of the CHCs provide services for caesarean delivery.
- 40% CHCs do not provide treatment to severely anemic women or children with severe respiratory / gastrointestinal infections; 60% do not have STD clinics.

District Hospital in Barwani district

- When admitted, some patients have to lie on floor and even in corridors. This was observed especially in Pediatric and orthopedic wards. Similar conditions exist in Mahila Hospital also where most of patients were seen to be lying on the floor.
- The water facility in the hospital is erratic and unhygienic. The district hospital has only one water tank but the water is likely to be contaminated as it is situated beside the septic tank.
- Only one ambulance in the District Hospital is in good condition.
- Many patients have to purchase medicines such as drugs/syrups/saline from private medical stores.

ROGI KALYAN SAMITI of Barwani District Hospital (Data for 2002-2003)

- RKS is not utilising almost 25 % of its collection even though the hospital is seriously lacking in many of the essential services due to lack of funds.
- 75% of the total money collected by RKS is earned from general patients. However, only 11% of the total expenditure is spent on services for general patients.
- Out of the total expenditure of Rs 15,26,201/- the major expenditure of (81.3%) RKS has been incurred on items not related directly to patient services like new installation of AC, coolers, grass cutter and water pump for lawn, building repair, electric expense of CMHO office and for salary of staff employed by RKS.

5. All the public hospitals and health centers should have minimum number of beds according to the norms.
6. In all hospitals (including PHCs, CHCs), ambulance with full-time drivers should be immediately provided so that during emergencies they may be used for referral. The ambulance facility should be made free for the people Below Poverty Line (BPL).
7. At every PHC/CHC/civil hospital a board giving information about the availability of various services and rates of services, should be put up.
8. All the primary and community health centers including district hospitals, should have all essentials drugs including Psychotropic Drugs. The emergency facilities like treatment for snakebites and dog bites should be available in all the hospitals and health centres.
9. All the PHC, CHC and District hospital should adopt minimum norms of service delivery and provisioning for it.
10. It is also important that delivery room should be functional at PHC level.
11. In all hospitals basic laboratory set of tests should be provided. In district hospitals, the laboratory should also be opened along with the OPD timings because people have to go for private laboratories for certain tests. Sonography, X-ray and certain tests facility should be available on all days of the week and timing should be user friendly.
12. The PHC staffing pattern needs restructuring to ensure utilization of manpower and better functioning of the facility. PHCs may appoint two or three male/ female multi-skilled employees.
13. All vacant posts in the health department should be filled immediately. With regard to this the most important posts are that of the lady doctor, ANM and medical officer.
14. The amount collected from the patients through the Rogi Kalyan Samiti should be made public and displayed in the facility on regular basis. These funds should be used for better patient service by providing enough medicines, disposable syringes, investigation facilities, beds and other facilities etc.
15. Public health system should support community level heath workers (Swasthya Sathis) working in three blocks of Barwani and providing basic health services at village level, by providing them free drugs and referral support.

CONCLUSIONS

The investigation report shows that Barwani has a very public health delivery system. Given the fact that the state has a poor health status this lack of public health services becomes a major barrier in improving health status. This poor state of health care services has been documented, published and presented, a number of health dialogues with the Government including Jan Sunwai's were held in Sendhwa and Pati, but yet the Government has been very slow and reluctant in responding to these peoples' initiative to improve public health.

'Health for All', which initially became the target to be achieved by 2000, and also the 'Health Guarantee Scheme' of M.P. Government which guarantees health care, the ground situation of today is very different. The investigation shows that that the public health system is grossly lacking in preparedness to achieve these objectives. Urgent action needs to be taken by the health bureaucracy for achieving these aims and GAURANTEE HEALTH SERVICES.

RECOMMENDATIONS

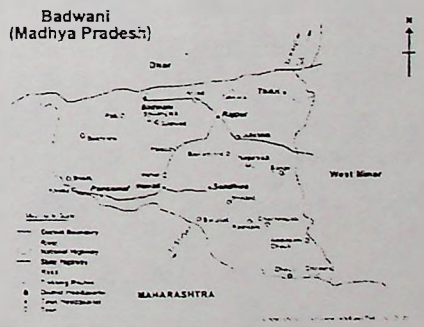
1. District and Block level 'health coordination committees' should be formed immediately. These can coordinate the efforts of the public health system and by the voluntary sector in the whole district. It should include representatives of Jan Swasthya Samiti, NGOs, People's organisations and representatives of the Health department at district and block level. These committees may conduct review and planning meetings every two months to monitor improvement in health services.
2. The services should be planned in such a way so as to give priority to areas which have difficult accessibility, and have no health facility at all. For example Roisar, Palsud, Bokhrata, Balwadi, Dhauli etc.
3. The outcome of the investigation shows that in Barwani district, there is a shortage of 23 PHCs. Therefore the Health department should ensure to adequate PHCs in every block. It should also ensure at least one CHC per block. Some of the PHCs like Sendhwa should be upgraded to CHC.
4. All the public hospitals should immediately ensure regular water supply and power supply and also ensure separate toilets and bathing facilities for men and women. Higher priority needs to be given to waste disposal systems in all health care facilities.

INTRODUCTION

Madhya Pradesh is located at the geographical centre of India with Bhopal as the capital. It shares its borders with five states, viz. Maharashtra, Gujarat, Rajasthan, Uttar Pradesh and Chhattishgarh. Erstwhile Madhya Pradesh was the largest Indian state in terms of area (spread over 443,000 sq. kms), and had accounted for 14% of India's land mass. According to 2001 census, Madhya Pradesh had a population of 60,385,118(male 31,456,873, female 28,928,245). The population sex ratio number of females per 1000 males was 920 in 2001. The state, has the highest population of Schedule Tribes (23% of the country) outside northeastern states. The literacy rate of the state is 64.11%. It is one of the most economically backward states with more than 42 percent population living below the poverty line (NCAER 2002) It is also one of the low literacy states in the country. Most of the villages in the state do not have an all season approach road. Tribal regions are mostly in hilly areas, where people have to walk nearly 15-20 Kilometers to get basic services.

In the western region of Madhya Pradesh, Barwani is one of the less developed districts. Ninety percent tribal population, mainly by Barelas, Bhilalas, and the Bhils, inhabits it.

According to 2001 Census the total population is 10,81,039, with 547837 males and 533202 females. The female literacy is 19.01% and the male literacy is 36.77%. Barwani district has 7 development blocks, 714 villages, 383 Gram Panchayat and 1121 AWW. The maternal mortality rate is 5 per 1000. In terms of health facilities it has 1 district hospital, 5 Community Health Centre (CHC), 31 Primary Health Centres (PHCs), 235 sub centers (SCs). At the village level, ANM/MPW are deputed to provide basic health services to people.



The declaration of Alma-Ata Conference in 1978, setting the goal of Health for All by 2000 AD has ushered in a new philosophy of equity, the new primary health

care approach. The National Health Plan (1983) proposed reorganization of primary health centres on the basis of one PHC for every 30000 rural population in the plains, and one PHC for every 20000 population in hilly, tribal and backward areas for more effective coverage.

Health problems like tuberculosis and Malaria in tribal communities are compounded by difficult terrain, mutual disbelief and mistrust between the community and health workers and non-availability of essential/life saving medicines in the area. Poor child and maternal health status, prevalence of infectious and diseases are common causes of early deaths in this area and the state has to improve the situation by improving its health services adopting an appropriate developmental plans and by co-operation with social and voluntary organisations.

Madhya Pradesh Government has given a Guarantee to provide all basic Health services through Swastha Jeevan Seva Guarantee Yojna, which was initiated in the year 2001. But over 2 years after the implementation of the Yojna, the failure of the public heath services in several districts of Madhya Pradesh continues to be a stark reality. This prompted the Jan Swasthya Samiti to initiate an investigation of Public Health Services in Barwani district.

OBJECTIVES:

1. To assess the level and limitations regarding availability of the health care services in the government health facilities.
2. To recommend improvements in organisation and delivery of public health care services.

METHODOLOGY:

Sample selection:

The data was collected from all the 5 Community Health Centers (CHCs), all the 31 Primary Health Centres (PHCs), and the District Hospital from Barwani District.

Sources of Information Gathering:

1. The data was collected using the M.P. government checklist, which is used to monitor the public health services. We decided to use the government checklist so as to demonstrate how the public health services are functioning even according to their own guidelines. The checklist for CHC had 131 parameters

Expenditure of Rs 2,14,634/- (11%) on services to general patients included:

- Lab, Blood Bank, Chemicals, ARV (6.3%)
- X-Ray Films (4.0%)
- Blood Collection Exp. (1.9%)
- Eye (1.6)
- Expenses on porridge for women who are admitted in delivery room (0.2%).

Out of the total expenditure of Rs 15,26,201/- the major expenditure of (81.3%) has been incurred on

- New Installations of (Air Conditioners, coolers, grass cutter and water pump for lawn) - 22.3%
- Repair - 12.9%
- Electric expenses for CMHO office - 11.6%
- Salary of staff employed by RKS - 7.8%

It shows that while the District Hospital is lacking in many of the essential services due to lack of funds the money is being spent on non essential repairs, installations etc.

ROGI KALYAN SAMITI (RKS), DISTRICT HOSPITAL, BARWANI

- RKS is saving almost 25 % of its collection even though it is seriously lacking in many of the essential services due to lack of funds.
- 75% of the total money collected by RKS was earned from general patients but out of this 11% of the total expenditure was spent on services to general patients.
- Out of the total expenditure of Rs 15,26,201/- the major expenditure of (81.3%) has been incurred on new installation of AC, Coolers and grass cutter and water pump for lawn, Repair, Electric expense of CMHO office, salary of staff employed by RKS.

RKS of DH

As per the information procured from the District Hospital, during the Financial Year 2002-2003, the total income of the RKS was Rs 20,07,762 and the total expenditure was Rs 15,26,201/- and a sum of Rs 4,81,561/- (24%) was saved in that financial year. RKS is saving almost 25 % of its collection even though it is seriously lacking in many of the essential services due to lack of funds. It was also gathered that the RKS has a large net saving lying as FDR in the bank amount, which was not disclosed.

On analysis of the accounts it was found that even though Rs 14,96,926 (75% of the total money out of total Rs 20,07,762 collected by RKS)) was earned from general patients but out of this only Rs 2,14,634/- (11% of the total expenditure made by RKS out of the total Rs 15,26,201) was spent on services for general patients.

Earnings of Rs 14,96,926 (75%) from general patients include mainly collections in the form of

- OPD (18.7%), collected @ Rs 2 per patient for case paper
- Indoor (18.3%), collected @ Rs 5 per patient
- Lab (10.2%), collected @ Rs 5-40 per patient
- X-ray (3.1%) @ 20-40 per patient
- Blood Bank (6.4%) collected - @ Rs50-100 per patient
- Sonography (5.4%) @ 100 per patient

and PHCs had 65 parameters. A similar checklist was used for the Civil Hospital with 152 parameters.

2. All the checklists were filled, observed and crosschecked with interviews from doctors, other staff, patients and villagers.
3. Beside the checklist, observation was also done to substantiate the data gathered by checklist.

The data was collected from doctors and other staff present at the health care facilities. The data was collected between mid July to September 2003.

In the following sections, we would be presenting the findings of the data collected from PHC, CHCs and district hospitals.

PRIMARY HEALTH CENTRES

REPORT CARD OF PRIMARY HEALTH CENTRES

- There is a shortfall of 15 PHCs in the district! One PHC is serving an average population of more than 29000 instead of 20,000.
- None of the PHCs fulfill the 2-6 beds norm: all PHCs have less number of beds and 8 out of 31 (26 %) have no admission facilities.
- 11 out of the 31 PHCs (36 %) building are in very bad condition.
- 15 out of 31 PHCs (48 %) do not have normal delivery facilities and 13 (42%) PHCs do not even have a delivery room.
- Out of 31 PHCs, 8 PHCs do not have connection of electric supply. In 40 % PHC the fans and the tube lights are not working. Not a single PHC had a generator backup.
- 6 (19%) PHCs did not have any source of water. 13 (41%) PHCs have water supply by hand pump and most of these run dry in summer months. Only 12 (42 %) of the PHCs had facility for running water.
- 26 PHCs (84%) do not have ambulance facilities. Only 5 PHCs (16%) had an ambulance facility and even in these 5 PHCs the drivers do not reside in PHCs.
- 13% PHCs are running without regular doctors. Only 3 PHCs had lady doctor. In 70 % percent of the PHC LHVs and MPWs were not posted.
- In 29 % of PHCs, doctors were not available in scheduled timings. Even for other staff in 20 % PHCs, staffs are not present at scheduled timings.

Findings of the PHCs:

1. Adequacy of PHC:

A PHC is supposed to serve an area of 30000 population in plains and to 20000 population in remote and tribal areas. Our area of study, Badwani district is a tribal area and thus a single PHC is supposed to serve 20000 rural population. According to 2001 census, the district has 9,23,063 rural population (Provisional Population Total, Directorate of Census Operations, Census of India 2001, MP). So according to the population criteria the district should have 46 PHCs but in reality the district have 31 PHCs. It means a shortfall of 15 PHCs in a district! Thus

2. Ambulances: There are three ambulances in the District Hospital. One is in good condition and used regularly, the 2nd one has breakdowns and goes frequently for repair and the third is not used, as there is no driver. According to people they don't find the service satisfactory, regular and affordable.

3. Availability of drugs: According to the norms, the district hospitals should have all essential drugs including vaccines for dog bite and snakebite. But the study found that patients had to purchase medicines from outside. This information was also corroborated from people who were admitted in the hospital. Many patients said that they have to purchase at least some medicine drugs/syrups/saline from private medical stores.

4. Blood Bank: Though there is a blood bank in the DH, people face difficulty when blood has to be acquired. There is a need for proper monitoring of the services of the blood bank so that it can be optimally used.

5. Diagnostic facilities: Though the DH is found to have facilities for basic diagnosis like a laboratory, X - ray, but patients are charged for the tests that are conducted and most of the time the cost of these tests are very high which a poor patients cannot afford.

Mahila Hospital : *"Prasuti ke nam par prataina jhel rahi hain mahilain "* Danik Bhaskar 1-102-2003. This news and several other reporting in local dailies highlights the bad state of the Mahila Hospital but little has been done to change the situation.

ROGI KALYAN SAMITI (RKS)

An initiative has been launched in the state under the Rogi Kalyan Samitis, where for the first time effort was undertaken to bring in people's participation in hospital and health centre management and to levy user charges. Today there are 604 hospitals and health centres across Madhya Pradesh that has a RKS (MP-HDR 2002). It was found that RKS is constituted in all the 5 CHCs but it was found that in 1 CHC (Thikri) RKS do not have regular meetings. During one of the Health Dialogue in Pati, it was found that in many PHCs under Pati CHC, RKS have formally not been constituted but staff is still collecting money from patients without proper receipts, opening the way for gross financial irregularities.

DISTRICT HOSPITAL (DH)

1. INFRASTRUCTURE:

1.1 Furniture: Even though the hospital has 283 beds due to lack of mattresses some of them are unused and therefore some of the admitted patients have to lie on floor and even in corridors. This is the condition especially in Paediatric and orthopedic wards and also Mahila Hospital where most of patients were seen to be lying on the floor. Condition of beds and general hygienic conditions of '16 Palang ward' are found to be in a bad state.

1.2 Beds Sheet and Linen: It was observed that those patents who are lucky to get a bed have to put up with dirty bed-sheets and pillows which are not washed and are stained with blood and urine.

1.3 Electricity: It was observed that in many of the rooms the fans and lights are not working and the wiring is loose. As Barwani gets very hot during summers it gets difficult for the staff and patients to be comfortable without a fan. Many patients are admitted and kept in the corridors, which have no fans.

1.4 Water: The patients especially the admitted patients need to have clean water for drinking, bathing and toilet. However, the water facility is erratic and unhygenic. The district hospital has only one water tank but the water is contaminated as it is situated beside the septic tank. Patients are thus not able to get safe water for drinking and for other purposes.

1.5 Toilet facility: Though there is toilet attached with most wards they do not have water facility and poses a threat to the overall hygiene of the hospital. The Sulabh Complex built with the money of RKS charges Rs 2/- per day per person and most admitted patients is not able to afford that.

1.6 Waiting facility: District Hospital caters for patients coming from far off places and many patients have to be admitted for long period. There is no proper place for relatives of patients who are admitted. The Ayushmati Bhawan is closed for the last 1 year and the Dhanwantri Dharamshala has broken doors and windows and no beds. In the last 1 year not even a single person has stayed in the Dharamshala. Therefore water, toilet, bathing, food and residential facilities should be available for the relatives of those patients.

in effect a PHC in the district is serving an average population of more than 29000 instead of 20,000.

2. Infrastructure arrangements:

2.1 Condition of building:

Of the 31 PHCs, 24 PHCs had their own building, whereas the rest 7 PHC are situated either in donated place (2), place given by Gram Panchayat (2), rented place (1) and in subcentre (2). As shown in the table below physical conditions of 11 PHCs are very bad.

Name of Block	% of Government Building		% of Non Government Building		Total PHC in The Block
	Satisfactory Condition	Bad Condition	Satisfactory Condition	Bad Condition	
Pati	66.7 (2)	33.1 (1)	0.0	0.0	3
Badwani	100.0 (3)	0.0	100.0 (1)	0.0	4
Rajpur	33.1 (1)	66.7 (2)	66.7 (2)	33.1 (1)	6
Newali	50.0 (1)	50.0 (1)	0.0	0.0	2
Pansemal	100.0 (4)	0.0	0.0	0.0	4
Sendhwa	28.6 (2)	71.4 (5)	0.0	0.0	7
Thikri	100.0 (2)	0.0	66.7 (2)	33.1 (1)	5
TOTAL of PHCs	15	9	5	2	31

(Figures in parenthesis indicate number of PHCs.)

In Rosar PHC the entire roof leaks. PHCs of Ojhar, Balwadi, Julwania, Dhawli, Warla and Sendhwa have very bad leaking roofs and water easily gets into the building and damages the walls, doors and windows, furniture, medical equipments and medicines. Leaking roofs affects other conditions of the building like electricity. A large number of the PHCs have new buildings under construction since long and the PHCs are being carried out from the old dilapidated buildings eg Julwania, Nagalwadi, ojhar,etc

2.2 Furniture:

As per norm every PHC is required to have admission facilities of minimum 4 to 6 beds. Our observation show that in large number of PHCs there are 1-2 beds and in some PHCs there is not even a single bed available and it is interesting to note that patients have to bring their own beds in case they want admission in Balwadi or Dhauli PHC. In some of the PHCs there are no wards but beds are there in corridor and in other PHCs there are wards but no beds. In Balwari PHC there is ward but no beds are there whereas in Nagalwadi even though beds are there no ward is there.

Those PHCs that have beds do not have clean and adequate linen like cushions, pillows and bed sheets for example in Dhanora and Rosar PHC. Either they are torn and in bad condition or they are extremely dirty and have not been washed for a long time which is the condition in Jhopali, Chachriya, Nagalwadi, Dawana, warla PHC.

Some PHCs lack basic furniture like chairs, tables and benches, examination tables etc. Lack of basic furniture hampers efficient performance of the medical staff. In many PHC patients had to stand while they wait for their turn to meet the doctor. Many PHCs did not have almirah which is needed to store medicines, linens, bandages, injections and equipments etc. In many of the PHCs medicines were either left on shelves or dumped on the floor or tied in bundles using clothes. Proper storage is essential for maintaining the efficacy of medicines and injections. In Chachriya the medicines are not stored properly in absence of almirah. In most of these PHCs the drugs supplied are without cover.

2.3 Delivery Room:

Forty two percent PHC (13) did not have a delivery room, and of the rest 18 PHC where there is a delivery room, delivery facility is not available in 6 PHCs for all 24 hours and in another 2 PHCs it is not available at all. No delivery facility in Balwari, Moida, rakhi Bajurg, Bandha Bajurg, Chatley PHC.

This non-availability of basic health service like delivery needs to be seen in the light that charges for normal delivery in private hospital vary from Rs 300 to Rs 1000 depending on the capacity of the individual to pay.

insertion services are available in 4 CHCs. All the CHCs reported that temporary methods of family planning are available. It was also observed that in most of the CHC, tubectomy camps were organised merely to achieve the targets and these camps are insensitive to the humane needs of the patients ignoring their basic rights and dignity. The most striking feature of these camps is that the insuffolation procedure (a procedure in key hole surgery where air is filed in abdomen to facilitate key hole surgery) is done using the cycle pump.

According to NFHS -2, more than 40 percent ever-married women in the state were found to suffer from any type of vaginal discharge or with symptoms of urinary tract infections (UTI). Our study found that only 2 CHCs have STD clinic, which is definitely quite inadequate with such a high prevalence of STI/UTI problems.

mortality is high in Madhya Pradesh (According to NFHS - 2 MP, neonatal mortality is as high as 54.9 for 4 year period preceding the survey). Certain CHCs were found unable to even perform a basic investigation such as estimation of Hemoglobin.

7. Type of services available (selected list):

As evident from the table below, the services available as per the norms of a CHC are quite inadequate. None of the CHCs provide services for caesarian delivery, which is an emergency service. Many maternal deaths take place due to obstructed labour and these lives can be saved with timely interventions and quality services.

Type of service	No of CHCs in which it is available
Caesarian delivery	0
Treatment of severe anemic pregnant women	3
Serious respiratory and diarrhea cases	3
ANC and PNC clinic	5
Immunization services	5
Laparoscope's	4
Female sterilization	1
Non scalpel sterilization	1
Cuts	4
STD clinic	2

Though the data gathered show that all the CHCs organise ANC and PNC clinic but there is a large scope of doubt about the range of services that are provided as ANC and PNC services.

As far as contraception services are concerned sterilisation services are available only in camps. It is reported that sterilisation follow-ups are done. Cut

CASE NO 5 - CHILD HEALTH PROBLEMS-

R is 2 and half years old child of Mr. V of village D of a block of Badwani district,M.P. He had fever & vomiting taken to private Doctor for two days. Later because of no improvement was taken to G PHC where treated by doctor. After treatment of 2-3 days his left eyelid dropped (pitosis) developed. He was referred to CHC, P where treated by doctor for 5 days, by this time the child had developed rigidity of limbs, and the doctor gave eye drops & ointment for rigid mussels for massage. He even took treatment from Jan Swasthya Rakshak of P block, where he was finally referred to Badwani District hospital, here he was shown in eye department from where he was referred to child (pediatric) department and admitted. Here no proper treatment was given to the child even though he remained there for 8days. Since condition of his eye worsted, he was asked to get admitted to the eye ward. Child was taken to eye department again; the eye doctor without treating him referred him back to the Pediatric department. He again was kept in the Pediatric department for 6days & his both eyes became infected and when his father protested then he was referred to private eye doctor.

From the prescription of private eye doctor (Part of case record) it is clear that the child had developed complete paralysis of all the mussels of both eyes (complete opthalmoplegia) and very little could be done to solve his eye sight.After seeing the prescription of private eye doctor the hospital instead of treating him, immediately discharged the child the unfortunate child became blind for life due to continued denial of health services at the all levels (Jan swasthya Rakshak, PHC,CHC,District hospital)

TYPE OF DENAIL:

1. Patient referred outside for doing investigations.
2. Negligence of the health staff.
3. Delay in treatment.

CONSEQUENCES OF DENIAL

1. Permanent damage leading to handicap
2. Moderate financial loss.

2.4 Indoor facility:

PHC by its norm is supposed to have admission facility. The study show that in 8 PHCs (26%) there is no indoor facility and only outpatient facility is available.

2.5 Electricity:

Out of 31 PHCs, 8 PHCs have power cable connected but the supply has not been connected at the time of data collection e.g. Rosar, Moida, Dhanora.

Chchariya etc. Even the PHCs with power connections have very erratic power supply (4-6 hours per day). The electricity wiring is also very bad. For patient examination and carrying our other routine activities availability of adequate light is very important. Unfortunately in all the PHCs it was observed that in many rooms have dim lights. In 40 % PHC the fans and the tube lights are in non working order. For sterilization, kerosene stoves are used by many PHCs by which one can only boil needles, syringes and metal equipments, but a large number of items need dry heat like gauze, cotton, plastic items etc. that cannot be heated in absence of electricity. Certain vaccines like polio vaccine, anti-rabies vaccine and certain essential injections and reagents need continuous refrigeration to maintain their potency. Even the ice packs for cold chain maintenance are required to be refrigerated, to carry polio vaccine into far of villages. Lack of electricity even in presence of a refrigerator. hampers the vaccination programmes.

Despite a poor erratic supply not a single PHC has a generator backup. Probably government has never thought of providing modern equipments like auto analyzer, auto-claves etc. to the rural areas.

2.6 Water supply:

As evident from the table below 6 PHCs did not have any source of water (e.g. Dhauli,Talwara, Bajurg). Thirteen PHCs have water supply by hand pump and most of these run dry in summer months. In Talwara Deb water has to be fetched from more than half a kilometer away from the PHC. Only 42 percent of the PHCs had facility for running water. As explained earlier, absence of water hampers cleanliness of the facility. Therefore it is not surprising that our survey found that cleaning is unsatisfactory in 12 PHCs (39%).

Source of water	No of PHC	Percent
No water Facility	6	19.4
Tap	12	38.7
Hand pump	13	41.9
Total	31	100.0

2.7 Toilet:

Most of the PHCs, dic not have a functioning toilet facility.

6. Required Equipments:

As evident from the table below, all the CHCs were found to have BP apparatus, microscope and X-ray machine. Weighing machines were found in 4 CHCs. In Pati CHC, x-ray facilities is available only once a week in Rajpur 3 days in a week. Only Rajpur CHC had a ECG machine. Newali and Thikri were found to have operation equipments but do not have a surgeon or an OT. There is thus a great mismatch of equipments, facilities and human power. This mismatch forces people to seek medical care from private providers. All the CHC had some of the equipments required for the cold chain, but none of them had all the required (as per the checklist) instruments.

Required Instruments	No of CHC	
	Yes	No
BP apparatus	5	0
Microscope	5	0
X-Ray machine	5	0
ECG machine	1	4
Weighing machine	4	1
Operation equipments	3	2
Equipments for cold chain	5	0
Neo-natal Equipments		
Resuscitation	1	4
Neonatal warmer	3	2
Incubator	3	2
Oxygen cylinder	3	2

Even life saving instrument like oxygen cylinder is absent in 2 CHCs (Pati and Rajpur). Important life saving neonatal instruments like resuscitation, neonatal warmer and incubator is present in only one CHC (Rajpur). No wonder neonatal

avail this facility due to variety of reasons like unavailability of drivers. According to the Rogi Kalyan Samiti norms people have to pay Rs 4 per kilometer but interaction with people show that most of the people are illegally charged more than that.

Vehicle for supervision: None of the CHCs had a vehicle for supervision, which in turns affects effective monitoring of extension/outreach work of the CHC.

3. Adequacy of staff:

Medical staff strength including availability of specialists at each CHC is important indicators of its provision of quality care. Of the CHCs studied, most did have medical officers but were found lacking in case of specialists. The norm is that each CHC should have 4 specialists - surgery, obstetrics and gynaecology, general medicine and paediatrics. Of the 5 CHCs only one CHC (Rajpur) had specialists that too only one surgeon and paediatrician. Only one CHC had a female doctor. Presence of female doctors assumes importance as women find it comfortable to share their health problems with female doctors especially related to their reproductive problems.

In terms of other staff, all the CHCs had a computer operator (though some CHC don't have computer!), compounder, technician, radiographist and other 4th class staff. Two CHC did not have Block Extension Educator (BEE) and clerk and one CHC did not have staff nurse. Absence of BEE means that supervision and monitoring of extension workers are not done, which might mean no or less than required extension services.

4. Residence facility:

The checklist only had one question that is whether the doctor stays at head quarters. It was found that doctors of all the 5 CHCs stay at the head quarters.

5. Functioning:

Though the study found that the CHCs were open for full time, in 2 CHCs (Pati and Newali) doctors are not present during scheduled timings. Also based on observation and with discussion with patients and villagers it was found that beside regular timings doctors hesitate to come to hospitals to attend serious cases and many of them are engaged in private practice during scheduled timings. This unavailability of doctors in health care facilities poses serious problems to patients in times of emergency in accessing health care.

3. Ambulance:

Only 5 PHCs (16%) had an ambulance facility and even in these 5 PHCs the drivers do not reside in the PHCs and take some time to reach the hospital in case of emergency loosing vital minutes in case of emergency. In the absence of some basic emergency facilities at PHCs at least ambulance can be handy during emergency cases, and proper transportation facility can be life saving. The charges for ambulance is Rs. 4.00 per kilometers, but in some places double the amount are being unofficially charged. However, in most PHCs the patients have to hire private taxis at very high cost if they are available, and if they are not available or too expensive then in case of emergencies the patients relatives becomes helpless and many patients die because of lack of transportation facility. For instance, in Sendhwa block there is only one ambulance attached to the Sendhwa PHC, which has to cater the needs of 6 other PHC of the block which do not have any ambulance.

CASE STUDY 2:

A clear example of 'denial of health care' is from J village of a block of Barwani district, where N, a poor adivasi, was residing with his family of 6 members. In the night of 23rd June his son K had a severe problem of vomiting and loose motions. Next day the MPW gave him an ORS packet.

When no improvement was observed in the child's condition, it was suggested that he be taken to nearest PHC, where the MO treated him. But, after sometime bleeding started from inside the mouth and nose of the child. At another doctor's suggestion, N had to shift his child to Sendhwa PHC. Due to lack of money he had to bring the critically sick child by a brick loaded truck just because nearest PHC didn't have ambulance for this emergency situation.

Even in Sendhwa hospital, he had to purchase injections and syringes worth over hundred rupees. Afterwards when the condition became more serious, it was suggested that he take the child to Barwani district hospital. But N, a poor adivasi, did not have money for the transport and further treatment, and ultimately decided to come back to home. On the way back home the child died.

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4. Adequacy of staff:

A PHC as per norms is to have a medical officer in charge, two sector supervisors - one male and female, a staff nurse, a laboratory technician, a compounder cum pharmacist and a dresser, a watchman and atleast one another class IV staff.

Type of personnel	% of PHCs
Doctor	87.1
Compounder	16.0
Staff nurse	18.7
Others	30.7
No staff	1.3

As evident from the above table, 87 percent PHCs have a doctor but what is significant to note is that 13% PHCs did not have doctors! For instance, Palsud and Roisar PHC do not have any doctor. In Moida and Dhanora PHC, the doctor comes sometimes. Only 3 PHCs had lady doctor. The presence of compounder and staff nurse is also very inadequate. In only around 30 percent of the PHCs, LHVs and MPWs were found. One PHC (Inderpur) from Rajpur did not have any staff.

Functioning:

Survey has shown that doctor stay in the Head quarter (HQ) in only 15 PHCs and in other 16 (52%) PHCs the doctor do not stay at the PHC. It is important for a PHC doctor to stay at the HQ in order to attend to emergency cases. As evident from the table below in around 29 percent of PHCs, doctors were not available in scheduled timings. Even for other staff in around 20 percent PHCs, staffs are not present at scheduled timings.

2. Infrastructure arrangements:

CHCs of the district are all situated in government owned building but none of the CHCs have 30 beds according to CHC norm. Only Rajpur and Pansemal CHC have 10 beds and the CHC at Pati has only 3 beds! Also 2 CHCs (Pati and Thikri) does not have the required furniture that a CHC is supposed to have. In absence of required furniture, drugs and other medical instruments gets damaged.

2.1 Electricity:

Uninterrupted supply of electricity is an important requirement for any medical facility. One CHC (Thikri) at the time of survey did not have electricity. In absence of electricity, drugs, and vaccines gets wasted and loses its potency, it also affects the cold chain and can become fatal in cases of operations. Even in CHCs where electricity is available, the wiring conditions are in bad shape. Alternative electric facility is available in only one CHC (Rajpur).

2.2 Water supply:

Three CHCs have facility for running water (i.e. tap) and for the rest two CHCs (Newali and Thikri), water is stored in a earthen pot. But any facility with inpatient facility should have running tap water, bathing facility and toilets. Even maintaining minimum cleanliness would be difficult to maintain in absence of such water supply.

2.3 Delivery room:

Maternal death is very high in our country. It is quite unfortunate to find that the CHC in Pati did not have a delivery room. Most of the villages in the district do not have trained birth attendants even, and therefore for delivery many women had to take recourse to untrained traditional birth attendants. In 4 CHCs, delivery room is present but it is in bad shape. It was observed that in Pansemal and Rajpur CHCs the delivery room is flooded with water during rains, and therefore become impossible to perform safe deliveries.

2.4 Operation theatre (OT):

There is no OT in 3 CHCs of the 5 CHCs in the district. It was observed that only stitching of wounds is done in OT, and due to lack of equipment, operations are not done and patients are referred to District hospital.

2.5 Ambulance facility:

All the CHCs had an ambulance, but during emergency people are not able to

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COMMUNITY HEALTH CENTRES

Report card on CHCs in Barwani district

- The district has less than half the required number of CHCs. Instead of 1 CHC per 80,000 population the district has 1 CHC for 1,84,612 population.
- None of the CHCs fulfill the 30 beds norm, all CHCs have 10 beds or less.
- 40% CHCs do not have running water facility.
- There is no functioning Operation Theatre in 60% CHCs; certain CHCs do not even have a delivery room.
- 80% of the CHCs have no specialists, the single CHC with specialists has only half of those required.
- Only one CHC has a female doctor.
- In 40% CHCs, doctors are not present during scheduled timings.
- 80% CHCs do not have neonatal resuscitation equipment or ECG machine; 40% do not have oxygen cylinder, incubator or adequate operation equipment.
- None of the CHCs provide services for caesarean delivery.

Forty percent CHCs do not provide treatment to severely anemic women or children with severe respiratory / gastrointestinal infections; 60% do not have STD clinics.

1. Adequacy of CHCs:

The CHCs is conceived as a 30 bed secondary referral centre and the norm expected is 1 CHC per block of 1 lakh population and for tribal areas is one CHC per 80000 population. At present Badwani district has 5 CHCs for a rural population of 9,23,063 (Provisional Population Totals, Rural-urban distribution, Census of India 2001, Directorate of Census Operations, MP), which means instead of 1 CHC per 80,000 population (as per tribal area norm) it has 1 CHC for 1,84,612 population approximately. A shortfall of 4 CHCs! Two blocks, Sendhwa and Badwani do not have any CHC. This shortage of CHCs in the district results in inadequacy of referrals services.

Availability of service providers	% of PHCs
Doctor available in scheduled timing	71 (22)
Other staff available in scheduled timing	80.6 (25)

Figures in parenthesis indicates number of PHCs.

5. Residence facility:

For doctor: Out of 31 PHC, 23 PHCs have residential facilities for doctors, but even these are very badly maintained and as a result doctors don't stay there. It was found that doctor's residences are occupied by other staff. For instance, iIn Mohda and Julvania they are occupied by compounders and dressers.

For Staff: Out of 31 PHC, only 13 provides staff-quarters, 18 PHCs don't have any staff quarters. Therefore LHVs, dresser and compounders working for 8-12 hours in a particular PHC are without a residence and had to stay in rented accommodation.

6. Required Equipments:

The PHCs were surveyed for basic and essential instruments and equipments. These included stethoscope, B.P. apparatus, weighing machine, basic surgical instruments like scalpel, forceps etc., microscope and oxygen cylinder. These equipments are either basic diagnostic tools even for routine and emergency diagnosis or very essential equipments for conducting lab investigation or providing emergency care. Out of 31 PHCs surveyed, 14 PHCs lacked essential supplies, and did not have more than 4 of these items. In Rosar PHC, paper pin instead of needles is used for making blood slides. It is shock to find that in a PHC needles are not available!

CASE NO 3 - WOMEN HEALTH CARE

M is a 30 year women residing in A village of B district. She was persuaded by Anganwadi worker to undergo LTT operation, she has 8 children and went to the camp where she only get a checkup regarding fitness to undergo the LTT operation but in the camp she was not only told that she is fit to undergo LTT operation but also immediately operated without giving any local anesthesia even though she had been 3 months pregnant and she had

specifically told then that she has missing her cycle for 3 months (on 4/5/04). There was no kit for testing Pregnancy and no Ultrasound machine in the camp. She was also discharged the same day.

In her village there are few more women who have had children after LTT operation and the entire village is now afraid to undergo an LTT operation.

Type of denial:

1. *Negligence of the health staff.*
2. *Non availability of the essential equipment required for the treatment.*

Consequences Of Denial:

Extreme financial Loss on account of bringing up a 9th Childs.

7. Laboratory facilities:

One can find a mismatch between laboratory facilities, required instruments and human power. In some PHCs there are labs equipped with microscope but there are no lab technicians and in others there are lab technicians but no microscopes are there e.g. Moida, Rosar, Bhandara, Bajurg which do not have lab technicians. In many PHCs there are microscope and lab technicians but in absence of reagents even basic routine tests like blood, urine and sputum examination cannot be done.

8. Type of services available (selected services):

Type of service	% of PHCs
Immunization	87.1
ANC/PNC clinic held	83.9
Referred new born cases treated	64.5
Treatment of communicable disease	61.3
Treatment of respiratory cases	58.1
Treatment of malaria	77.4
Laparoscopies	48.4
Female sterilization	54.8

As evident from the above table, none of the above essential services were available in all the PHCs. Immunization services are available in 87 percent PHCs. though there is much scope to doubt whether all the doses of immunization is provided to the children. If one goes by NFHS-2 data, complete coverage in the state has come down from the earlier NFHS survey, the above figure seems doubtful. Many child deaths happen due to respiratory problems, and one of the major barriers for seeking treatment is unavailability of services. This is evident from this situational analysis of Badwani district, where only 58 percent PHCs are found treating respiratory cases. Little more than 61 percent PHCs were found to treat communicable diseases. Even treatment of common illnesses like malaria is not available in more than 22 percent of the PHCs. Sterilisation services, which is very much emphasised in public health facilities that too was not found inadequate in many PHCs, then one can imagine what can be the case for other services. Sterilisation services were mostly provided through camps.

NATIONAL PROGRAMMES:

Malaria Control is a National Programme but in most PHCs there is no provision for testing of malaria parasite e.g. Julwania PHC. In many PHCs even though slides are prepared, patients do not receive the reports or the appropriate follow up treatment.

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HEALTH IN GUJARAT:
A Brief Overview of Points of Concern

Prepared for the Western Region Public Hearing on Denial of Right to Health Care. July 29, 2004, Bhopal

Introduction

We focus, in this report for the NHRC Public Hearing, on Maternal and Children's Health and Occupational Health only. In Sections 2-8 we discuss the former and Section 9 discusses Occupational Health Issues. We begin with giving salient findings of the NFHS Survey 2 of 1998-99. Some of these figures are central to our report of Gujarat's health system (see annexure 1 for the NHFS Fact Sheet for Gujarat)

Percent using govt. health facilities for sickness 27.7

Current Contraceptive Use
Any modern method.....53.3

Quality of Family Planning Services6
Percent told about side effects of method 9.5

Percent of births3 whose mothers were assisted at delivery by a:
Doctor 37.4
ANM/nurse/midwife/LHV..... 16.1
Traditional birth attendant.....42.4
Percent5 reporting at least one reproductive health problem.....28.6

Awareness of AIDS
Percent of women who have heard of AIDS.....29.8

Nutrition
Percent of women with anaemia11.....46.3
Percent of women with moderate/severe anaemia11.....16.8
Percent of children age 6–35 months with anaemia11 .....74.5
Percent of children age 6–35 months with moderate/ severe anaemia11 ..... .50.4
Percent of children chronically undernourished (stunted)12 ..... .43.6
Percent of children acutely undernourished (wasted)12.....16.2
Percent of children underweight12.....45.1

1. Background Characteristics of Population in Gujarat

About three-fifths (59 percent) of Gujarat's population lives in rural areas. The age distribution is typical of populations that have recently experienced a fertility decline, with relatively low proportions in the younger and older age groups. Thirty-three percent of the population is below age 15, and 5 percent is age 65 and above. The sex ratio of the *de facto* population is 947 females per 1,000 males for Gujarat as a whole, and is lower in urban areas (935) than in rural areas (955), suggesting that more men than women have migrated to urban areas.

Missing Girl Children

The overall sex ratio is prone to migration from rural to urban area in search of employment, education etc **The sex ratio in population category of 0-6 years** is relatively immune to such bias/aberrations and **can be said to be relatively secular indicator. On this account also, the State of Gujarat has fared badly as the 0-6 years sex ratio has decreased from 928 in 1991 to only 878 in 2001.** In general this ratio is poorer in urban areas compared to rural areas. In 2001 the 0-6 years sex ratio in urban areas was only 825 compared to 905 in rural areas of the State. The district of Mahesana fared worst in 0-6 years sex ratio having only 798 female children per 1000 male children in this age group, while the district of The Dangs was the best having 974 female children per 1000 male children.

While the Juvenile Sex Ratio is indicative of women's status and the health status, it also raises serious questions about the implementation of the Pre-natal Diagnostic Techniques Act, 1994. Gujarat's performance in the area is abysmal.

Twenty-seven percent of women age 15–19 are already married, including 5 percent who
are married but *gauna* has yet to be performed. In rural areas, 33 percent of women age 15–19 have already married. Older women are more likely than younger women to have married at an early age: 25 percent of women who are now age 45–49 married before they were 15, compared with 7 percent of women who are now age 15–19. **Although** this indicates that **the proportion of women who marry young is declining rapidly, 41 percent of women in Gujarat still marry before reaching the legal minimum age of 18 years.**

2. Malnutrition and Food Security

Annexure 2 (Tables 1-7) show the **poor food and nutritional security status of Gujarat, despite its image as a developed state. The percentage of severely stunted and severely underweight children is the highest in the country (see Table 7).** *The Food Insecurity Atlas*[1] has given the label of *extremely (food) insecure* to Bihar, the sole claimant to that status; and *severely insecure* States to Gujarat, Madhya Pradesh, Uttar Pradesh, Rajasthan and Orissa – in that order. *Moderately Insecure States* are W.Bengal, Maharashtra, Assam, Andhra Pradesh, Karnataka, and Haryana while Moderately Secure States are Tamil Nadu and Kerala with Punjab being the Most Food Secure State.

Gujarat, as per the analysis of the Atlas, is the second most food insecure State in India after Bihar, among the 16 states considered; while Tamil Nadu despite its dismal calorie intakes fares third best after Punjab and Kerala scoring because of relatively good health infrastructure.

Malnutrition among Women in Gujarat

Percent of women with anaemia	46.3
Percent of women with moderate/severe anaemia	16.8
Percent of children age 6–35 months with anaemia	74.5
Percent of children age 6–35 months with moderate/ severe anaemia	50.4

Source: NHFS 2

- **Based on a weight-for-height index (the body-mass index), more than one-third (37 percent) of women in Gujarat are undernourished.**
- Nutritional deficiency is particularly serious for women in rural areas and women in disadvantaged socioeconomic groups.
- Women who are undernourished themselves are also much more likely than other women to have children who are undernourished.
- **Overall, 46 percent of women in Gujarat have some degree of anaemia, and 17 percent are moderately to severely anaemic.**
- **Anaemia is a serious problem among women in every population group, with prevalence rates ranging from 38 to 58 percent among the various groups.**
- Pregnant women are much more likely than nonpregnant women to be moderately to severely anaemic.

[1] *Food Insecurity Atlas of Rural India*: MS Swaminathan Research Foundation and World Food Programme, Chennai, April 2001

Child Malnutrition

NFHS-2 has used three internationally recognized standards to assess children's nutritional status.weight-for-age, height-for-age, and weight-for-height. Children who are more than two standard deviations below the median of an international reference population are considered underweight (measured in terms of weight-for-age), stunted (height-for-age), or wasted (weight-for-height). Stunting is a sign of chronic, long-term undernutrition, wasting is a sign of acute, short-term undernutrition, and underweight is a composite measure that takes into account both chronic and acute undernutrition.

Malnutrition of Children in Gujarat

Percent of children chronically undernourished (stunted) 43.6
Percent of children acutely undernourished (wasted)12.....16.2
Percent of children underweight (weight for age).....45.1

Source: NHFS 2

- About 45 percent of children in Gujarat under age three years are underweight, a similar proportion (44 percent) are stunted, and 16 percent are wasted.
- Child nutritional status has improved in Gujarat since the time of NFHS-1, when 48 percent of young children were underweight, but it is still a serious problem.
- Undernutrition is much higher in rural areas than in urban areas and is particularly high among children from disadvantaged socioeconomic groups.
- The prevalence of undernutrition is somewhat greater for girls than for boys.
- Three-quarters of children age 6–35 months are anaemic, including a large majority of children in every subgroup of the population.

3. Health Care Delivery System in Gujarat

- **Urban-rural difference in high order health facilities is quite high in the state compared to all-India figures (Table 11). For example, the number of hospitals per lakh population in urban areas in Gujarat is 16 times higher than in rural areas. In India the difference is only six times.** With respect to beds per lakh population, urban-rural difference is 11 in Gujarat as well as in India. Gujarat stands second (after Kerala) among 15 large states with respect to hospitals per lakh population (based on Duggal et al 1995) and first with respect

to dispensaries per lakh population. Once again, their share is higher in urban areas than in rural.

- **There is a non-availability of skilled personnel in the rural areas. 71.3% of total doctors are in urban areas as against 65% population in rural areas. (GOG Vision 2010).**

- **The good spread of high order health facilities in Gujarat is supported by public expenditure.** However, the private, voluntary sector, and charity institutions also are playing an important role. A number of hospitals and dispensaries have been set up in the past by princely states, especially the Vadodara state and the states of the Saurashtra region. Many of these are either run by charity trusts or have been handed over to the public sector.

Quality of Care Issues

- **Private sector is largely beyond the purview of legislation. Quality of care and user fee remains largely unregulated. (Vision 2010 GOG)**
- **There are no performance review systems of those working in the health sector from the point of view of quality of services. (Vision 2010, GOG)**

Urban health

- **Urban health for poor people is a problem. There is an uneven distribution of health facilities and limited outreach to the poor.**
- **There is inadequate infrastructure and insufficient facilities at the health centers. (Vision 2010)**

Resource allocations for health

As evident from the following table, **over the last five years the allocation of resources to the health and medical sector that outlay has declined from 4.81 percent to 2.87 percent.**

Plan and Non -Plan outlays of the Government of Gujarat over the last 5 years

Item	Unit	1999-2000	2000-2001	2001-02	2002-03	2003-04
Total State Annual Plan & Non Plan Outlay	Crore	20673.57	24670.98	37792.84	31054.02	31998.03
Plan & Non Plan Outlay for Medical and Public Health (PM&PH)	Crore	995.40	973.08	953.83	948.74	919.41
% of PM & PH to Total Outlay	%	4.81	3.94	2.52	3.06	2.87

PM&PH = Plan for Medical & Public Health
NPM&PH = Non-Plan for Medical & Public Health

Source:

Government of Gujarat's Vision 2010 (Health section)

- Although GOG's Vision 2010 statement mentions **several areas of concern** like lack of Core Infrastructure, low utilization of PHCs, shortage of health staff, skewed development of medical education and research, the Vision section per se says little on **how these areas of concern will be addressed**. The Vision of GOG is to develop Telemedicine, Interactive Health Communication System (GIHCS) and a network of technologically sophisticated Mobile Dispensaries.

4. Government Policies and Programmes on Health as affecting Women

- Gujarat State Population Policy (2002)

The Population Policy statement was developed in 2000 as a step towards formulating a State Population Policy, which came out in 2002. The Statement was a product of a high level committee and a working group headed by the Health Minister. The Gujarat Government set up a Social Infrastructure Development Board for achieving overall development in the State. Population stabilisation was stated to be a priority of the Board. Apart from population stabilization by 2008 being a priority, it would be useful to know other priorities of the Board. This would help us to analyse the total context within which Gujarat's Population Policy was developed and to assess links for consistency in approach.

The Goal of Gujarat's Population Policy (GPP) has a focus on improving the quality of life of people. However the paragraph on Objectives reveals a domination of demographic objectives like Unmet Need for Contraception, reducing the Total Fertility Rate (TFR) and increasing Contraceptive Prevalence Rate (CPR). Other objectives like increasing safe Medical Termination of Pregnancies (MTPs), providing quality maternal health services and so on, would better reflect the goal of improving the quality of life of the people and a shift away from the demographic orientation of all population policies.

One objective of the GPP is to reduce MMR to 100 per 100,000 live births by 2010. However, a reading of the policy does not clarify how this would be done.

- National Maternity Benefit Scheme

Under the Scheme, maternity benefit in the form of lumpsum cash assistance is provided to women of households below the poverty line. Only pregnant women for up to the first two live births provided they are of 19 years of age and above are eligible. Thus, young

married girls who have to prove their fertility and become mothers at an early age are excluded.

- Gender Equity Policy

In 2002 the Government of Gujarat initiated the process of formulating a Gender Equity Policy for the state. The policy aims to narrow the gender gap and strive for an equitable social structure. The Gender Equity Policy has recently been finalized by the state government. Among the broad objectives of this policy, the health related ones are:

- To promote best socio-cultural practices, and develop capacity in the society to eliminate gender discrimination;
- To incorporate gender perspectives into various developmental programmes of the State, and strengthen partnership between government organizations, professional bodies, civil society, national and international organizations.
- To strengthen access to client-centered and good quality health services by women, men and adolescents in order to ensure their survival and quality of life, including the right to safe drinking water and sanitation;
- To ensure access to and improve the quality of education for girls and women as a prime vehicle for an egalitarian society;
- To strengthen gender perspectives in the legislative framework to ensure gender justice, and improve access to competent legal aid/support by women in need;
- To advocate gender equity in all awareness programmes through various means including media;
- To strengthen advocacy and IEC from a gender equity perspective to impact upon attitudinal changes and practices in society.

4.1 Government Programmes in Gujarat for Women

- Maternal and Child Health (MCH) care services are being provided by the Government of India since the 1950s by developing a network of PHCs and sub-centres staffed by doctors and ANMs.

- Child Survival and Safe Motherhood Programme was initiated in 1992-93.

- **Reproductive and Child Health Programme** launched in 1996, integrating maternal and child health, family planning and reproductive health services. The important elements of RCH programme for Safe Motherhood are:

    - Provision of antenatal care (ANC), ensuring at least three ANC visits, iron and folic acid tablets for pregnant and lactating mothers, two doses of tetanus toxoid vaccine, detection and treatment of anaemia in mothers, management and referral of high-risk pregnancies
    - Encouraging institutional deliveries or home deliveries assisted by trained health personnel.

- Provision of post natal care, at least three postnatal visits
- Providing the public health care system with critical inputs in terms of infrastructure, staff, training supply of various equipment, drugs, vaccines, training of medical and paramedical staff for effective delivery of services.

- **Schemes under Safe Motherhood are:**

  - Supplementary food, health education and essential care for women during pregnancy and lactation from the village anganwadi centre.
  - Safe delivery services from the primary health centre
  - Emergency obstetric services form the First Referral Units/District Hospital
  - Emergency transport fund for referral during obstetric emergencies from the village panchayats.
  - The PHC/village panchayat provides Rs. 500/- as a monetary support to all pregnant women from the disadvantaged sections of the society, upto two births.

The Maternity Benefits Act, 1961, provides for 12 weeks' maternity leave for women alone and only to those who have put in 160 days of work within 12 months of the expected date of delivery. As most women in the organized sector never manage to retain continuous employment , this does not benefit them (Qadeer, 2002).

Our recommendations

1. S.2 of the Act should be amended to include all industries including home based industries. Hence, S.2 of the Act needs to be amended in the following manner.

   The Act applies in the very first instance to every establishment being a factory, mine or plantation, or an establishment covered by Contract Labour Act or an establishment covered under Bombay Shops and Establishment Act and also shall apply to all other establishments whether industrial, commercial, agricultural or otherwise.

2. Considering the fact that enforcement of Laws in small establishments is very difficult it is suggested that the definition of the employer be amended in the following manner:

   Employer means

   *a. **in relation to an establishment under the control of the Government, a person appointed for the supervision and control of employees***

b. *the person who has the ultimate control over the affairs of the establishment and where such affairs are entrusted to any other person whether called a manager or agent or contractor, such person*

c. *In relation to an establishment covered by any law which creates a separate body or a board for the welfare of the employees, such board.*

d. *In all other cases, the Government for the limited purpose of payment of any dues under the Act.*

3. Rate of Maternity Benefit should not be less than minimum wage prevalent under law at the time

4. The penalty for violation of any of the benefits should be increased to a minimum of Rs. 5000/- or more and imprisonment up to the period of one year. 25% of the fine amount should be given to the woman. S.21 of the Act needs to be appropriately amended.

   The person incharge and contractor should be held responsible jointly and severally. The ultimate responsible body must impose terms and conditions with the contractor to ensure compliance with the law.
   The contractor should be responsible for fine and imprisonment where as the person ultimately responsible should be liable for compensation.

5. The definition of miscarriage in the act excludes any miscarriage the causing which is punishable under the I.P.C. this includes acts leading to miscarriage to which the woman is not a party. Hence, the definition of miscarriage in S.3(j) needs to be changed in the following manner :

   Miscarriage means expulsion of the contents of a pregnant uterus at any period prior to or during the 26th week of pregnancy.

6. S 21 of the Act needs to be amended as follows

   a) *S.21 (3) Where a claimant has a complaint regarding the non-performance of the inspector, she has a right to complain against him in appropriate forum. The inspector should be made personally liable to pay the woman her dues if the non-payment is due to his negligence.*

   b) S.16 A should be added to read as follows - *All Primary Health Centers must keep the forms needed to be filled.*

5. Maternal Mortality in Gujarat: A Continuing Problem

Though female death rates are higher than that of males in all age groups, it is especially higher in between the 0-9 and 15-29. The high mortality rates among females can be attributed to neglect of the girl child from birth onwards, high maternal mortality, less access and use of health services. Maternal mortality rate in India and Gujarat continue to be high.

- While infectious diseases cause nearly 65 percent of the deaths among women of and only 2.5 percent are caused by childbirth, among women in the reproductive age group, 12.5 percent of the deaths are due to childbirth and related conditions and only 2.6 percent deaths are caused by infectious diseases.
- Complications such as bleeding, sepsis, eclampsia, obstructed labour and severe anaemia account for at least three-fourths of obstetric deaths.
- Many of these, for instance, anaemia and sepsis can be prevented by measures such as therapeutic/prophylactic doses of iron, safe delivery trained health personnel and regular antenatal check ups and referral support in times of emergency/complication deliveries (Government of Gujarat, 2003).
- Thus a large number of women continue to die of causes that can be prevented.

The *maternal health indicators* for Gujarat show that health services are reaching more women during pregnancy than during delivery or after childbirth. In Gujarat,

5.1 Percent of births whose mothers received:

- antenatal check-up from a health professional – 86%;
- antenatal check-up in the first trimester – 36%;
- at least 3 check-ups from a medical professional - 60%
- two or more tetanus toxoid injections - 73%;
- iron and folic acid tablets or syrup -85%;

5.2 Percent of births whose mothers

- had safe delivery (assisted by a trained health professional) – 54%
- **had delivery attended by a TBA – 42% (yet TBA training and continuing support to TBAs have not received the attention that is required)**
- had delivery attended by friends, relatives – 4%
- **Majority of the institutional deliveries take place in the private medical sector (low accountability of the private sector and inadequate controls of quality of care)**
- Non-institutional deliveries were followed by a postpartum check-up within 2 days – 10%. (IIPS & ORC Macro, 2001).

5.3 Maternal Mortality and Morbidity

Various estimates of maternal mortality for Gujarat are:

- 398 per 100,000 (Government of Gujarat, 2000)
- 310 per 100,000 live births in 1993 (Bureau of Health Intelligence, Commissionerate of Health Medical Services and Medical Education, 1996 cited in Department of Women and Child Development, 2003)
- less than 400 per 100,000 live births in the early 1990s (UNFPA, 1997; Bhat et al., 1995).
- 393 for 100,000 live births in 1998-99 (computed on the basis of NFHS 1 and 2 data by IIHFW, 2003).
- 3.89 for every 1000 pregnancies (Health Monitor, 1998).
- 5 maternal deaths out of 992 live births during January 1996 to October 1999 in a baseline household survey in rural Vadodara (PRC, 1999).

The State Population Policy Statement of Gujarat and the Vision 2010 document aim at reduction of maternal mortality rate to less than 100 per 100,000 live births by 2010.

Morbidity

- **Twenty-nine percent of currently married women in Gujarat report some type of reproductive-health problem**, including abnormal vaginal discharge, symptoms of urinary tract infections, and pain or bleeding associated with intercourse.
- **Among these women, 67 percent have not sought any advice or treatment.** These results suggest a need to expand reproductive health services and information programmes that encourage women to discuss their problems with a health-care provider.

6. Programme and Policy Level Barriers: Women's Health

Non-availability and accessibility of a trained health provider

- the number of medical officers living in the PHC or within the PHC village
    - only 55% PHCs have quarters for MO/MO in charge (ORG-Marg, 1999)
    - there is a huge backlog (35%) in construction of staff quarters at CHCs. In December 1999 GOG

Non-availabilty of Staff – NGO perspective

Village Tikkar in Halvad Taluka of Surendranagar district, is very well connected by transport, it has a high school, the community is very cooperative. Three single women community workers of the NGO are staying alone in the village. Personal safety is not an issue. There is a quarter for the ANM, but she still does not live there. The Tikkar PHC has a new building and is well equipped , but not a single delivery take place in this PHC.

reports that there were 3359 quarters as against 5182 required.(Vision 2010)

- only 27% MOs are available and staying in the PHC compound and 10% MOs staying within the PHC village (ORG-Marg, 1999)

The issue of adequacy of medical health services was also addressed in Paschim Baga Khet Mazdoor Samiti vs. State of West Bengal{(1996)4 SCC 37}. Here the Supreme Court held that the Medical Officers in government hospitals are duty bound to provide medical assistance for preserving human life. Further the court ordered that Primary Health Centers should be equipped to deal with medical emergencies. Failure on the part of the government hospitals to provide timely medical treatment is violation of his Right to Life.

- **number of ANMs living in the sub-centre village**
  - 70% PHCs have at least one quarter for ANM/health assistant/nurse. (ORG-Marg, 1999)
  - 71% ANMs (range 48-93%) ANMs in rural areas of four districts live within the sub-centre village, but only 30% of them (range 18-52%) provided government accommodation and live in it, 35% not provided government accommodation (Visaria, 1999).

- **The maternal health services under RCH continue to be focused on ANC and have the high-risk approach. Provision of delivery care and provision of emergency obstetric care are being neglected (Mavlankar, 2001).**

- **PHCs, the most proximate health facilities after the sub-centre are not designated to provide EmOC services**

- **Emergency obstetric care continues to be inaccessible to many rural women due to the following policies:**
  - **Only postgraduate qualified obstetrician can perform obstetric surgical procedures,** basic doctors are restricted from performing these procedures including cesarean section even in remote areas, where there is no specialist obstetrician available. They can do only basic EmOC procedures, like manual removal of placenta, suturing tears, assisted vaginal delivery etc.
  - **Para-medics** – ANMs, lady health visitors - are **not allowed to manage or stabilize obstetric emergencies,** like treating infection with antibiotics, stabilizing a case of eclampsia, and manual removal of placenta. All such cases are referred to higher level facilities. Thus women have to travel long distances in emergency and referrals add to the cost of treatment.
  - **Basic doctors and nurses cannot give anesthesia,** though there are limited number of anesthetists in rural areas, thus reducing access to emergency, life saving surgery.

- **Access to blood transfusion in rural areas is reduced** due to many unrealistic infrastructure and staff requirements for licensing blood banks (Mavlankar, 2001).
- With the aim of promoting safe deliveries, the RCH programme there exists since October 2000 a scheme of **training of traditional birth attendants** (TBAs) or dais in 142 districts of India. In Gujarat, the Dangs district has been identified for this scheme. An evaluation of the programme, however showed that:
    - Out of 426 enlisted dais, 398 were trained and passed the post training evaluation, however, none received a certificate and identification card.
    - After the training, the quality of work of the trained dais was not reviewed by the ANM or by the medical officer, as laid out in the Scheme. (Das, Dey , Bhatt and Patel, no date).

- GOI norms are 3 specialists for each CHC, in Gujarat there is only 1 specialist in each **CHC. 50% of specialist positions were vacant in 2000**. Out of the 283 sanctioned posts only 142 were filled.

Barriers to Maternal Health

- **Importance of antenatal care is not sufficiently emphasized by the health care system**, as a result there most women who did not seek antenatal care did not consider it necessary (70%) or customary (13%). (IIPS and ORG Marg, 2001).
- **Lack of recognition of pregnancy complications**. The concept of 'pregnancy complication' is non-existent in the rural communities of Vadodara, Mehsana and Rajkot. The 'problems' (complications) related to pregnancy are considered a natural part of childbearing. It appeared that the community recognised only those signs and symptoms as serious and possibly fatal, which they had either heard or witnessed in their villages. (Barge et al., 1994).
- **Lack of information** about the danger signs, recognition of possible pregnancy complications, the causes and consequences of pregnancy, delivery and post delivery complications leads to delay in treatment seeking. (Barge et al., 1994)
- **Lack of awareness in the community that ANMs are trained** and can be contacted for assistance during delivery (Visaria, 1999).
- **ANMs' concern regarding their personal safety** when called at night, antagonism of the villagers towards them, fear of the risks involved in when called to attend a complicated delivery (Visaria, 1999).

Affordability of health services

An analysis of the lending pattern of 30 women's savings and credit groups (90% belonged to BPL families) in the Panchamahals district, over 1996-98 shows that after agriculture, health is the next major expense for which women take loans (Source: ANANDI).

Why women do not go to PHC for services.

a) The clerk at the case registration window asks for a bribe to issue the case paper.
b) Doctors would not attend on the women and make them wait.
c) These women had been pinched by the Doctors on their legs but would not examine them for the complaint. At the CHC women were slapped on the thighs if they were a little shy to completely take off their petticoat at the delivery table.
d) Doctors and particularly nurses use abusive language.
e) At the OPD women are not given complete instructions about the medicines and the dosage. often they do not complete the course and therefore do not completely heal. This leads to the belief that PHC medicines do not really cure.
f) Women are in general afraid that they might be made unconscious through the intravenous medicines and then they will be sterilized with out their knowledge.

Based on interview of women Galibeli village of Ghogamba block Panchmahaals district and Fangia village - Devgadh Baria block Dahod district.
Source: ANANDI

Access to Services

- The aim of 100% availability of the critical inputs in the public health facilities has been brought down to 60% as adequate/doable. However, only 54% FRUs and 18% CHCs have adequate critical inputs, while 64% PHCs have adequate critical inputs.
- 33% PHCs, 25% CHCs and 8% FRUs were not conducting deliveries in the three months preceding the facility survey.
- 85% CHCs and 75% FRUs not conducting any lower segment sterilization or C-section.
- Obstetrician gynaecologist available in only 17% FRUs and 18% CHCs.
- Anaesthesiologist available in none of the FRUs and 13% CHCs.
- The post of obstetrician gynecologist sanctioned in only 11 of 24 FRUs and in 7 of 40 CHCs, but filled in only 4 FRUs and 6 CHCs.
- Only 17% FRUs and 45% CHCs have separate aseptic labour room.
- Normal delivery kit not available in 69% PHCs, 54% FRUs, 20% CHCs.
- Emergency obstetric drug kit not available in 96% FRUs, 95% CHCs, essential obstetric care drugs not available in 88% PHCs.
- Sufficient stock of TT vaccine only in 13% FRUs, 10% CHCs, 71% PHCs.
- Sufficient stock of IFA tablets large and small in only 17% FRUs, 30% CHCs and 65% PHCs.

(Source: ORG-MARG, 1999).

- Less than 30% ANMs in sub-centres report the equipment they regularly use for ANC was in working condition.
- Nurses do not stay in the village and cannot be called, or put to inconvenience, and they do not come even if they are called.

(Source: Visaria, 1999).

- In Vadodara district, due to non-availability of an obstetrician gynaecologist, none of the 12 CHCs surveyed provided 24-hour EOC services. Even the 4 CHCs having a gynecologist only partially treated EOC cases and referred them further. The non-availability of an anaesthetist in 11 CHCs, affected the provision of emergency services. As none of the CHCs had any blood bank facilities, all cases requiring blood transfusion were referred to higher level facilities.

(Source: Ansari and Patel, 2001)

Access to Secondary Health Care

- The operation theatres (OT) in many of the CHCs were ill-maintained. Cracked floors in the OT (n=7) and dirty floor (n=4), unclean, dusty and bloodstained operation table (n=6) were observed in some of the CHCs. Only half of the CHCs had any arrangement for uninterrupted power supply (four had emergency light and one had a generator).

- The component of counselling in all reproductive health services like antenatal and postnatal care, EOC, family planning, MTP, infertility and RTI/STD, was generally poor.

- Women with reproductive morbidities consult male doctors as the last resort; since they have to undergo physical examination, they prefer a female doctor. Few male doctors carried out pelvic or physical examination of their female clients who came for services like IUD insertion, MTP, RTI/STD, antenatal or postnatal care.

- In the interaction between clients and providers, doctors seemed to be more sympathetic to women who sought services for MTP and infertility, compared with clients who came for ANC or FP services. Clients' opinion about the providers seemed to be influenced to a great extent by how they were greeted by the providers.

- Exit interviews with 206 women patients at the CHC revealed
  - Only 44% were explained about their health problem
  - 43% were explained how to take the medicine
  - 50% were advised on follow-up visit
  - 57% said auditory and visual privacy was maintained during examination.

Source: Ansari and Patel, 2001

7. Domestic Violence

- In Gujarat, there is widespread acceptance among ever-married women that the beating of wives by husbands is justified under some circumstances.
- Approximately one-third (36 percent) of women accept at least one of six reasons as a justification for a husband beating his wife.
- Ten percent of ever-married women in Gujarat have experienced beatings or physical mistreatment since age 15, and 6 percent experienced such violence in the 12 months preceding the survey.
- Most of these women have been beaten or physically mistreated by their husbands.
- Domestic violence against women is especially prevalent for women who are not currently married and women living in households with a low standard of living.

Violence against women is on the increase. The existing laws are not able to address the situation. **Our recommendations in criminal law are as follows**:

- Sections 498-A (IPC) and 304-B of the Indian Penal Code (IPC) do not seem to be enough to provide justice to women. Section 306 (IPC), as per the opinion of the Gujarat High Court cannot be seen as operative when cruelty under section 498-A (IPC) is proved.

  The following 'note' could be appended to section 498-A (IPC)

  The cruelty could be proved, inter alia, by (i) a medical certificate showing that injury was inflicted and that treatment was taken in a hospital or (ii) a complaint lodged at a police station by the victim of mental / physical torture by husband or any relative of the husband or (iii) the woman had to invite third party to intervene on her behalf in the quarrels between her and her tormentors or (iv) that the woman was completed to return to her natal home repeatedly

The changes are proposed to make the section applicable to unnatural deaths on account of domestic violence.

- Along with section 498-A a married woman has added (IPC) section 113-A to the Indian Evidence Act in1983 to raise a presumption regarding abatement of suicide. From this section it is suggested that phrases delimiting the section to seven years be deleted. The section amended as per above comments will read as follows.

  113-A. When the question is whether the commission of suicide by a woman had been abetted by her husband or any relative of her husband and it is shown that she had committed suicide and that her husband or such relative of her husband had subjected her to cruelty, the court may presume having regard to all the other circumstances of the case, that such suicide had been abetted by her husband.

8. HIV-AIDS Awareness

- **Only 30 percent of women in Gujarat have ever heard of AIDS.**
- Awareness of AIDS is particularly low among rural women, poor women, scheduled-tribe women, and illiterate women.
- Among women who have heard of AIDS, 86 percent learned about the disease from television and 15 percent from the radio, suggesting that government efforts to promote AIDS awareness through the electronic mass media have achieved some success.
- **Among women who have heard of AIDS, however, more than one-third (35 percent) do not know of any way to avoid infection. Survey results suggest that health personnel could play a much larger role in promoting AIDS awareness. In Gujarat, only 4 percent of women who know about AIDS learned about the disease from a health worker.**

9. Infant and Child Health

NFHS-2 provides estimates of infant and child mortality and factors associated with the survival of young children. During the five years preceding the survey,

- the infant mortality rate was 63 deaths at age 0–11 months per 1,000 live births, down from 69 per 1,000 live births in NFHS-1.
- The child mortality rate declined more, from 38 deaths at age 1–4 years per 1,000 children reaching age one to 24 per 1,000 in NFHS-1.
- The rates in NFHS-2 imply that 1 in 16 children still die in the first year of life, and 1 in 12 die before reaching age five.

Immunisation

Child immunization is an important component of child-survival programmes in India, with efforts focussing on six serious but preventable diseases tuberculosis, diphtheria, pertussis, tetanus, polio, and measles. The objective of the Universal Immunization Programme(UIP), launched in 1985–86, was to extend immunization coverage against these diseases to at least 85 percent of infants by 1990.

- In Gujarat, 53 percent of children age 12–23 months are fully vaccinated, another 40 percent have received some but not all of the recommended vaccinations, and 7 percent have not been vaccinated at all.

- Immunization coverage, although far from complete, has improved somewhat since NFHS-1, when only 50 percent of children were fully vaccinated and 19 percent had not been vaccinated at all.
- Eighty-five percent of children age 12–23 months have been vaccinated against tuberculosis, 64 percent have received three doses of DPT vaccine, and 69 percent have received three doses of polio vaccine.
- The largest increase in vaccination coverage between NFHS-1 and NFHS-2 is for Polio 1, where coverage increased from 78 to 90 percent.

Full immunization coverage is not as high as it might be, primarily because only 64 percent have received three doses of DPT and only 64 percent of children have been vaccinated against measles. Dropout rates for the series of DPT and polio vaccinations are also a problem. Eightythree percent of children received the first DPT vaccination, but, as already mentioned, only 64 percent received all three doses; 90 percent received the first polio vaccination, but only 69 percent received all three doses. It is also recommended that children under age five years should receive oral doses of vitamin A every six months starting at age nine months.

10. Occupational Health in Gujarat: A Major Public Health Issue Ignored Completely

10.1 Gujarat is considered one of the most developed states in India. It **is leader in manufacture and supply of Salt, Soda Ash, Dyes & Intermediates, Spectacle Frames, Ceramics, diamonds, pesticide formulations, fertilizers and other petrochemicals.** It houses 25,000 registered factories.

- **Gujarat has the highest number of units identified as Major Accident Hazard Units.**
- "Golden Corridor" – From Umargam- Vapi in South to Mahesana in North houses most of the chemical units.
- Tata Chemicals, Reliance Refinery, Dhrangadhra Chemicals, Gujarat Heavy Chemicals, GSFC, Saurashtra Chemicals, Indian Rayon are some of the major units in Saurashtra area. Saurashtra also have major Cement Units.
- **There are large numbers of units, which do not get themselves registered.**
- Gujarat has one of the biggest ship breaking yard in Asia, where more than 50,000 workers are engaged in ship breaking.

- Gujarat has largest sea coast in the country (one third of India's sea-coast). On it 1600 km long cost, fishing is main business activity. (Fish production second only to Kerala). Kandala is second big port on western cost after Bombay. Now, several small ports have come up.

10.2 Among its population of 50 million, 20-30 million are workers. Agriculture is biggest sector employing about 3 million workers. **Most agriculture workers do not get full employment of 365 days. Though there is law for paying minimum wages, most do not enjoy that right.**

- **Most agricultural workers do not have any legal cover for protection of health and safety at work.**
- **They are exposed to toxic pesticides and physical, mechanical and biological hazards like organic and inorganic dust, heat, bacteria etc.**
- **Each year large numbers of workers die of Leptospirosis and pesticides.**

In another Supreme Court judgement Dr. Ashok v/s Union of India {(1997) 5 SCC 10} the Hon'ble Supreme Court held that insecticides are carcinogenic and so banned the production, distribution and sale of such insecticides as it causes health hazard affecting Article 21. Right to life enshrined in Article 21 means right to have something more than survival and not mere existence.

10.3 Construction is another major industry employing about 1 million workers. Until recent past, there was no legal cover fro protection of health and safety of these workers. Rules recently passed by Government of Gujarat may still take one year to get implemented. **Most construction workers are intra-state migrants. 70 % of them migrate with family and stay in open near site.**

In Bandhua Mukti Morch v/s Union of India {AIR 1984 SC 802} the Supreme Court held that workers should not be deprived of their Right to Life. They should be provided with humane working and living conditions.

- **Large numbers of workers die in accidents at work.**
- **Either they fall from height or struck with falling objects or get electrical shock.**
- **Cement dust and silica dust causes dermatitis, non-specific lung diseases or fatal Silicosis. No reliable data is available for accidents or serious injuries.**

10.4 In manufacturing sector, 0.8 million workers are employed in registered factories while another 1 million are employed in small-scale manufacturing sector.

- **Workers are exposed to large number of toxic materials and hazards like organic solvents, pesticides, dyes, and all sorts of organic and non-organic dusts, noise. Factories Act and other Acts protect workers in registered factories. Each year more than 200 workers die in fatal accidents and**

thousands get injured. The rate of fatal accidents is 25 per 1,00,000 workers employed which is much higher than ILO estimates of 11 per 10^6.

- By and by, more and more workers are compelled to work under contractor. where they do not get minimum wages or social security like insurance. Those who are covered by the Employees State Insurance Act, get very poor services Area in which this Act is not applicable, Workmen's compensation Act applies. Under this Act, few workers dare to claim compensation. Those who dare do not always get justice.

10.5 Occupational Health is a major public health issue but, neither the Health Department nor the Labor Department take it seriously As a result, cases of occupational diseases are neither diagnosed nor notified

- There is legal provision for compensation of occupational lung diseases under ESI Act as well as Workmen's Compensation Act. Since cases are not diagnosed no compensation is paid. After independence, there is not a single case of Occupational cancer though workers handle known human carcinogens like Benzene, benzidine, chromium, Asbestos, Vinyl Chloride etc. There are no cases registered of occupational nephritis or toxic jaundice. Until recently, there was not a single case of dermatitis compensated. Large numbers of workers die of Silicosis in Agate, Ceramic, Glass, construction and other industries, but do not get any compensation. After workers struggled they have been able to claim compensation for Byssinosis and Silicosis (in Glass industry). **We have only one known case of Occupational Asthma compensation and one case of dermatitis.**

- Thousands of workers in textile, Handloom, engineering, chemical, transport are exposed to high noise, but few claim compensation and fewer get compensation. Workers pay their contribution for these risks but they do not get benefit when they deserve. Workplace environment remains unmonitored, though there is legal provision for monitoring it.

In Kirloskar Brothers Ltd. v/s. Employees State Insurance Corporation {(1996) 2SCC 682} it has been held that right to health is the fundamental right of the workmen. Just and favorable conditions of work imply to ensure safe and healthy working conditions to the workmen.

10.7 Government of India has ratified many ILO resolutions but not the resolution No.155. If ratified, this would offer legal cover for health and safety for millions of workers in primary and secondary sectors like service sector and agriculture sectors. We strongly demand ratification for this resolution.

10.8 Numbers of cases of occupational diseases registered in 1998 in India were 1963. Among these 52 were from Gujarat and rest were from Orissa. No other states reported

any case of Occupational disease. (Report of working group on Occupational Health & Safety for 10th Five Year plan, 2002)

In the judgement of Consumer Education and Research Centre and others v/s Union of India and others {(1995) 3 SCC 42} the Supreme Court has held that right to heath and medical care to protect the health and vigor of the workmen while in service or post retirement is a fundamental right of a worker. Under article 21 Supreme Court directed that compensation be paid to the worker suffering from Lung cancer.

10.9 Dismal record of Compensation

- In a decade from 91-2001, ESIC paid compensation to 191 workers for various diseases, out of which 149 were textile mill workers for **Byssinosis.** They also paid compensation to 21 workers who died of occupational diseases. (KSSM Bulletin, Feb 2002)
- In 1996, certifying Surgeon of Baroda Factory Inspectorate identified 53 cases of Chromium toxicity. ESIC paid compensation to 5 workers among these and rest were rejected. 21 petitions are pending before Medical Appeal Tribunal And ESI Court at Baroda for hearing.
- In 1988, ESI paid compensation to about 100 workers of Glass Factory in Baroda for Silicosis. (*Dhulia fefsa*; Gujarati booklet; PRIA, 1995)
- Large numbers of cases have been reported of acute poisoning from chemical units by Modi Hospital in Ankleshwar. In a period of two years, i.e. January 93 to December 94, 1079 cases of industrial accidents were admitted in this hospital, out of which 211 were that of chemical exposure. 33 cases of pesticide exposure were brought to this hospital in the period from June 94 to October 94. In 93 the Hospital received 34 cases of Aniline poisoning. In year 89-90, they received 65 cases of acute chemical exposure.(Behind Iron Gates;PRIA,Dec,95)

- In the article titled "Epidemiology of poisoning in an industry based hospital of South Gujarat", Dr. R. Calton reports 521 cases of poisoning during the period June'97 to June'2000. He writes, 'A total of 521 cases were admitted with a suspected poisoning between June 1997 to June 2000, out of which 439 cases met the inclusion criteria and were included in the analysis. Majority of cases (157, 35.8%) suffered from Aniline poisoning, followed by the Organo-phosphorus (OP) Compounds (135, 30.8%). A large majority of the cases were asphyxiated by gases. Toxicity of known gases was found in 41 (9.3% cases while a large majority of cases had toxicity to some unknown gases (48, 10.9%). (Indian Journal of Industrial Medicine, Oct. 2002)

10.11 India has 1461 Major Accident Hazard (MAH) units. Gujarat state has highest number of these units with 28% share followed by Maharashtra state with 22%. In Gujarat 416 Major Accident Hazard (MAH) units were identified, out of which 44 were closed and 372 were working. Bharuch district had maximum concentration of such units (78 units) followed by Baroda (82 units), Ahmedabad (43), Valsad (46) and Surat (32). These five districts have 75% of the total working units. This area is known as "Golden Corridor". Situation of fatal accidents may be summarized by following table:

Comparison of Industrial Accidents in 1998

	Gujarat	Maharashtra	India
Fatal Accidents	223	163	-
Non-fatal accidents	11930	17120	-
Incidence rate for fatal	0.56	0.16	0.34
Incidence rate for non-fatal	30.01	16.28	6.7
Frequency rate for fatal	0.18	0.05	0.09
Frequency rate for non-fatal	9.79	4.92	1.8

Fatal Accidents in Chemical Factories

No.	Year	No.of fatal accidents
1	2001	42
2	2002	68
3	2003	50

Specific Demands

1. State Government should co-ordinate with Factory Inspectorate and Rural Labor Commissioner to take stock of the situation of Occupational Health
2. State Government should give out budget for Health education for Occupational diseases and injuries.
3. State Government should form a Commission for Occupational Safety and Health for co-ordination between various departments.
4. Health department should take up research projects to know the status and economical burden on Society.
5. Health department should create Industrial hygiene department and monitor workplace environment.
6. Health department should publish data and report of its efforts.

[1] Source KSSM Bulletin. Feb 2002
[2] Source KSSM Bulletin. Feb 2002

No. of Cases Compensated by ESIC[1]

Disease/Condition	*No. of cases*	*Year*
Byssinosis	8	1991
Byssinosis	3	92
Byssinosis	10	94
Byssinosis	35	95
Asbestosis	1	95
Byssinosis	26	96
Byssinosis	7	97
Byssinosis	16	98
Byssinosis	31	99
Deafness	8	99
Silicosis	6	99
Byssinosis	13	2001
Deafness	26	2001
Dermatitis	1	2001
Total	**191**	

No.of cases of compensation for deaths[2]

Disease	*Numbers*	*Year*
Byssinosis	2	1991
Byssinosis	1	94
Byssinosis	10	95
Byssinosis	3	96
Byssinosis	1	97
Byssinosis	1	98
Byssinosis	1	99
Byssinosis	1	2001
Deafness	1	2001
Total	**21**	

Annexure I

FACT SHEET, GUJARAT

NATIONAL FAMILY HEALTH SURVEY, 1998–99

Sample Size

Households	3,952
Ever-married women age 15–49	3,845

Characteristics of Households

Percent with electricity	84.3
Percent within 15 minutes of safe water supply[1]	74.0
Percent with flush toilet	31.3
Percent with no toilet facility	54.9
Percent using govt. health facilities for sickness	27.7
Percent using iodized salt (at least 15 ppm)	56.1

Characteristics of Women[2]

Percent urban	42.5
Percent illiterate	50.3
Percent completed high school and above	20.1
Percent Hindu	89.7
Percent Muslim	8.2
Percent Jain	1.1
Percent regularly exposed to mass media	66.2
Percent working in the past 12 months	50.8

Status of Women[2]

Percent involved in decisions about own health	71.4
Percent with control over some money	73.6

Marriage

Percent never married among women age 15–19	73.5
Median age at marriage among women age 20–49	17.9

Fertility and Fertility Preferences

Total fertility rate (for the past 3 years)	2.7
Mean number of children ever born to women 40–49	4.0
Median age at first birth among women age 25–49	20.1
Percent of births[3] of order 3 and above	40.9
Mean ideal number of children[4]	2.5
Percent of women with 2 living children wanting another child	17.2

Current Contraceptive Use

Any method	59.0
Any modern method	53.3
Pill	1.5
IUD	3.1
Condom	3.5
Female sterilization	43.0
Male sterilization	2.3
Any traditional method	5.6
Rhythm/safe period	4.8
Withdrawal	0.8
Other traditional or modern method	0.1

Unmet Need for Family Planning[5]

Percent with unmet need for family planning	8.5
Percent with unmet need for spacing	4.8

[1]Water from pipes, hand pump, covered well, or tanker truck
[2]Ever-married women age 15–49
[3]For births in the past 3 years
[4]Excluding women giving non-numeric responses
[5]Among currently married women age 15–49

Quality of Family Planning Services[6]

Percent told about side effects of method	9.5
Percent who received follow-up services	70.8

Childhood Mortality

Infant mortality rate[7]	62.6
Under-five mortality rate[7]	85.1

Safe Motherhood and Women's Reproductive Health

Percent of births[8] within 24 months of previous birth	31.9
Percent of births[3] whose mothers received:	
Antenatal check-up from a health professional	86.3
Antenatal check-up in first trimester	35.8
Two or more tetanus toxoid injections	72.7
Iron and folic acid tablets or syrup	78.0
Percent of births[3] whose mothers were assisted at delivery by a:	
Doctor	37.4
ANM/nurse/midwife/LHV	16.1
Traditional birth attendant	42.4
Percents reporting at least one reproductive health problem	28.6

Awareness of AIDS

Percent of women who have heard of AIDS 29.8

Child Health

Percent of children age 0–3 months exclusively breastfed 65.2

Median duration of breastfeeding (months) 22.0

Percent of children[9] who received vaccinations:

BCG 84.7

DPT (3 doses) 64.1

Polio (3 doses) 68.6

Measles 63.6

All vaccinations 53.0

Percent of children[10] with diarrhoea in the past 2 weeks who received oral rehydration salts (ORS) 28.9

Percent of children[10] with acute respiratory infection in the past 2 weeks taken to a health facility or provider 71.2

Nutrition

Percent of women with anaemia[11] 46.3

Percent of women with moderate/severe anaemia[11] 16.8

Percent of children age 6–35 months with anaemia[11] 74.5

Percent of children age 6–35 months with moderate/severe anaemia[11] 50.4

Percent of children chronically undernourished (stunted)[12] 43.6

Percent of children acutely undernourished (wasted)[12] 16.2

Percent of children underweight[12] 45.1

[6]For current users of modern methods

[7]For the 5 years preceding the survey (1994–98)

[8]For births in the past 5 years (excluding first births)

[9]Children age 12–23 months

[10]Children under 3 years

[11]Anaemia–haemoglobin level < 11.0 grams/decilitre (g/dl) for children and pregnant women and < 12.0 g/dl for nonpregnant women. Moderate/severe anaemia –haemoglobin level < 10.0 g/dl.

[12]Stunting assessed by height-for-age, wasting assessed by weight-for-height, underweight assessed by weight-for-age

Annexure 2

Table 1[1]

		1	2	3	4	5	6	7	8	9	10	11
Sr. No.	State	Cereals	Cereals Substitute	Sugar	Pulses	Vegetables	Fruits	Fats & Oils	Milk	Eggs	Meat	Fish
1.	Bihar	1.14	0.00	0.36	0.60	0.50	0.35	0.44	0.48	0.01	0.09	0.16
2.	Gujarat	0.85	0.00	1.07	0.31	0.60	0.35	0.98	1.01	0.02	0.07	0.03
3.	Tamil Nadu	0.93	0.01	0.49	0.57	0.54	0.71	0.39	0.42	0.10	0.23	0.23
4.	Uttar Pradesh	1.10	0.00	0.58	0.82	0.45	0.36	0.58	1.09	0.02	0.15	0.05
	All India	1.04	0.05	0.83	0.58	0.48	0.45	0.52	0.97	0.06	0.15	0.28
	ICMR Norm in gms	*420*	*3.73*	*24.92*	*23.29*	*59.63*	*22.60*	*11.52*	*146.23*	*2.76*	*3.69*	*7.04*

Consumption Index with ICMR as the Base (=1) for Various Food Items

Source: Col. 1,2,4 NSSO, 50th Round (Report No.402), Level and Patterns of Consumer Expenditure (1993-94)

Col. 3,5-11, NSSO, 50th Round, Quantity of Consumption of all Food Items (Rural)

[1] Source: Table 3.2 of the Food Security of India Atlas, MSSRF, Chennai

Table 2[1]

Calorie Intake among the States

			2	3	4	5
Sr No	State	Average Intake per Consumer Unit Per day Kcal	Average Per Capita intake Per day Kcal	Calorie Intake Of the lowest Decile (Kcal) Per cu/day	Average Intake Of lower Exp Groups <Rs.190 Per cu/day Kcal	Percentage of Households in The lower Exp Groups <Rs. 190
1.	Bihar	2637.00	2115.00	1790.88	2142.75	39.53
2.	Gujarat	2470.00	1994.00	1788.34	1685.25	12.93
3.	Tamil Nadu	2347.00	1884.00	1551.38	1683.75	22.99
4.	Uttar Pradesh	2899.00	2307.00	2103.15	2240.00	26.29
	All India	2683.00	2153.00	1954.03	2049.25	22.19

Source: Col. 1-5, NSSO, Sarvekshana, Vol.XXI, No.2, 73rd Issue (1997)

[1] Table 3.3 of the Atlas

Table 3[1]

Deficient Calorie Intake (per consumer unit per day)

		1	2
Sr. No.	State	Percentage of Households Consuming Less than 1890 Kcal	Percentage of Households Consuming Less than 2400 Kcal
1.	Bihar	14.10	41.80
2.	**Gujarat**	**20.40**	**53.70**
3.	Tamil Nadu	28.20	61.30
4.	Uttar Pradesh	8.00	31.00
	All India	13.40	42.00

Source: Col. 1-2, NSSO, Sarvekshana, Vol. XXI, No.2, 73rd Issue (1997)

Table 4[2]

Calorie Intake of Landless Labourers and Cultivators

		1	2	3	4	5	6
Sr. No.	State	Percentage Of landless Labour Households To total HH	Percentage of Landless labour HH consuming <2300 Kcal to total landless labour HH	Percentage of Landless labour HH consuming <2300 Kcal to total HH	Percentage of Submarginal Cultivators (with <0.40 ha) to total holding	Percentage of Cultivator Consuming <2300 Kcal to total cultivators	Percentage Of hungry Submarginal Cultivators To total Cultivators
1.	Bihar	19.00	45.00	8.55	52.03	27.00	31.22
2.	**Gujarat**	**17.90**	**56.00**	**10.02**	**26.77**	**40.00**	**19.12**
3.	Tamil Nadu	26.60	65.00	17.29	53.65	43.00	35.49
4.	Uttar Pradesh	7.60	41.00	3.12	38.00	20.00	18.53
	All India	14.20	49.00	6.96	37.71	29.00	22.32

Source: Col. 1-6, Kumar Praduman and Joshi, P.K., "Determinants of Food Intake and Nutritional Status of Farm Households in Rural India" (2000), Mimeograph

[1] Table 3.4 of the Atlas
[2] Table 3.5 of the Atlas

Column 3 clearly indicates that non-implementation of Minimum Wages Act badly affects the health status of the landless labour. The minimum wages fixed by itself are not based on the minimum calories requirement even if it were to be followed.

Table 5[1]
Protein Calorie Inadequacy (Percentage of population with protein and/or calorie deficiency)

		1	2	3	4
Sr. No.	State	P-C-	P-C+	P+C+	P+C-
1.	Bihar	12.3	1.2	76.5	10.0
2.	Gujarat	2.5	0.0	60.3	37.3
3.	Tamil Nadu	41.4	0.0	29.7	28.9
4.	Uttar Pradesh	NA	NA	NA	NA

P: Protein C:Calorie +: Adequate -: Inadequate
Calorie Adequacy: 2425 Kcal per consumer unit per day. Protein Adequacy: 60 gms per consumer unit per day
Source: Col 1-4, MHRD, India Nutrition Profile (1998)

Table 6: Life Expectancy at Age One[2]

		1	2
Sr. No.	State	Life Expectancy At the age one (1992-96)	Rank
1	Andhra Pradesh	65.2	8
2	Assam	60.6	1
3.	Bihar	63.2	5
4.	Gujarat	65.1	7
5.	Haryana	67.6	12
6.	Himachal Pradesh	68.1	13
7.	Karnataka	66.6	11
8.	Kerala	73.2	16
9.	Madhya Pradesh	61.2	2
10	Maharashtra	68.1	13
11.	Orissa	62.6	4
12.	Punjab	70.5	15
13	Rajasthan	64.6	6
14	Tamil Nadu	66.1	10
15	Uttar Pradesh	62.2	3
16.	West Bengal	65.8	9

Source: GOI, Registrar General and Census Commissioner, Sample Registration Surveys (1992-96)

[1] Table 4.1 of the Atlas
[2] Table 4.6 of the Atlas

Table 7[1]

Child Health Indicators

			2	3	4	5
Sr. No.	State	Percentage Of severely Stunted Children Under five	Percentage Of severely Underweigh t Children Under five	Percentag e Of severely Wasted Children Under five	Child Mortalit y Rate (1990)	Infant Mortalit y Rate (1997)
1	Andhra Pradesh	27.00	22.20	3.50	17.00	70.00
2	Assam	32.60	17.90	5.30	28.00	79.00
3.	Bihar	44.00	29.50	9.50	27.00	73.00
4.	Gujarat	54.20	36.27	3.90	24.00	69.00
5.	Haryana	34.70	19.10	3.70	23.00	70.00
6.	Himachal Pradesh	38.90	19.70	2.00	16.00	64.00
7.	Karnataka	37.70	22.80	1.10	20.00	63.00
8.	Kerala	37.30	15.70	2.90	3.00	11.00
9.	Madhya Pradesh	40.00	33.40	4.20	35.00	99.00
10	Maharashtra	43.30	28.60	1.10	14.00	56.00
11.	Orissa	26.50	22.00	3.10	29.00	100.00
12.	Punjab	38.20	19.10	2.80	16.00	54.00
13	Rajasthan	37.20	16.40	3.90	32.00	89.00
14	Tamil Nadu	21.50	16.10	1.70	15.00	58.00
15	Uttar Pradesh	40.50	24.60	3.80	32.00	89.00
16	West Bengal	37.60	18.40	1.20	18.00	58.00
	All India	7.69	6.29	2.05	8.46	21.35

Source: Col. 1,2,3 NNMB 1996, MHRD, India Nutrition Profile (1998) and Shariff, A., (NCAER) India Human Development Report (1999). Col. 4,5 GOI, Registrar General and Census Commissioner, Sample Registration Surveys (1990 and 1997).

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[1] Table 4.9 of the Atlas

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NHRC to hear cases of denial of healthcare in Western Region public hearing

National Human Rights commission taking cognizance of the denial of health care cases in the country, today heard over 40 blatant cases of denial of health care in its Western Region public hearing on Right to Health Care organized by NHRC and Jan Swasthya Abhiyan (JSA).These cases include avoidable deaths due to untreated snake bite, denial of delivery care leading to women delivering in the open outside health centers, operating without anaesthesia in sterilization camps resulting in severe anguish to the operated women, discrimination against persons with HIV and failure of the public health system to promptly respond to an outbreak leading to deaths. These cases were reported from five states including Madhya Pradesh, Rajasthan, Gujarat Maharashtra and Goa.

In Madhya Pradesh, a 25-year-old man died of a dog bite as the nearest Ratlam civil hospital did not have any anti-rabies vaccine. While in Maharshtra three girl students died of snake bite because of non –availability of anti snake venom in the Rural Hospital.In another case in Madhya Pradesh a two-an-a-half years old child was referred to Badwani civil hospital after a long and tedious process for treatment of his continuing eye-problem. However, the child was not treated in the eye department and did not receive adequate eye care finally resulting in both his eyes becoming infected and complete loss of eye sight in both eyes.

In Gujarat , many such cases were reported where the doctors advise patients to go to private hospital, if not they demand money for medicines and treatment. In fact Ahemdabad Cancer Hospital, did not even have an ambulance to transfer a patient leading to an early death of a patient. In Rajasthan cases clearly highlight the infrastructural deficiencies and lack of access of health care facilities. A stone quarry worker in Jodhpur developed silico-tuberculosis had to pay for his treatment at the District Hospital and had to buy drugs from private medial stores. During six month of treatment and after spending Rs 20,000 for which he had to sell off all his land and belongings he died leaving behind his family in heavy debt.Large-scale corruption in the district and rural hospitals are the norm in all the states. The doctors often directly charge money from poor people although they possesses the BPL cards and do not provide treatment if their demands are not met.

This hearing is being attended by Justice Bhaskar Rao, Member NHRC, Dr N.H.Antia, Chairperson Health Committee NHRC, Dr B Ekbal, National Convenor, JSA, Health Secretaries /Health Commissioners of all five States and Secretaries of various State Human Rights Commissions. Nearly 200 delegates from the JSA units in the concerned States are also participating in this hearing.

The Western region public hearing is first of the series which will be followed by four more hearings in other regions of the country (South, North, East and North-east) followed by a national public hearing on Right to health care in December 04 in Delhi. Thus the Bhopal public hearing acquires historic importance by inaugurating a process of highlighting and moving towards establishing the right to health care in India. It is expected that the NHRC will direct various state governments to implement a range of improvements in health services and greater interaction with civil society in order to ensure the health rights of all citizens. Jan Swasthya Abhiyan would carry forward the campaign that has been strengthened by this process, to demand the making of right to health care a fundamental constitutional right.

Dr Abhay Shukla National Joint Convenor (JSA)
Dr Ajay Khare, State Coordinator MP JSA

मध्य प्रदेश के बड़वानी जिले में सामुदायिक, प्राथमिक स्वास्थ्य केन्द्रों तथा जिला अस्पताल में उपलब्ध स्वास्थ्य सेवाओं की स्थिति पर एक अध्ययन रिपोर्ट

बीमारु राज्यों की श्रेणी में शामिल मध्यप्रदेश का 42 प्रतिशत भाग गरीबी रेखा के नीचे (NCAER 2002) आता है। 60,385,118 जनसंख्या वाले इस राज्य में 2001 में महिलाओं का अनुपात प्रति 1000 पर 920 पाया गया है। साथ ही यहाँ शिक्षा का स्थर भी अत्यंत कम है। आर्थिक रुप से कमजोर इस राज्य में देश की कुल आदिवासी जनसंख्या का 23 प्रतिशत भाग निवास करता है। राज्य का अधिकांश भाग पक्की सड़क जैसी आम सुविधा से वंचित है।

आल्मा-आटा में 1978 को सन् 2000 तक 'सबके लिए स्वास्थ्य' का नारा दिये हुए 25 साल बीत जाने के बाद भी आम जनता बेहतर स्वास्थ्य सेवाओं से कोसों दूर है।

यहाँ दूरदराज के आदिवासी इलाकों में मलेरिया, टी.बी. (तपेदिक) जैसी बीमारियों का प्रकोप आज भी कायम है, वहीं दूसरी ओर जनता स्वास्थ्य कर्मचारियों के बीज अविश्वास, आवश्यक-जीवनदायक दवाओं के अभाव व मूलभूत प्राथमिक सेवाओं की कमी ने स्वास्थ्य संबंधी समस्याओं को और बढ़ाया है।

मध्यप्रदेश के पश्चिमी क्षेत्र में स्थित बड़वानी कम विकसित जिलों में आता है, जहाँ 90 प्रतिशत आदिवासी जनता निवास करती है। बड़वानी जिला सात विकासखण्डों में फैला है जिसमें 714 गाँव, 383 ग्राम पंचायते एवं 1121 आँगनवाड़ी कार्यकर्ता है।

जिले में 1 जिला अस्पताल, 5 सामुदायिक स्वास्थ्य केन्द्र, 21 प्राथमिक स्वास्थ्य केन्द्र और 235 उप-स्वास्थ्य केन्द्र हैं। वहीं गाँव स्तर पर मूलभूत स्वास्थ्य सुविधा देने के लिए ए.एन.एम./एम.पी.डब्ल्यू. को नियुक्त किया गया है।

म.प्र. ही एक ऐसा प्रदेश है जहाँ स्वास्थ्य जीवन सेवा गारंटी योजना के तहत स्वास्थ्य की गारंटी दी गई थी लेकिन लागू होने के 2 वर्षों के बाद से सार्वजनिक स्वास्थ्य सेवाएँ पश्चिमी म.प्र. के अनेक जिलों में असफल हुई है।

इसी संदर्भ में बड़वानी जिले में स्वास्थ्य सेवा की वास्तिविक स्थिति का जायजा लेने और उसकी पुष्टि हेतु विभिन्न संस्थाओं, संगठनों के प्रतिनिधियों द्वारा बड़वानी के सभी सामुदायिक/प्राथमिक स्वास्थ्य केन्द्रों, उप-स्वास्थ्य केन्द्रों तथा जिला अस्पताल में एक अध्ययन किया गया है जिसकी रिपोर्ट निम्नानुसार प्रस्तुत है:-

क. उद्देश्य

1. सरकारी अस्पतालों में दी जाने वाली स्वास्थ्य सुविधाओं के स्तर एवं अभावों का विश्लेषण/मूल्यांकन करना।
2. स्वास्थ्य व्यवस्था से संस्थागत एवं दी जाने वाली स्वास्थ्य सेवाओं में सुधार के लिए अनुमोदन करना।

ख. सर्वेक्षण विधि

1. **नमूना चुनाव**

   अध्ययन हेतु सभी 5 सामुदायिक स्वास्थ्य केन्द्रों, 31 प्राथमिक स्वास्थ्य केन्द्रों एवं बड़वानी जिले के जिला अस्पताल से जानकारी के रुप में सामग्री एकत्रित की गई है।

2. **जानकारी के स्त्रोत**

   अ. जानकारी एकत्रित करने के लिए सामुदायिक स्वास्थ्य केन्द्र के लिए 131 वैकल्पिक प्रश्नों वाली, प्राथमिक स्वास्थ्य केन्द्रों के लिए 65 वैकल्पिक प्रश्नों वाली एवं जिला अस्पताल हेतु 152 प्रश्नों वाली एक चेकलिस्ट (प्रश्नावली) का उपयोग किया गया।

   ब. चेकलिस्ट भरते समय विश्वसनीयता की जाँच के लिए अवलोकन विधि एवं साक्षात्कार का प्रयोग किया गया जिसमें चिकित्सक तथा अस्पताल के अन्य कर्मचारियों, मरीजों व गाँव के लोगों का साक्षात्कार लिया गया है।

3. **तथ्य संग्रहण -**

   सामग्री एकत्र करने के लिए म.प्र. सरकार की चेकलिस्ट का उपयोग किया गया जो सरकारी स्वास्थ्य सेवाओं की निगरानी के लिए उपयोग की जाती है। हमने इस चेकलिस्ट का चुनाव विशेषतौर पर किया ताकि बताया जा सके कि उन्हीं के चेकलिस्ट के अनुसार, उन्हीं के नियमानुसार सरकारी स्वास्थ्य सुविधाऐं किस तरह काम कर रही है।

   चेकलिस्ट के अलावा अवलोकन विधि का भी उपयोग किया गया ताकि एकत्रित सामग्री/जानकारी को और विश्वसनीयता दी जा सके।

   सामग्री का एकत्रीकरण मध्य जुलाई से सितम्बर 2003 के बीच अस्पतालों में उपस्थित चिकित्सकों व अन्य कर्मचारियों के साक्षात्कार, अवलोकन व लोगों से चर्चा द्वारा किया गया है।

सामुदायिक/प्राथमिक स्वास्थ्य केन्द्रों एवं जिला अस्पताल के अध्ययन से एकत्र की गई जानकारी से प्राप्त निष्कर्ष निम्नानुसार है:-

प्राथमिक स्वास्थ्य केन्द्र

बड़वानी जिले के प्राथमिक स्वास्थ्य केन्द्रों के अध्ययन से प्राप्त मुख्य निष्कर्ष:-

1. **अपर्याप्त केन्द्र:** बड़वानी जिले में 15 प्राथमिक स्वास्थ्य केन्द्रों का अभाव है। यहाँ प्रति 29000 से ज्यादा जनसंख्या वाले गाँव में एक प्राथमिक स्वास्थ्य केन्द्र सेवा प्रदान कर रहा है जबकि नियमानुसार 20000 जनसंख्या पर एक प्राथमिक स्वास्थ्य केन्द्र होना चाहिए।

2. **बिस्तर :** किसी भी प्राथमिक स्वास्थ्य केन्द्र द्वरा 2-6 पलंग एवं बिस्तर की उपलब्धता के अनुबंध का पालन नहीं किया जा रहा है। सभी प्राथमिक स्वास्थ्य केन्द्रों में से 8 प्राथमिक स्वास्थ्य केन्द्रों में मरीजों को भर्ती करने की सुविधा ही नही है।
3. **भवन :** कुल 31 प्राथमिक स्वास्थ्य केन्द्रों में से 11 स्वास्थ्य केन्द्रों (36 प्रतिशत) में चिकित्सालय भवन जर्जर अवस्था में है।
4. **प्रसव सुविधा :** जहाँ एक ओर कुल 31 प्राथमिक स्वास्थ्य केन्द्रों में से 15 (48 प्रतिशत) प्राथमिक स्वास्थ्य केन्द्र साधारण डिलीवरी की सुविधा प्रदान करने में असमर्थ है, वहीं दूसरी ओर 13 (42 प्रतिशत) प्राथमिक स्वास्थ्य केन्द्रों में तो डिलीवरी रुप (प्रसव कक्ष) ही नहीं है।
5. **बिजली :** कुल 31 प्राथमिक स्वास्थ्य केन्द्रों में से 8 प्राथमिक स्वास्थ्य केन्द्र में बिजली की कोई व्यवस्था नहीं है। जिनमें बिजली सुविधा है उनमें पंखे और ट्यूब लाईट्स बंद पडे हैं। यहाँ तक कि किसी एक में भी बिजली की वैकल्पिक व्यवस्था के रुप में जनरेटर उपलब्ध नहीं है, जबकि म.प्र. में बिजली की उपलब्धता की स्थिति क्या है, यह सर्वविदित है। आकस्मिक समय (Emergencies) में इन प्राथमिक स्वास्थ्य केन्द्रों पर बिजली की कोई व्यवस्था नहीं है।
6. **पानी :** 6 प्राथमिक स्वास्थ्य केन्द्रों (19 प्रतिशत) में पीने के पानी की कोई व्यवस्था या स्त्रोत नहीं है। 13 प्राथमिक स्वास्थ्य केन्द्रों (14 प्रतिशत) मे नलकूप पानी के एकमात्र स्त्रोत के रुप में उपलब्ध है जिनमें से अधिकांशतः गर्मियों में सूख जाते हैं।
7. **एम्बुलेंस :** कुल 31 में से 5 (16 प्रतिशत) प्राथमिक स्वास्थ्य केन्द्रों में एम्बुलेंस सुविधा है, अन्य 26 (84 प्रतिशत) मे कोई व्यवस्था नहीं है, वहीं इन 5 प्राथमिक स्वास्थ्य केन्द्रों में भी वाहन चालक प्राथमिक स्वास्थ्य केन्द्र परिसर में निवास नहीं करते हैं। आकस्मिक समय में पहले वाहन चालक को बुलाना पड़ता है, जिसमें बहुत समय लगता है।
8. 13 प्रतिशत प्राथमिक स्वास्थ्य केन्द्रों बिना डॉक्टर्स के चल रहे हैं। वहीं केवल 3 प्राथमिक स्वास्थ्य केन्द्रों में महिला चिकित्सक उपलब्ध है।
9. 70 प्रतिशत प्राथमिक स्वास्थ्य केन्द्रों में पुरुष स्वास्थ्य कार्यकर्ताओं एवं LHVs के पद नहीं भरे गए हैं।
10. प्राथमिक स्वास्थ्य केन्द्रों के लगभग 29 प्रतिशत चिकित्सक समय पर अस्पताल में उपलब्ध नहीं पाए गए। वहीं अन्य कर्मचारियों में से लगभग 20 प्रतिशत प्राथमिक स्वास्थ्य केन्द्र कर्मचारी समय पर अस्पताल में उपलब्ध नहीं थे।
11. सभी 31 प्राथमिक स्वास्थ्य केन्द्रों में टॉयलेट सुविधा उपलब्ध नहीं है और जिनमें टॉयलेट्स है वे अच्छी तरह से कार्य नहीं कर रहे हैं।

सामुदायिक स्वास्थ्य केन्द्र

सामुदायिक स्वास्थ्य केन्द्र के अध्ययन से प्राप्त मुख्य निष्कर्ष –

1. **नए केन्द्रों की आवश्यकता :** बड़वानी जिले में कुल सामुदायिक स्वास्थ्य केन्द्रों में से आधे से भी कम सामुदायिक स्वास्थ्य केन्द्र उपलब्ध है। जहाँ प्रति 80000 जनसंख्या पर एक सामुदायिक स्वास्थ्य केन्द्र होना चाहिए वहाँ जिले में 1,84,612 की जनसंख्या पर एक सामुदायिक स्वास्थ्य केन्द्र उपलब्ध है।
2. **बिस्तर :** किसी भी सामुदायिक स्वास्थ्य केन्द्र में नियमानुसार 30 पलंग उपलब्ध नहीं है। 10 या उससे कम पलंग ही उपलब्ध है।
3. **पानी :** 40 प्रतिशत सामुदायिक स्वास्थ्य केन्द्र में नियमित पीने के पानी की कोई व्यवस्था नहीं है।
4. **ऑपरेशन थिएटर :** 60 प्रतिशत सामुदायिक स्वास्थ्य केन्द्रों में ऑपरेशन कक्ष काम नहीं कर रहे हैं, बंद पड़े हैं या निष्क्रिय है। जबकि कुछ सामुदायिक स्वास्थ्य केन्द्रों में प्रसव कक्ष ही उपलब्ध नहीं है।
5. 80 प्रतिशत सामुदायिक स्वास्थ्य केन्द्रों में कोई विशेषज्ञ डॉक्टर नहीं है, मात्र एक सामुदायिक स्वास्थ्य केन्द्र में ही आवश्यक सभी विशेषज्ञों में से आधे उपलब्ध है।
6. केवल एक सामुदायिक स्वास्थ्य केन्द्र में महिला चिकित्सक उपलब्ध है।
7. 40 प्रतिशत सामुदायिक स्वास्थ्य केन्द्रों में चिकित्सक, अस्पताल की समयावधि में उपलब्ध नहीं रहते हैं।
8. आवश्यक सुविधाओं में से 80 प्रतिशत सामुदायिक स्वास्थ्य केन्द्र पर 'नेओनेटर रेसीस्टेशन' नामक उपकरण का अभाव है तथा 80 प्रतिशत में ECG मशीन का अभाव है। 40 प्रतिशत सामुदायिक स्वास्थ्य केन्द्रों में ऑक्सीजन सिलेण्डर, इन्क्यूबरेटर या पर्याप्त ऑपरेशन हेतु पर्याप्त उपकरण नहीं हैं।
9. कोई भी सामुदायिक स्वास्थ्य केन्द्र सिजेरियन डिलेवरी के लिए आवश्यक सुविधाऐं उपलब्ध कराने में असमर्थ है।
10. 40 प्रतिशत सामुदायिक स्वास्थ्य केन्द्र गंभीर एनीमिया से पीडित महिलाओं, श्वसन तंत्र संबंधी बीमारियों से ग्रस्त बच्चों एवं दस्त के मरीजों का इलाज करने की सुविधा प्रदान नहीं करते हैं।
11. 60 प्रतिशत सामुदायिक स्वास्थ्य केन्द्रों में यौन संक्रमित रोगों के लिए कोई क्लिनिक नहीं है।

जिला चिकित्सालय

1. **बिस्तर :** बिस्तरों की अपर्याप्तता के कारण हड्डी रोग विभाग, महिला विभाग एवं शिशु विभाग में की रोगियों को जमीन पर ही लिटाकर इलाज किया जाता है। बिस्तरों पर चादरें, तकिये आदि भी बहुत गंदी अवस्था मे होते हैं जिससे अस्पताल में साफ-सफाई की स्थिति का पता चलता है।
2. **पानी :** जिला अस्पताल में पानी की सुविधाओं पर भी उचित ध्यान नहीं दिया जा रहा है। अस्पताल में केवल पानी का एक ही टैंक है जो कि सेप्टिक टैंक के पास होने से दूषित होता रहता है और जो किसी दिन बडी दुर्घटना का कारण बन सकता है।
3. **बिजली :** कई वार्डों तथा कमरों में पंखे तथा लाइट ठीक से काम नहीं कर रहे हैं तथा बहुत समय से इन्हें सुधारा भी नहीं गया है। चूंकि बडवानी एक बहुत ही गर्मी वाला क्षेत्र है अतः गर्मी के दिनों में मरीजों तथा स्टॉफ के लोगों का अस्पताल में रहना मुश्किल हो जाता है।
4. **शौचालय :** अस्पताल के हर कमरे के साथ शौचालय तो उपलब्ध है परन्तु कहीं पानी की सुविधा नहीं है तो कहीं शौचालय दयनीय स्थिति में है। अस्पताल

परिसर में सुलभ शौचालय बनाया गया है, जिसमें प्रति व्यक्ति 2 रुपये प्रतिदिन चार्ज लगाया जाता है जो कई गरीब व्यक्ति इसे वहन नहीं कर पाते।

5. मरीजों के साथ वालों के ठहरने की भी कोई व्यवस्था नहीं है। आयुष्मती भवन पिछले 1 साल से बंद पडा है तथा धनवन्तरी भवन के दरवाजे आदि टूटे-फूटे हैं साथ ही बिस्तर आदि भी उपलब्ध नहीं है।
6. जाँच सुविधाऐं : यद्यपि जिला अस्पताल में विभिन्न जाँच सुविधाऐं उपलब्ध तो है परन्तु कुछ जाँचों के शुल्क इतने अधिक होते हैं कि गरीब मरीज उन्हें वहन नहीं कर सकते।
7. ब्लड बैंक तो अस्पताल मे उपलब्ध है परन्तु कुछ जाँचों के शुल्क इतने अधिक होते हैं कि गरीब मरीज उन्हें वहन नहीं कर सकते।
8. अधिकतर पेशेंट्स को बहुत सी दवाईयाँ बाहर बाजार से दवाई की दुकानों से खरीदनी होती है। अस्पताल में सभी आवश्यक दवाईयों का अभाव है।

रोगी कल्याण समिति, जिला अस्पताल, बड़वानी

1. रोगी कल्याण समिति अपनी आय का 25 प्रतिशत भाग बचत कर रही है जबकि अस्पतालों में धन के अभाव में आवस्यक एवं मूलभूत सुविधाऐं उपलब्ध नहीं हो पा रही है।
2. रोगी कल्याण समिति की कुल आय का लगभग 75 प्रतिशत भाग (3/4) सामान्य मरीजों से एकत्र किया जाता है जबकि उनको मिलने वाली सुविधाओं पर समिति लगभग 11 प्रतिशत खर्च करती है।
3. समिति द्वारा किए गए 15,26.201/- रुपये के व्ययों में से लगभग 81.3 प्रतिशत रकम मरीजों की सुविधाओं पर खर्च नहीं करते हुए, एयर कंडीशनर व कूलर लगाने तथा मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी के कार्यालय पर बगीचे की घास कटाई मशीन व पानी की मोटर तथा बिजली मरम्मत आदि पर व्यय हुआ है।

निष्कर्ष एवं सुझाव

निष्कर्ष -

बडवानी जिला में स्वास्थ्य की समस्याओं के अध्ययन द्वारा विभिन्न रिपोर्ट्स एवं दस्तावेज लिखे, प्रकाशित एवं प्रस्तुत किए गए हैं, इतना ही नहीं सरकार के साथ विभिन्न प्रकार से चर्चा व विचार विमर्श द्वारा जिले में स्वास्थ्य सुविधाओं की अपर्याप्तता एवं समस्याओं को रखा भी गया है जिसमें देश की सबसे बड़ी जन सुनवाई भी सम्मिलित है जो पाटी एवं सेंधवा विकासखण्डों में रखी गई थी। परन्तु इसके उपरांत भी सरकार इस सभी के द्वारा उठाए गए मुद्दों तथा जन स्वास्थ्य के प्रति अधिक संवेदनशील दिखाई नहीं देती है।

एक तरफ हम सभी के लिए स्वास्थ्य एवं स्वास्थ्य ग्यारण्टी जैसे बडे-बडे आश्वासन दिये जाते हैं जबकि दूसरी तरफ जैसा कि इस अध्ययन से ज्ञात होता है बडवानी जिले में स्वास्थ्य सुविधाओं की स्थिति अत्यंत दयनीय है। सभी के लिए स्वास्थ्य के उद्देश्य की पूर्ति के लिए सरकार को अभी और अधिक प्रयास करने बाकी हैं साथ ही तुरन्त कुछ आवश्यक कदम उठाए जाने जरुरी है।

सुझाव -

1. अध्ययन से स्पष्ट है कि बडवानी जिले में कुल 23 प्राथमिक स्वास्थ्य केन्द्रों का अभाव है जिसका मतलब है कि स्वास्थ्य विभाग द्वारा जिले के हर क्षेत्र में या प्राथमिक स्वास्थ्य केन्द्र उपलब्ध कराने एवं विकसित करने की आवश्यकता है। प्राथमिक स्वास्थ्य केन्द्रों के अलावा हर ब्लॉक में कम से कम एक सामुदायिक स्वास्थ्य केन्द्र स्थापित किये जाने की आवश्यकता है। कुछ प्राथमिक स्वास्थ्य केन्द्र जैसे सेंधवा प्राथमिक स्वास्थ्य केन्द्र को सामुदायिक स्वास्थ्य केन्द्र के रुप में विकसित किया जाना चाहिए।
2. सभी प्राथमिक स्वास्थ्य केन्द्र, सामुदायिक स्वास्थ्य केन्द्र एवं जिला अस्पताल में नियमानुसार अधिकांश मूलभूत सुविधाऐं मरीजों के लिए उपलब्ध होनी चाहिए।
3. प्राथमिक स्वास्थ्य केन्द्र में अस्पताल कर्मचारियों की व्यवस्था पर पुर्नविचार के साथ कुछ परिवर्तन करने की आवश्यकता है ताकि उपलब्ध मानवशक्ति का पूरा-पूरा सदुपयोग किया जा सकें और बेहतर स्वास्थ्य सेवाऐं प्राप्त हो सकें। प्राथमिक स्वास्थ्य केन्द्र में 2 महिला और 3 पुरुष अनेक विधाओं में दक्ष कर्मचारी रखने का आवश्यकता है।
4. अस्पतालों में सभी महत्वपूर्ण पद तुरंत भरे जाने चाहिए, खासकर महिला चिकित्सक, महिला स्वास्थ्य कार्यकर्ता एवं इलाज के लिए डॉक्टर्स के पद।
5. जिला अस्पताल सहित सभी प्राथमिक एवं सामुदायिक स्वास्थ्य केन्द्रों में सभी आवश्यक दवाऐं उपलब्ध होनी चाहिए।
6. सभी सरकारी अस्पतालों में नियमानुसार पलंग एवं बिस्तर उपलब्ध होने चाहिए। साथ ही साथ अस्पतालों में प्रसव कक्ष एवं अन्य प्रसव संबंधी अनिवार्य सुविधाओं की उपलब्धता होनी चाहिए।
7. अस्पतालों में पानी एवं बिजली की नियमित उपलब्धता सुनिश्चित की जानी चाहिए साथ ही साथ महिला एवं पुरुष प्रसाधन कक्षों एवं नहाने आदि की व्यवस्था होनी चाहिए। अस्पतालों में मल गंदे पानी एवं कचरे की निकासी की व्यवस्था पर प्राथमिकता के साथ ध्यान देने की आवश्यकता है।
8. सभी अस्पतालों में सभी प्रकार की जाँचों के लिए प्रयोगशाला की सुविधा दी जानी चाहिए। जिला अस्पताल में प्रयोगशाला, ओ.पी.डी. शुरु होने के समय से ही खुलनी चाहिए क्योंकि अभी लोगों को बाहर जा कर जाँच करवानी पड़ती है। सोनोग्राफी, एक्स-रे एवं कुछ जाँचोंकी सुविधा हर समय उपलब्ध होनी चाहिए।
9. सभी अस्पतालों में आकस्मिक समय पर तुरंत एम्बूलेंस की सुविधा 24 घण्टे ड्रायवर सहित उपलब्ध होनी चाहिए। साथ ही जो लोग गरीबी रेखा के नीचे जीवन यापन करते हैं उन्हें एम्बुलेंस सुविधा निःशुल्क देनी चाहिए।

10. मरीजों से रोगी कल्याण समिति द्वारा ली जने वाली राशि का उपयोग दवाईयों, डिस्पोजेबल सुइयों, पलंग आदि आवश्यक चीजों पर प्राथमिकता से खर्च करनी चाहिए।
11. आकस्मिक समय पर आवश्यक सुविधाओं जैसे कुत्ते, सांप, बिच्छू को काटने पर लगने वाली आवश्यक दवाइयों एवं इंजेक्शन हर अस्पताल में उपलब्ध होने चाहिए।
12. प्रत्येक स्वास्थ्य केन्द्र एवं जिला अस्पताल पर उपलब्ध सुविधाओं की सूची व लगने वाली राशि के विवरण सहित सूचनार्थ बोर्ड पर उपलब्ध होनी चाहिए।
13. जिले में स्वास्थ्य सुविधाओं की स्थिति पर निगरानी रखने हेतु एख जिला स्तरीय स्वास्थ्य समिति का गठन किया जाना चाहिए। जिसमें सदस्यों को सम्मिलित किया जाना चाहिए।
14. जिन प्रायमिक/सामुदायिक स्वास्थ्य केन्द्रों पर मूलभूत सुविधाओं का अभाव है उन्हें ध्यान में रखते हुए प्राथमिकता देकर स्वास्थ्य सुविधाओं की प्लानिंग की जानी चाहिए।

केस स्टडी 1 : क्या प्राथमिक स्वास्थ्य केन्द्र उल्टी–दस्त जैसी सादी बीमारी का भी इलाज करने में असमर्थ है ?

बड़वानी जिले के 'झ' गाँव में 'न' अपने परिवार के साथ रहता है। पिछले दिनों उसके परिवार के साथ जो घटना घटी उसने म.प्र. के गाँवों में खासकर आदिवासी क्षेत्रों में प्राथमिक स्वास्थ्य केन्द्र, सरकारी अस्पतालों और स्वास्थ्य के नाम पर चल रही योजनाओं की कलाई खोल दी है। 'न' के परिवार में 6 सदस्य थे जिसमें 'क' उनके तीन बच्चों में सबसे छोटा (3 साल) बच्चा था। पिछले महीने 23 जून 2003 तक वह बिल्कुल स्वस्थ था। पर अचानक उसी रात पहले उसे 2–3 बार उल्टी–दस्त लगे और सुबह फिर से उल्टी–दस्त लगे। पुरुष स्वास्थ्य कार्यकर्ता (एम.पी.डब्ल्यू.) द्वारा बच्चे को ORS पावडर दिया गया पर आराम न लगने पर उसे 'घ' प्राथमिक स्वास्थ्य केन्द्र ले जाने के लिए कहा गया। यहां सरकारी अस्पताल में डॉ. 'ड' ने उसे देखा और उनके आदेश पर सीधे ही सलाईन चढ़ा दी गई। आधी सलाईन चढ़ाते समय ही बच्चे के नाक व मुँह से खून निकलने लगा इसलिये उसे सेंधवा ले जाने को कहा गया। रुपये ना होने व एम्बुलेंस की उपलब्ध ना होने की वजह से गरीब 'न' अपने बच्चे को ईंट से भरी गाड़ी से सायं 6.00 बजे सेंधवा सरकारी अस्पताल लेकर आया। जहाँ डॉ. 'स' ने उसे देखा। बहुत कोशिश करने के बाद बाद भी उसे सलाईन नहीं लगाई जा सकी। आनन–फानन में 'न' को बाहर से इंजेक्शन लाने पड़े, जिनकी कीमत 100/– रुपये थी। साथ ही उसे डिस्पोजल सिरिंज भी बाहर से लाने पड़े। उसके बाद भी स्थिति ज्यादा बिगड़ने के कारण उसे बड़वानी ले जाने को कहा गया। पैसों की कमी के कारण 'न' अपने बच्चे को बड़वानी ले जाने में असमर्थ था। तमाम कोशिशों के बाद भी 'न' अपने बच्चे को नहीं बचा सका और वापस घर ले जाने के समय रास्ते में ही रात 8.00 बजे उसका बच्चा शांत हो गया।

इस घटना ने हमारी स्वास्थ्य व्यवस्था पर अनेक सवालिया निशान लगा दिये है। ये सिर्फ एक दुःखद घटना नहीं है बल्कि स्वास्थ्य विभाग की अनदेखी का नतीजा है। 'झ' में उल्टी–दस्त की माहमारी फैलने के दौरान भी स्वास्थ्य विभाग के द्वारा सही समय पर ठोस कदम न उठाये जाने का परिणाम एक बच्चे की मौत के रुप में हमारे सामने आया है।

यह घटना इस बात को उजागर करती है कि एक तरफ सुविधाओं के अभाव में मरते हुए बच्चे को इलाज देने में असमर्थ प्राथमिक स्वास्थ्य केन्द्र एम्बुलेंस जैसी एक मूलभूत आवश्यक सुविधा का भी इंतजाम नहीं कर सकती है।

केस स्टडी 2 : एक और टारगेट पूरा हुआ !

'म' बाई पति 'र' एक 30 साल की महिला है जो कि गांव 'अ', जिला सेंधवा की निवासी है। इस महिला के 8 बच्चे हैं। पिछले साल सितम्बर 2003 में आँगनवाड़ी कार्यकर्ता 'स' ने 'ज' उपस्वास्थ्य केन्द्रों में होने वाले नसबंदी कैम्प की जानकारी देते हुए वहाँ जाने की सलाह दी। महिला अपने पति के साथ 18/9/03 को कैम्प में गयी। वहाँ डॉ. 'स' (प्रा. स्वा. केन्द्र, सेंधवा) द्वारा LTT कैम्प में उसका ऑपरेशन किया गया। ऑपरेशन के करीब 6 महीने बाद 4/5/2004 को 'म' बाई को लड़का हुआ। इससे साफ स्पष्ट होता है कि ऑपरेशन के वक्त 'म' गर्भवती थी। महिला एवं उसके पति के द्वारा जांच के वक्त ही गर्भ ठहरने का संदेह व्यक्त किया जा चुका था, क्योंकि उसे 2–3 महीने से महावारी नहीं आ रही थी। इसके बावजूद 'म' की गर्भवती होने की कोई जानकारी नहीं दी गई और उसे 8 बच्चों के बाद 9 वें बच्चे का बोझ न चाहते हुए भी उठाना पड़ रहा है।

इस गाँव में 'म' के अलावा अन्य महिलाओं को भी ऑपरेशन के बाद बच्चे हुऐ है। जहाँ एक ओर गाँव वालों का विश्वास LTT (दूरबीन पद्धति से किया जाने वाला नसबंदी ऑपरेशन) कैम्प से उठ चुका है, वहीं दूसरी ओर सरकार नसबंदी का टारगेट पूरा करने में लगी हुई है।

यह अध्ययन जन स्वास्थ्य समिति बड़वानी/सेंधवा तथा जन स्वास्थ्य अभियान म.प्र. द्वारा जन स्वास्थ्य सुविधाओं की स्थिति पर दस्तावेजीकरण हेतु किया गया है। यह अध्ययन जन स्वास्थ्य अभियान, म.प्र. की सहयोगी संस्थाओं के सहयोग से किया गया है। जिसमें CEHAT, इन्दौर आशाग्राम ट्रस्ट, बड़वानी, जागृत आदिवासी दलित संगठन, आदिवासी मुक्ति संगठन सम्मिलित हैं। अध्ययन में मुख्य सर्वेक्षक के रुप में संजय तिरके, MSW विद्यार्थियों में आनन्द वर्मा, मनीष दीक्षित, चेतन अत्रे, हिरदेश सिंह, पंकज अग्रवाल का सहयोग मिला। रिपोर्ट संकलन में मुख्य रुप से संजय तिरके, अमूल्या निधि, आशीष गुप्ता, काजल जैन तथा शैली साहा का सहयोग रहा।।

सेहत संस्था द्वारा प्रकाशित

जन स्वास्थ्य समिति, बड़वानी/सेंधवा