Whither Health Rights

A Study Conducted in the state of Chhattisgarh

to explore various strategies to establish

Right to Health Care as a Basic Human Right

As part of Ratan Tata Fellowship

Summary Report

Submitted to

Community Health Cell, Bangalore

by

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Chapter 1: Introduction

Background of the Study: 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.

The Government of India has been unable to fulfil it's commitment of ' Health for All by 2000 A.D.' till now. In fact, primary health care services are becoming more and more difficult to obtain for people living especially in urban slums, villages or remote tribal regions. The condition of government hospitals is worsening day by day. Nowadays, in most of the Government hospitals there is inadequate staff, the supply of medicines is insufficient and the infrastructure is also inadequate. There are very inadequate facilities for safe deliveries or abortions in Govt. hospitals. Given the fact that women do not even get adequate treatment for minor illnesses such as anaemia, services for problems such as the health effects of domestic violence remain almost completely unavailable. At the village level, there is no resident health care provider to treat illnesses or implement preventive measures. All hospitals are located in big cities, and here too public hospitals are increasingly starved of funds and facilities. Thus there is lack of availability of government health care services on one hand and the exorbitant cost of private health services on the other. This often leaves common people in rural areas with no other option but to resort to treatment from quack doctors who often practice irrationally. Thus most of the population is being deprived of the basic right to health care, which is essential for healthy living. The introduction of new economic policy and similar measures has further reduced government attention to such burning issues. Unfortunately, social attention and towards such a serious situation is considerably low.

Such a context needs larger efforts to mobilise the community, build up strategies to further deepen the attention towards public health issues and to redress the problems faced by the deprived and marginalised. There are enormous social advocacy modes in use for such complex situations but most of them are untested and many are too difficult to replicate. So it is the role of a social scientist to systematically look at the effectiveness of each of these measures and to vibrantly spreading the effective ones. The context of the present study is this.

In this situation, organisations that have emerged from struggles for identity and survival have begun to question this serious denial, and have started raising the issue of people's right to health and health care. Some of those organisations have been involved in developing people's health initiatives, while also demanding accountability of public

health services in a Rights-based framework. This is the context of campaign for right to health care, which is being considered as attaining the first step of right to health.

The Jan Swasthya Abhiyan (Peoples Health Campaign), the national level platform of health related networks and organisations, since its inception is working on the issue of Health rights and strengthening of public health systems and it has recently planned Public Hearings on denial of health care as a joint initiative with National Human Rights Commission. The Aim of this initiative was to find out the gaps in provision of health care facilities at various levels and to find out the causes for such gaps as well as to ensure all possible organisational efforts to fill them up. Right to health care here was envisaged as the first step to achieve the broader health rights. The identification of systemic gaps was through identifying and analysing individual cases of denial of health care services. The loss of life, physical damage or severe financial loss of the patient due to denial of health care services are being identified and as a strategy of advocacy and systemic redressal, they are presented to the National Human Rights Commission at a public hearing. These case studies would help to depict the real status of provision of the primary health services by the government, would strengthen the demand for improving public health services and would help in dialoguing with the public health system.

Objectives of the Study: Major objective of the study was to examine the possibilities of the strategy of documenting denial of health care and to develop the same as tools for people's advocacy for enhancing access of common people towards health care services. It also aimed, through various networking and support seeking strategies, to catalyse an effective networking of peoples movements/community based organisations towards such a goal.

Another objective was to have a close look at the effectiveness of various measures adopted/initiated by NGOs/CBOs and government towards better quality and outreach of health care services. In this context, Mitanin programme (a hamlet based community health worker programme) and the initiatives for quality enhancement of primary health care under health sector reforms process implemented in the state by Government of Chhattisgarh with massive civil society involvement, was to be covered as a central theme. If further support is available as part of the fellowship or from any other reliable sources, It was also proposed to publish the final document.

Strategy: The task of documenting the denial of health care/ health care services was done closely working with Jan Swasthya Abhiyan Network and its member organisations in the state. Efforts were made to collect all basic information and evidences for specific cases, so that those issues can be strongly raised when presented to NHRC. Tools and formats developed by JSA with state specific amendments were used and a report on status of health care services in the state also have prepared. One such public hearing (of western region held at Bhopal) was also attended as part of the study.

To initiate/organise such steps in Chhattisgarh, contacts with local groups/ NGO networks/concerned individuals were widely used and many of these organisations and individuals in due process have been incorporated to Jan Swasthya Abhiyan Network in

the state. Government functionaries/institutions were also contacted to gather various supporting data and evidences in various places.

Other than documenting the cases of denial, Focus was on seeing the effectiveness of Mitanin Programme and other ongoing health sector reforms processes in the state, towards facilitating better access to the health care services and improving the quality of them. This was done through observing the grassroots details of the ongoing processes in various localities and closely working with State Health Resource Centre, which is the Key agency implementing this initiative on behalf of the state. Focus was on how the programme works in the remotest areas of the state, particularly in some tribal & border areas. Which of the services has marked measurable improvement as result of such initiatives and which has not, whom it benefited and whom it not and why so- these issues were also looked at.

A Brief Note on the Health profile of the State and the Health Services Situation :The state was part of Madhya Preadesh, and declared as a separate state on 1st November 2001. It is having 16 Revenue districts, 146 blocks and around 10000 gram panchayats. The state is rich with natural resources and thick forests, and 34% of the state population is of tribes- presence of some primitive tribal culture makes state anthropologically important. So far health is concerned, the status of the state is not satisfactory in many aspects, though in some of them the state is above the national average.

Some Basic 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
**Rise in Female Literacy Rate since 1991 (% points)	24.88			15
**Decadal decline in the number of illiterates (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 Facilities and Gaps:

***Sub-Centers**:* There are 3818 subcentres currently functioning in the state, and 875 more has been sanctioned recently. Out of these, 1458 have its own building.
***PHCs**:* there are 512 primary health centres in the state where the actual need as per the norms is 720. PHCs with own building & adequate space are 327.
CHCs: Total CHCs sanctioned is 116 where there should be 180 as per norms and at least 130 should be there to meet the minimum requirements. Only 34 out of the current 116 have adequate infrastructure..
District hospitals and Medical Colleges: Though all the 16 districts have a sanctioned district hospital, only 6 have adequate infrastructure. Two medical colleges run by the government.
Other than above, facilities provided by Bhilai Steel Plants, mines hospitals, missionary run hospitals/rural health care centres, NGO/Trade Union run hospitals are there in the state, to provide necessary health care to the community.

Measures by the State Government to Close These Gaps: The State Government at its level is doing a lot of things in this direction, as part of health sector reforms. The major effort at community level is Mitanin programme, which has been envisaged as a community health worker programme with a difference- a partnership programme of state and civil society. It is covering all 54000 hamlets of the state. This massive programme aimed to deploy a trained woman health volunteer each in all 54000 hamlets of the state, after 18 days of camp based training and 30 days of on the job training over 18 months. There is a planned set of preventive, promotive and curative tasks for each Mitanin. Objectives of the programme are to increase in health awareness, to improve health services utilisation, to base disease control eforts at the community level, to improve outreach of first contact care through training Mitanins on this, to enhance organisation and empowerment of women and to improve involvement and capability of panchayats in health.

So far the other ongoing approaches on strengthening public health systems are concerned**,** a block-by-block approach on enhancing quality of primary health care (EQUIP) -by closing gaps in terms of infrastructure, equipments, manpower, skills and Motivation- has been launched in 32 blocks. GRADED Essential Drug List (EDL) and Standard treatment guidelines (STG) and State drug formulary (SDF) are adopted by the state. Training of Doctors on the EDL, SDF and STGs and STG trainings for MPWs have been held. Mitanins training on first level curative care is underway. Reform in drug procurement and drug distributions systems is also initiated. Purchases have been limited to essential drug list and quality certification measures like GMP and post-purchase quality testing measures also has been adopted, though these are yet to become practice. To initiate, support and guide the reform process, a State Health Resource Centre (SHRC) has been formed after consultations and agreement with civil society groups.

All these measures are of course important and highly appreciable in the present day socio-political context of a state. But quite a lot of problems and burning issues are still there to be addressed- like comparatively low quality of health care services, the discrimination to poor, tribes and the marginalised etc.

A Brief Note on Jan Swasthya Abhiyan and other Peoples initiatives in Health: Without a statewide grassroots peoples movement which is keen on regular advocacy and action, it is difficult to address various important issues on peoples health. Political Interventions are also equally important, but the problems and irregularities are the rate limiting factors in that segment to initiate such steps. Hence the measures like JSA and other civil society initiatives has a lot of important roles to play on these situations. This role becomes further crucial so far the case of Chhattisgarh is seen.

The coverage of initiatives Peoples Health Assembly -2000, for both national and global, was wide enough in the state. But its follow up activities could not be sustained for various reasons including absence of a vibrant state group to lead such an initiative. Thus, the Jan Swasthya Abhiyan in the state is not functional though some efforts were made to sustain/revive the movement by some individuals/groups. Establishing individual level contacts to involve possible groups/individuals was hence the only way to revive the spirit of an initiative like JSA.

Though a number of NGOs/CBOs work in the state, only a few got focuses on grassroots issues related to public health and health care with a proper socio-political understanding. Activities of many are oriented around issues where availability of funds are high, rather than around issues which are important in terms of common man's life. Coverage of the positive groups also is limited to small localities, and their immediate priorities vary from place to place.

Chapter 2: A Brief Overview of the Activities

Launching the Study: The study was launched in April 2004. 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. 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 were held. So far, more than 10 organisations have significantly contributed to this process. To get an exposure to state run Mitanin Programme and other initiatives, I was closely working with State Health Resource Centre Chhattisgarh, the implementing agency for those initiatives, of Dr Sundararaman, my mentor, is the director.

Activities 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.

Within a very short period of 3-4 months, 36 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 other reasons that lead to such situations were also identified.

A number of Activities were planned at the state and zonal levels before the eastern region public hearing. Some of them could not be held before the eastern region public hearing held by NHRC and JSA on 11 October at Ranchi. But the participation of the state with a very good number of NGO activists, testimony givers and observers was an important achievement. Also, I personally got an opportunity to present some of my observations as part of the panel presentations. (Summary given in Annexure-2)

Groups Supported the study: ActionAid India (Koria Initiative-Manedragarh and Disability initiative-Raipur RO), Chhattisgarh Kisan Mazdoor Andolan (Sarguja), Chhattisgarh Vigyan Sabha(Kanker), Lok Shakti Samiti (Raigarh), Rupantar (Dhamtari), Sahyogi Mitra Mandal (Durg), Srijan Kendra (Janjgir), SROUT (Raipur and Korba), State Health Resource Centre (all over Chhattisgarh), and Vanvasi Chetna Ashram (Dantewada), have contributed to the initiative in terms of case collection and mobilising testimonials. Abhivyakti SRC (Raipur), Bharat Gyan Vigyan Samiti Chhattisgarh, (Raipur, Korba, Janjgir and Sarguja Dist Units) have also extended support. Many individuals also extended support to the study. Other than right to health care groups, there was an association with right to food campaign organisations as well.

Chapter 3: Learning and Observations

State and civil society joint initiatives: The initiatives in Chhattisgarh on state-civil society partnership are innovative. SHRC is a great example of what can be the achievement of civil society initiative if they can play their actual role of both cooperating and negotiating with the government at the same time. The understanding emerged under an MoU between ActionAid and Govt of Chhattisgarh, The State Advisory Committee comprising of all peoples movement representatives and govt officials to guide health sector reforms are examples for the same. Similarly, Mitanin Programme can be seen as a community health initiative with the same prospects.

Mitanin Programme: The cardinal principles that govern the Mitanin Programme are Woman as health volunteer and hamlet as the unit, six month long process of selection- by the community but guided by the trained facilitator, no honorarium (only token compensation for work day loss), sustained training and support over 18 months by a cadre of trainers, Curative care – supplementary –not central to the programme, State-Civil Society Partnership at all levels, Parallel improvements in Health facilities to provide referral back up to Mitanins have been listed as the seven cardinal principles for this programme. Wherever these principles are not met or ignored, the programme effectiveness has found weak.

As on today, the programme now has reached to more than 58000 Mitanins covering all the hamlets of the state. Of these, 30000 of them completed at least 5 rounds of training and the rest completed either 1st or 2nd round of training. Programme evaluation in 25 blocks is complete. According to the study, 88.97% of the Mitanins selected were literate, 91.96% of them were married. 31.50% cared for 41 to 60 households. 61.27% of Mitanin selection was at village level meetings. 72.33% of the surveyed Mitanins completed 11 to 15 days of training. 87.04% of the Mitanins gave a correct answer regarding treatment of Diarrhoea. 80.48 % of Mitanins gave an acceptable answer in treatment of fever, and 44.54% of them gave the correct dose and duration. 23.3% being able to relate all six messages on child nutrition correctly, but only 5.58% made a perfect score on six messages regarding neonate. 46.18% stated that the most important message was breastfeeding in the first hour. 31.54% of Mitanins knew that in Grade II Malnutrition child is very weak and needs urgent action. A total of 60.03% gave adequate answer for anaemia. 82.36% of the Mitanins reported making house visits for counselling in the previous week of survey. 82.44% of Mitanins surveyed maintained the village health register. 66.57% of Mitanins report that ANMs meet them regularly during visits. 72 % of Mitanins reported that there is a hamlet level committee in their hamlet. Involvement of Panchayat in their activities is 29.29%.

The study indicates a slow but steady improvement in critical health awareness right upto the hamlet levels. It shows a better impact at the community level - in generating a measurable community involvement in health programmes and health service delivery. The low involvement of Panchayats at this point cannot be taken as a final result as actual intervention towards this direction is yet to be initiated. But the critical issue in this regard would be that the department health care delivery system should be able to

reciprocate the community spirit generated through this effort and should be able to address at least the important community needs generated vis-à-vis health care.

The programme is having good support and enthusiasm at the field level, interventions and troubleshooting part from the top is regular, varying strategies have been adopted for varying situations and effective coordination established through this. As an outcome, Mitanins started to respond to various health issues and their local initiatives have slowly becoming visible. The strategies adopted for programme management also also new. Being a massive administrative task, some usual but costly gaps are also there- in training, in regular field support, various slowdowns in monitoring and reporting, etc. Funds flow problems due to negligence or corruption, intra-departmental issues and problems, transfers of critical officials and issues related political support/commitment are also some of the issues that affecting the programme. Another issue is of sustaining the programme in a long run maintaining the state ownership. Local Specific issues (tribal/remote areas) are also there. The challenge would be to sustain such innovations under all changing political and administrative circumstances. Need of parallel community level advocacy and action is the next and important development that is yet to take shape.

Right to Health/Right to Health Care: There is a need of constant alertness from the community side on health service delivery, which the local JSA partners can do. Some regular mechanisms for these initiatives need to be developed, which does not exist presently. There are Challenges of case collection like preference of individual issues to systemic issues while documenting the cases. The other weaker element is media advocacy. Legislative/executive level lobbying and judiacial interventions should also happen in parallel.

Right to Food Campaign: A joint action with JSA is seen helpful in light of Chhattisgarh experience. Importance should be given to community level action along with gaps identification and policy and implementation interventions with Supreme Court support.

Chhattisgarh NGO Scenario: There is a need of political education to NGO activists and policymakers. Jan Swasthya Abhiyan as a network can play a necessary role on this. Through initiatives like Mitanin also, it is possible to reorganise local groups with conceptually fit people.

Tribal Health Scenario: The Groups already working on the issue are some NGOs, largely attracted by flowing funds. Missionaries (both Christian and Hindu), are also working. Health, Education and Forest Depts functionaries are there largely as service providers. The major problems with them are that almost all working or leading these setups are outsiders to tribal existence. What they propose as development are almost not locally sustainable, though a large chunk of services of the missionaries are necessary and adopted by the locality. Above all these are the issues of communalisation. Health services outreach and the attitude of workers to the locale is also an area needs lot of change. Issues of food and nutrition for tribal area is also an area needs priority attention.

Annexure-1

:Chronology of Activities During the Study:

April-15 to May 15:

- Preparation of the tools for identifying the gaps in various service provider levels and formats for docunmenting the cases of denial in Hindi.
- Translation of Peoples Health Charter-India to Hindi.(would forward all these documents to you after consulting Dr Sundar- this will be done once he is back after his holidays.(by 22nd May)
- Meetings with 5 organisations who are part of the JSA Network. They are-
  - Actionaid, Koriya dist (Manendragarh block- Koriya Dist)
  - BGVS, Koriya Dist (Chirmiri/Ghadgaon Block)
  - BGVS, Korba dist (Podi Uprora Block)
  - Lokshakti, Raigarh dist (3 blocks in Raigarh)
  - ASMI, Rajnandgaon dist (Block Khairagarh)

Initial meetings with key activists held, objectives and strategies presented and the initiated some village level infocollection in Koriya. 2 Villages are personally visited. CHC & PHC visited. Had Interactions with select Mitanin Trainers and Mitanins.

16 to 22 May- Dist Korea, Block Manendragarh.
Associate NGO: Actionaid Korea Initiative
Contact persons: Sulakshana Nandi, Sameer Garg.
Location: Manendragarh is a bordering place to Madhyapradesh in the northwest end of Chhattisgarh, located some 400 KMs away from Raipur. This is a tribal area where Actionaid project covers 2 blocks namely Manedragarh and Janakpur.

Major Activities:

- Meeting with Mitanin Trainers
- Village level health volunteer meeting
- Field visit with Mitanin Trainer (to collect cases)
- Gram Panchayat Visits-Kelhari,Dugla,Manvari,Chainpur-(Block Manendragarh,Distt.Koriya)
- Visit to Community Health Centre, Manendragarh

Outcomes:

5 cases of denial were recorded during village visits. Material were handed over and orientation and training given to NGO activists, for further identification of cases. Finalised possible dates for the conduction of public hearing (august last week).

23 to 27 May : at Raipur
Major Activities:

- Report writing
- Meetings with mentor
  - Discussion and analysis of cases
  - Modifications on case presentation
- Reading Assignments: Executive Summary of Macro Economics and Health(WHO), Strengthening Public Health Systems(SHRC).

29-30 May : Visit to Charama, District Kanker

Location:

Kanker was previously part of Bastar District, a known and primitive tribal destination and tourist spot in southern Chhattisgarh. Kanker is around 160 kms away from Raipur.

This visit was with Dr Sundararaman, mentor, whose purpose was:

1. To analyse the functions and services at the CHC Charama.
2. To analyse the of health care so as to look at the feasibility of public private partnership on emergency obstetric care.
3. Meeting with Mitanins, Mitanin Trainers and ANMs.

Personal goal on this was to learn by observation and to assist mentor.

Major Activities:

- Visit to CHC, Charama.
- Visit to PHC, Sarna.
- Visit to Lakhanpuri Health Sub Centre
- Visit to Ayurvedic dispensary, Lakhanpuri.
- Village visits- Gedhali, Ratideeh, Markatola.

Major Learnings:

Got an internal account of personnel and facilities management in Public Health Systems. How to identify the strengths and gaps in public health facility were observed. Community linkages were analysed. Monitoring and troubleshooting as well as field training and support in Mitanin programme were looked at, in detail.

1 to 5 June- Meeting with NGOs

Meeting with the key persons held of the following organisations:

- Lokshakti, Raigarh. Contact Persons: Shyam Sundar, Rajesh Thripathi.
- Chhattisgarh Action Research Team (CART). Contact Person: Gautam Bandopadhyay
- Rupantar. Contact Person: Ilina Sen
- BGVS Chhattisgarh.Contact Person: Lalbabu & Kumar Girish

6 to 8 June- Activities with Lokshakti Field Team, Raigarh.

Location:

Raigarh is a district at east north Chhattisgarh, bordering to Orissa, which is located around 270 KMs from Raipur. Lokshakti is working in the district for over a decade on various social/development issues.

Major Activities:

- Meeting with Field Workers
- Orientation on information gathering and tools
- Field Visits for helping case identifications at Ravo Panchayat.

10 to 14 June : National Convention on Right to Food and Work, Bhopal

The national convention was held at Gandhibhavan, Bhopal, where around 500 people from all corners of the country attended. Three sessions of 4 parrellel workshops where held and 2 pleanary session. A number of decisions to take forward the campaign was taken. Rally was organised to mark the convention on 13th June. I have attended the parrellel sessions on PDS, rights of children and womens health rights. A seperate report of the convention has been made.

Other than attending the convention, a meeting was held with Gangabhai Pekra and team of Chhattisgarh Kisan Mazdoor Andolan on right to health care initiatives in Sarguja district.

15 June- Kharsia Block, Raigarh –Mitanin trainers meeting

Lokshakti is running the Mitanin Programme in this block as pilot programme. The meeting was meant to brief its field workers on right to health care and to train them on how to identify and intervene in denial of health care issues as well as how to document the cases if severe.

16 June- Meeting with Mentor

Major Activities:

- Briefing of Chhattisgarh Initiatives to Tejram Bharti who came to Chhattisgarh for an exposure visit.
- Sharing of Bhopal Convention Experience

19 to 21 June- Field Visit to Kharsia Block

- Gram panchayats Visited: Bade Jamapali, Kireetmal, Darri, Bilaspur, Mauhapali

22 to 24 June:

- Translation from English to Hindi of Draft Trainig Policy for Chhattisgarh, being prepared by SHRC. The job was entrusted by Mentor

24 to 26 June: Visit to Dist. Sarguja, Udaipur, Chhattisgarh.

Location:
Sarguja is the largermost district of Chhattisgarh with 19 blocks and vast tribal population. This falls in the northern end of the state, bordering to Jharkhand and Uttarpradesh. Udaipur is around 350 KMs away from Raipur.
Organisation: Chattisgarh Kisan Mazdoor Andolan, largely working on tribal issues.
Contact Person: Gangaram Pekra.

Major Activities:

- Briefing to activists on right to health care and on documenting denial of health care.
- Fixation of dates for further information gathering
- A Jan Sunvai was proposed in September 1st week and an NGO meeting in this regard would be held on 14th July 2004.

26 June to 4 July : Visit to Raebareilly, U.P.

Purpose of the visit was to orient the health workers under Multisectoral Approach to Health Project run in 3 blocks of Raebareli by BGVS-U.P. Information on campaign on right to health care, documenting denial of health care and NHRC Public hearings were shared, which would be part of their women self help group activities.

9 July to 11 July 2004: Garudole, Biharpur PHC, Manendragarh & Lalpur Gram Panchayat, Manendragarh.

Location :

Garurdole is 10 KMs away from Biharpur PHC with hamlets Charcha, Balshiv,Bijour with high tribal population. Biharpur PHC is 27 KMs far from Manendragarh. Lalpur is hardly 2 KMs away from block headquarters. Hamlet where the case reported was Basod, of scheduled caste population.

Activities:

Investigation of reported cases of denial: case discussion with the families of affected, collection of details from PRI authorities and Mitanin programme functionaries, discussion with medical officer PHC.

Outcome:

Identification of five cases of denial- of TB, dysentery and measles.

12 July to 13 July 2004: at Bilaspur

Activity:

Attended Mitanin programme field coordinator review meeting and reorientation on monitoring strategy and analysis of monitoring reports.

3rd week of July- at Raipur

Major Activities:

- Meeting with mentor
- Reporting of previous tasks
- Analysis of discussions on public health during last session of Chhattisgarh Legislative Assembly.
- Listing of forest villages for identifying cases of denial and for studying status of health care services - this would be finalised by the mentor.
- Understanding of EQUIP (Enhanced QUality In Primary health care) programme.
- Preparatory discussions and initiatives for JSA state meeting.

22 to 23rd July, at State Health Training Centre, Raipur:

Attended state level trainers workshop on coordination between Multipurpose Health Workers(MPWs), Anganwadi Workers(AWWs) and Female Community Health Volunteers(Mitanins). Participants of the workshop were nodal officers for all 16 districts and state level training coordinators. Major objective of the workshop was to derive a regular coordination mechanism between these grassroots level health functionaries and to develop a training curriculum and package for MPWs. Establishing an effective linkage of Mitanins towards ensuring provision of health services, regular/effective nutrition counselling at family level, first level contact care and assured visits to houses immediately after vital events was also discussed at length. Training Material for various levels of training and MPW to Mitanin trainings were finalised.

24th and 25th July 2004: at Raigarh

Activities:

To review the progress in case identification process going on at Kharsia and Pussaur blocks taken up by Lokshakti activists, and to assist in the midterm review of Mitanin Programme conducted in Tamnar and Raigarh blocks run by BGVS.

Learning:

How to motivate the field level activists and how to identify and troubleshoot various gaps in the programme- in training, monitoring, reporting and documentation, day to day programme management etc. The role of effective leadership in successfully implementing the programme was also discussed in detail.

28 to 29th July: NHRC public hearing on right to health care for western region - at regional science centre, Bhopal.

States participated:

Maharashtra, Goa, Gujarat, Rajasthan and Madhya Pradesh.

Panelists:

Justice Y Bhaskar Rao, Dr NH Antia, YSR Murthy, Dr B ekbal.

Coordinated by:

Dr Abhay Shukla.

Prominent JSA Groups attended:

Locost, Anandi(Gujarat), Prayas, MKSS,PUCL(Rajasthan), CEHAT(Maharashtra), MPVS, BGVSMP, CEHAT(Madhya Prdesh) and observers from JSA U.P, Punjab, Chhattisgarh, Bihar, Orissa, Bengal, Karnataka and Delhi. Four fellows from CHC also attended. All higher authorities from state health departments and state human right commissions were present during the sessions, as directed by NHRC.

Outcomes:

40 testimonies and status of health care in all these states were presented to the panel in two parrellel sessions and all the concerned state health department officials responded to the presentation before the NHRC panelists made their observations. Joint enquiries by the departments and concerned JSA representatives are proposed by NHRC on the situations which led to the reported issues of denial of health care rights.

Observations:
Though the public hearing was fruitful in terms of unveiling various systemic issues that are leading to denial of health care to the needy and marginalised sections, some internal issues were visible like lack of adequate preparations at JSA state groups level for such an important event. Gaps in grassroots work in states other than Maharashtra and in a district of Madhya Pradesh were observable. Variety in types of cases were also lacking though a number of cases were identified and preparations were done by states. No state JSA groups other than Maharashtra could conduct preparatory public hearings/workshops at state/zone level. Media coverage also was an area needed more attention.

30th July: JSA national coordination committee meeting-Gandhi Bhavan, Bhopal

Attended JSA National coordination committee meeting as an observer. The meeting critically analysed the NHRC public hearing in depth and chalked out strategies for rest of the regional hearings. The meeting also discussed and finalised strategies on issues like legal and legislative action, interaction with the new government, appointment with Dr. Ramdas - Health Minister, initiate a process with new parliamentarians, WHO National Seminar - Policy Dialogue on operationalising the Right to Health, Pakistan National Health Assembly - India's Participation, Equador 2005 meeting - preparing issues from India, Official List of State level groups/organisations - to put on website and circulate for common knowledge, Review of the National Secretariat - for better coordination, JSA funding at the national level, JSA Publications - authorship and other issues, Petition on Pravin Togadia's medical council registration, etc.

1st August 2004: JSA state level meeting at Action Aid office, Raipur:

Agendas:

- State core committee for Right to Health Care
- Preparation for regional public hearings
- Civil society intervention in Mitanin programme
- Publication related to JSA
- Networking at district and block level

Outcomes:

- Formed a state working group on right to health.
- For campaign against denial of health care, the state would be divided into 4 zones-
    - Zone 1: districts Raipur, Mahasamund, Durg, Kawardha, Dhamtari and Rajnandgoan.

- Zone 2: districts Korba, Bilaspur, Janjgir, Raigarh,
- Zone 3: districts Bastar, Kanker, Dantewada,
- Zone 4: districts Koriya,Saguja and Jaspur

- Dates and responsibilities finalised for all 4 zonal meetings

6th August 2004: Raipur zone meeting at BGVS office, Raipur

- 22 people from 14 organizations attended the meeting
- 10 member zonal core group has been formed
- Next meeting on 11 september for the preparation of public hearing at Sankalp office, Raipur.
- Date of public hearing finalised 21st September

9-10 August 2004: Action Aid Consultation at Raipur on Right to Health as part of forming their country strategy on health.

- Was invitee to the workshop
- Dr Abhay Shukla(Right to health), Dr Sundararaman(Health Sector Reforms, Community health approaches), Dr Yogesh Jain(Jan Swasthya Sahayog Experience), Dr Ilina Sen (Patriarchy, Gender and health) Ms Christy(HIV-AIDS), Dr Babu Mathew(ActionAid and Health) did the major presentations.
- Theme and vision for the country strategy paper discussed.

11 August 2004: Korba zone meeting at Srout office, Korba:

- 3 NGOs participated in the meeting
- Next preparation meeting on 20th August
- Zonal public hearing date -18 september
- Janjgir district meeting on 24 august was fixed
- Raigarh district meeting on 25 august was fixed

12 August 2004: Sarguja zone meeting at IGNOU centre, Sarguja

- 35 peoples from 17 NGOs participated
- A 20 member core group formed
- Next meeting on 29 Aug at same place
- The proposed date of public hearing is 25thSeptember.

14thAugust 2004: Bastar zone meeting at Punjabi Bhavan, Jagdalpur

- 28 peoples participated - 4 NGOs and 20 individuals.
- Two distict level hearings were proposed,one in Dantewada on 28thsep and another in Bastar on 29thsep.

19-22nd August 2004: SHRC Field Coordinators Annual Orientation Camp, at Jagadalpur, Bastar:

- All 28 Field Coordinators of Mitanin Programme attended, where my role was of a panelist for presentations.
- The theme for the camp was "We, Our Organisation, and Our State", where all the field coordinators were to present on vision and strategies for year 2010 on various issue related to development of state, like:

- Vision on Child Health and related issues
- Vision on Womens Health and related issues
- Vision on Tribal Health, Tribal Life and issues related to Dalit-Marginalised sectors
- Vision on Socio-cultural-linguistical issues
- Vision on Organisation (SHRC)
- Vision on Individuals Working with Organisation

- Lectures and discussions also were there by SHRC Officials and guests. Major among them was:
  - Experience of organising tribal women on ethnic, forest, life and environmental issues- by Mr. Iqbal and Mrs Kalavati, Adivasi Harijan Kalyan Samiti, Bastar.
  - Health and Health Services in Chhattisgarh- by Dr Kamlesh Jain, Programme Coordinator, SHRC.
  - Why Poverty and Exploitation- By Dr Sundararaman, Director, SHRC.
  - Building up the future- by VR Raman, Programme Coordinator, SHRC.

<u>August 23-29: Preparation for Summing up Get-together at CHC, Bangalore</u>:

- Follow up with JSA groups on Case identification and documentation
- Preparation of reports, presentations.

<u>August 29- September 9 : Final Presentations at Fellows Get-together at CHC, Bangalore</u>:

- Reviewing the Group Learning:
  - Learning of Fellows on themselves
  - Feed back session on places/ teams visited
  - Views on obstacles, blocks and challenges to community health
- Presentations on Personal Reflections
  - On Society for Peoples Action for Develpment- SPAD- Experiences by Sunil
    - *Healthy Highway Programme for truck drivers on HIV/AIDS*
    - *Behaviour Change Communications for school children and general public: through infotainment and multimedia interventions.*
  - On JAVADIH (Fragrance) Hill Tribals by Amir
    - *Regarding the tendencies and changes in agriculture, gender, heritage, health care services and access to it, festivals and other cultural issues.*
  - On SANGAMITRA Interventions by Abraham
    - *On Various rural development intervention by the organisation at the outskirts on Medak District, AP.*
  - On MITRA- Medicine Institute for Tribe and Natural Advancement- Interventions by Amen

        - *On Various Health, Education Interventions of the group at Bissam Cuttuck, Orissa.*
    - On SANGAMITRA Interventions by Abraham
        - *On Various rural development intervention by the organisation at the outskirts on Medak District, AP.*
    - On Mitanin Programme by Shalini
        - *Reflections On the state owned community health programme covering the entire state of Chhattisgarh- Challenges of a massive approach and how they are addressed.*
    - On State Health Resource Centre, Chhattisgarh by Jyoti
        - *On the state-civil society institution set up at Chhattisgarh and its various initiatives on Health Sector Reforms.*
    - On Jowar Health assurance by Neeta
        - *Regarding the Health Insurance initiative run at SEWAGRAM.*
- Group Discussion on the significance of Right to Health Care Campaign
- Political Mapping of JSA Partners and Historical Overview of building up the Jan Swasthya Abhiyan India and Peoples Health Movements International- By Dr Ravi Narayan.

10 September to 13 September

- Contact various JSA member organisations on collection of denial of health care cases.

14 September

- JSA state coordination committee meeting to review case identification process and to finalise state level activities towards eastern region public hearing on denial of health care services by NHRC

15-30 September

- Follow up with various JSA member groups in Chhattisgarh for expediting the case identifications and submitting the case details.
- Documenting Chhattisgarh cases and preparing brief case reports.
- Coordination Support:
    - Contact JSA Groups in West Bengal, Bihar, Orissa and Jharkhand for expediting the sending of cases to be presented at the hearing.
    - Documentation of telephonic and postal grievances received from the public at SHRC, Raipur as a result of NHRC newspaper advertisement regarding the eastern region public hearing on denial of health care services.
    - Preparatory meeting for organising the Ranchi hearing- drafting of tendative schedule and finalising the checklist for organising group at Ranchi.

3 October

- Meeting of Chhattisgarh JSA coordinating Group: to screen and select the cases from Chhattisgarh to be presented as testimonials and finalise presentations from Chhattisgarh.

4-9 October

- Preparation of reports, presentations and documenting further cases identified by Chhattisgarh JSA groups.

- Coordination Support:
    - Contact JSA groups in other eastern region states.
    - Assistance in Documentation of cases sent by the public and by the JSA groups in other eastern region groups.

9 October

- Accompanied Chhattisgarh delegation to Ranchi for eastern region public hearing: 35 participants including 12 testimony givers, some of the local JSA member group representatives and observers.

10 October

- Attended a seminar on Heath Scenario in Jharkhand, organised by Jharkhand JSA as part of the Public Hearing.
- Final round of preparation for public hearing: briefing of procedures to the testimony givers, various event management activities.

11 October

- Eastern Region Public Hearing at Administrative Training Institute, Ranchi: Major Sessions and Deliberations:
    - Opening Remarks and welcome by Dr.T.Sundararaman, National Co-convenor, JSA.
    - Remarks by Shri P.S.S.Thomas, Secretary General, NHRC.
    - Inaugural Address by Justice Shri Y.Bhaskar Rao, Member, NHRC
    - Case Presentation : Health rights of the handicapped by Praveen G, Chhattisgarh JSA.
    - Case presentation : Health Rights of the Homeless by Baishali, West Bengal.
    - Hearing of Denial Issues in Parallel Sessions: After presentation of testimonies, responses from the health departments from each state was recorded and then responded the panelist.
        - Session 1: Hearing of Cases from Chhattisgarh & Jharkhand. (Chair: Justice Shri Y.Bhaskar Rao, NHRC. Panelist: Dr T Sundararaman- JSA. Attended by Health Secretary of Jharkhand and Dr Jaya Prakash, representative of Health Secretary, Chhattisgarh. From Chhattisgarh, 12 testimonies presented and 11 from Jharkhand presented.
        - Session 2: Hearing of cases from West Bengal, Orissa and Bihar. (Chair: Mr PSS Thomas Secretary General, NHRC. Co- Chair: Amitava Guha, JSA. Panelist: YSR Murthy, NHRC. Attended by Secretary Health, Bihar, Director General Health Services, Orissa and representative of Secretary Health, West Bengal).
    - During the Plenary, there were panel presentations on common recurrent denial issues and their systemic roots and ways to their redressal:
        - Medically underserved areas with focus on Tribal areas and their problems by Sulakshana, JSA Chhattisgarh.
        - Issues and Solutions related to corruption in provision of Health Care Services and by Shalini, JSA Chhattisgarh.
        - Other Issues like

- the huge gaps in access to emergency obstetric care and safe abortion services,
- The provisioning, prescription and regulations of drugs and supplies in both public and private facilities and costs, quality
- Regulation in private sector

by Dr T Sundararaman.

- **Responses from the panel on testimonies and reccomendations.**

- Major Outcomes:
  - Major systemic issues leading to denial of health care raised and discussed in length at a suitable forum
  - State specific issues were highlighted
  - Departments were largely convinced and there was a positive spirit towards filling the gaps
- Drawbacks:
  - The entire schedule was so tight in terms of time as the NHRC Officials had to return at about 2.30 in the afternoon. This affected the presentations.
  - Preparation at some of the states was inadequate.
  - Local organisation of the event also had some gaps.

<u>13-15 October</u>

- Assisting finalisation of reports and proceedings of the Eastern Region Public Hearing.

Finalisation of Fellowship Report.

Annexure-2

EASTERN REGION PUBLIC HEARING ON RIGHT TO HEALTH: RANCHI, 11th OCTOBER 2004

1. Introduction

The Eastern Region Public hearing on the Right to Health Care was one step in a process to promote health rights being carried forward by the National Human Rights Commission (NHRC) and Jan Swasthya Abhiyan (JSA). The NHRC has been actively involved in promoting the issue of health rights by conducting workshops and issuing recommendations on key health issues such as Maternal Anaemia, HIV/AIDS, and Access to Health Care in the last few years. The Jan Swasthya Abhiyan, which is a national level coalition of networks, voluntary organizations and people's movements involved in health care delivery and health policy, has been active on issues related to health rights since it's formation during the People's Health Assembly process in the year 2000.

Establishing the Right to Health Care and ensuring access to quality health care for all is an important step towards realising the goal of "Health for All". With this perspective JSA had organised a National Consultation on the Right to Health Care in Mumbai on 6th September, the 25th Anniversary of the Alma Ata Declaration. Over 250 delegates from different organisations and rights based groups working on health issues from 16 states across the country attended this public consultation. Justice Anand, Chairperson of NHRC gave the inaugural address for the programme as the Chief Guest, and heard selected testimonies of various persons who had suffered serious 'denial of health care'. This event also constituted the launching point of 'Right to Health Care' campaign by Jan Swasthya Abhiyan. Subsequent to this, NHRC in collaboration with JSA has organised a series of Regional Public hearings to highlight the denial of health care, with a view to clearly establish and operationalisation the right to health care in the country. The Eastern Region Public Hearing at Ranchi was the fourth in this series.

The Eastern Region Public Hearing on the Right to Health care was scheduled at Ranchi on 11 October 2004 at Administrative Training Institute, Mayor Road, Ranchi-834008, and was hosted by Jharkhand Jan Swasthya Abhiyan. Cases of denial of health care from Bihar, Jharkhand, Orissa, West Bengal and Chhattisgarh will be presented in this public hearing.

During the long-day public hearing, selected cases and instances were presented before the panel by individuals and groups who have suffered denial of right to health care. Justice Y.Bhaskar Rao, member NHRC, Mr PSS Thomas, Secretary General NHRC, and Mr Y.S.R Murthy, Deputy secretary of NHRC, represented National Human Rights Commission. Jan Swasthya Abhiyan representatives were Dr. T.Sundararaman, Mr Amitava Guha, and office bearers and activists from JSA state groups. Top officials from respective state governments also attended and responded to the presentations.

Inauguration and concluding session were held as plenary where as actual public hearing was held in two parallel sessions. In the first parallel session, the testimonies and presentations from Chhattisgarh and Jharkhand states were presented to the panel comprising Justice Bhaskar Rao and Dr T Sundararaman. Another parallel session held with Dr PSS Thomas and Mr Amitava Guha as panellists, to hear the cases from West Bengal, Bihar and Orissa. Dr YSR Murthy also attended this session. Presentations on status of health care with respect to various social segments also were presented to the panel, during the inaugural and valedictory sessions.

The NHRC has proposed to take up certain serious instances of denial of health care and redress them under the procedure laid down in the protection of Human Right Act, 1993 for complaints of Human Rights Violation. Based on these hearings, the NHRC has also proposed to send detailed recommendations to Union and State Governments on systemic issues related to denial of health care.

2. PROCEEDINGS OF THE RANCHI PUBLIC HEARING

Session 1: Inaugural

The welcome address was given by Sister Prabha, Director of Catholic Health Association in Bihar and Jharkhand and president of the Jharkhand JSA. Then Dr. T. Sundararaman, National Joint convenor of the Jan Swasthya Abhiyan introudced the objectives of the public hearing , the background of the Jan Swasthya Abhiyan and how the NHRC and JSA had decided to organise these public hearings.

Inaugural address:
Speaking next in his inaugural address, Justice Shri Y. Bhaskar Rao, Member, NHRC,

delineated the legal basis of the right to health care . To quote: "In Art. 47 of the Directive Principles of State Policy the Constitution obligate the State to raise the level of nutrition and standards of people and improve public health. Article 39 (e) directs the State to frame policy towards securing health and standard of the workers and to see that men and women and children of tender age are not abused. Article 21 of the Constitution guarantees the life of persons. The essence of above articles is that right to health is one of the fundamental rights and obligates the State to cater to the health care of the needy."

Further Justice Bhaskar Rao described the basis of this right as emerging from a number of International covenants viz. The 1948 Universal Declaration of Human Rights, The International Covenant on Economic, Social and Cultural Rights , the 1978 Alma Ata "Health for All" Declaration, the Convention on elimination of all forms of discrimination against women and the Convention on the Rights of the Child (Art. 24 [1])

However he stated that despite this clear legal position the situation in the nation was one where to quote " Health service today remains inaccessible, unaffordable, inequitably distributed and inappropriate to the needs of women, children, tribal, poor, dalits and other vulnerable groups being the most affected. It needs to be emphasized that the poor health care is primarily not a technical hindrance but it is due to poverty and negligible systems, which leads to inadequate health care. Thus the majority are not able to enjoy the fundamental right to health." This is he said led to an "obligation on the part of the State to effectively deal with health care for providing all facilities and required infrastructure."

Justice Bhaskar then further evidenced this statement by quoting the situation on infant deaths, on maternal deaths, on access to safe deliveries, and on the high prevalence of malnutrition, maternal anaemia and low birth weights. Turning to health equity he mentioned that the differentials across socio economic class could be seen from the fact that IMR in the working class was 2.5 times the IMR in the top 20%, and the fact that though tribal constituted 8% of the population they accounted for 60% of malarial deaths. He explained that the right to health care has got various facets - Right to basic public health service, right to emergency medical care, right to essential drugs at affordable

price and within the reach, right to know redressal and accountability mechanisms for failures and lacunae in implementing the provisions of the Act, right to health care of HIV-AIDS patients and senior citizens.

Quoting from rulings of the Apex court, Bhaskar Rao stated that the following aspects had been established by apex court rulings:

- The government has a positive duty to provide the basic conditions necessary to lead a life that is more than mere animal existence, including a Right to Health, Right to Clean Environment, Right to Privacy.
- Whether the patient was innocent or a criminal, it was an obligation of those in charge of community health to preserve the life of the patient.
- There must be adequate medical facilities to give immediate primary treatment to stabilise the patient's condition.
- There must be upgradation of hospitals at the district level and sub-division level so that serious cases can be treated there and there must be facilities for accessing specialist treatment here.
- There must be a centralized communication system so that an emergency patient can be sent immediately to the hospital where bed is available, and where appropriate treatment is available.
- There must be proper arrangement for ambulance transport of a patient from the primary health center to the district hospital or sub-division hospital and from the district hospital or subdivision hospital to the State hospital. The ambulances, which are adequately provided with necessary equipment and medical personnel.
- There must be emergency preparedness in health centers and hospitals for larger volumes of ` patients needing emergency treatment during certain seasons, accidents, or mass casualty.

The sum of these rulings is that right to health is fundamental with an obligation on the State to cater to the needs of the health of the people. Art. 144 of the Constitution envisages that all authorities, civil and judicial, in the territory of India shall act in aid of the Supreme Court. Thus a mandatory duty is cast on all officials concerned with medical and health department of the State and Centre to act in aid of the Supreme Court, i.e. to make people realize and reap the right to health as a fundamental right.

The discussing the issue of bribery, graft and corruption in the public heath system he recommended that the "Directorate of Medical Service in each State has to create it's own vigilance department getting on deputation a police officer not below the rank of Superintendent of Police or Deputy Superintendent of Police with required assisting staff, so that they can visit hospitals in peak hours in civil dress and watch whether there is any demand of illegal gratification from the patients and take appropriate action against the persons who are collecting money from patients and their attendants, otherwise the right of health becomes a mockery."

Then in conclusion he outlined some important suggestions for strengthening the public health system:

1. Public Health facilities should guarantee a Health Centre within walkable distance with qualified doctors and infrastructure.
2. Facility to refer patients with serious ailments to specialized hospitals including transport (Ambulance/Vehicles) with minimum life-sustaining treatment facilities during transit.
3. Drugs availability at reasonable rate within reach of common man:
   a. Supply of quality drugs
   b. Ban of spurious drugs envisaging violation as grave crime entailing severe punishment.
   c. A Drug Price Control Policy where violators should be held accountable, including penal action.
4. Social responsibility of providing 10% of free service or service on nominal charges fixed by the State should be made mandatory for all Corporate Hospitals and Private Nursing Homes with regular accountability entrusted to a State body created to monitor the system.
5. A Vigilance Department with Medical Directorates to control corruption in the hospitals.
6. In each Government hospital, it should be written in regional language and languages spoken by the people of the State that no money should be paid to any employee of the hospital as the Government pays them salaries, which is public money. If anybody demands money, a complaint should be given immediately to the officer of the hospital and a copy of the same should be sent to the Vigilance Officers of Directorate of Health Services, on which action should be taken, so that people are aware that demanding money from patients and their attendants is illegal and that no money is required to be paid.
7. Visit of Mobile Hospitals with adequate infrastructure and doctors, at least twice a month, to a village to treat the ailing people where there is no hospital facility and refer serious patients to Health Centers or District hospitals.
8. To examine the children in all primary and middle schools regularly twice a year and send report to District Magistrates and/or Collectors, along with names and attestation of Head Master and Sarpanchs of the village.
9. The diet specialist doctors should prepare a list of food articles available in local area and prepare a chart showing the proportions of food articles to be taken by children, young boys and girls, pregnant women, old citizens and women from weaker sections, etc. for strengthening the nutrition of body and to end malnutrition. This exercise should be made every year and published in local language, put up on Notice Board of Panchayat offices, Schools and Hospitals of every village.
10. It should also publish that the parents should examine their children regarding their hearing problems, vision, speech, etc. immediately they notice any one symptom so that at young age itself the same could be treated.
11. The Gram Panchayats (full body) and recognized Non-Governmental Organisations at village, taluka, and district levels should send quarterly reports about the functioning of hospitals in their village stating presence or absence of doctors, the

period for which one is absent or no doctor is posted at all, including women doctors, nurses, other medical staff of hospital and availability of drugs to the District Medical Officer, Collector or Commissioner, Director of Medical Services of the State and one to the Health Secretary.

12. A Monitoring body should be formed with Chief Secretary as Chairperson, Health Secretary, Director of Medical Services and Secretary in-charge of Vigilance as Members to scrutinize the reports and suggest action to be taken immediately as time-bound programmes. The reports of Monitoring Committees should be placed before the Legislative Assembly every six months for consideration of elected representatives.

Speaking next in a short address, P S S Thomas, Secretary General of NHRC, greeted all those who had assembled and the efforts made for the public hearing and the importance of the occasion.

Session 2:
Presentations on Special Themes:

The next session also held as a plenary was two special themes - one on the health rights of the handicapped and the second on the health rights of vulnerable urban sections-homeless and rickshaw pullers.

Praveen who is heading a disability action programme with Actionaid Chhattisgarh made the presentation on health rights of the handicapped. The presentation was accompanied by a testimony by a handicapped woman from Raigarh who recounted how she had become disabled due to wrong treatment from an unqualified village quack, and how subsequently even getting s disabled certificate was a time consuming and costly process and the handicaps she had in getting care and help for rehabilitation.

Praveen's presentation highlighted the preventable causes of disability and the need to sensitise and train regular health sector staff on identification, assessment and primary health care of the disabled. He also suggested that certification should become available at the village and primary health care level and that each district should have one centre capable of managing most cases of disability management and rehabilitation. The need to involve panchayats was also highlighted.

Baishali from Action Aid, Kolkata made the presentation on vulnerable sections of the urban poor, accompanied with one testimony of a rickshaw puller and their difficulties in seeking health care.

Session 3:
Public Hearing – Parallel Session – 1 : Chhattisgarh and Jharkhand

Panelists : Justice Shri Y. Bhaskar Rao & Dr. T Sundararaman
Government representatives:
Mr. Sharma, Secretary, Health, Jharkhand and Dr. Jayprakash, Deputy Director, Health, Chhattisgarh.

Cases of Chhattisgarh presented:

The following cases were presented as testimonies by the affected individual/family member:

1. CH-33: Disability : Difficulty in getting a certificate and costs therein:Ms Sureta:
2. CH-10: Emergecny Obstetric Care: Excessive costs and problems in access :Lalu Ram Kunjam:
3. CH-5: Pregnancy care: Poor quality of care and antenatal services: Lalitha:
4. CH-37: Hunger deaths in Dantewada: Paravathi (comments: Binayak Sen).
5. CH-6 epidemic: Poor response to epidemic, poor quality of care and illegal fees in public health care facility: Amarsai:.
6. CH-17: Outbreak of diarrhoea. Somaru, pt. admitted and died. Poor quality of care, extortion of fees even after death of child:Amarnath:
7. CH-25: Unsafe abortion, fails and leads to birth of visually handicapped child: Hiradevi.
8. CH-16: Animal bite: denial of treatment due to inability to pay illegal fees in district hospital: Subran Singh
9. CH-9: tuberculosis: Poor quality of care in public facility, exorbitant fees in private facility leads to denial of care and death:Hirasai(pt.)
10. CH-14: Inadequate and expensive treatment and over-prescription.(a collection of 7 cases presented by a grassroot NGO activist Bhubaneswari.)
11. CH-1: Dogbite: high cost of care and non availability of drug in the district hospital.

Other than these oral presentations written submissions were made of 35 cases.

Responses from government officials:

Represented by Dr. Jayprakash, Deputy Director, Health, Chhattisgarh

Dr. Jayprakash expressed concern and grief at hearing the trauma the patients had to go through. He regretted the lapses and apologized for them. He said that all the cases of deriliction of duty or illegal charges would be investigated and where guilt was established they would be punished. The non-availability of TB drugs and anti-rabies vaccine will be investigated and the gaps would be corrected. . He especially mentioned that in the case of Shri Subran Singh, case of bear bite, all efforts will be given to him at the Medical College to get the necessary surgery done. Dr. Jayprakash mentioned that an additional 874 sub-centers have been sanctioned in Chhattisgarh and this should improve access in remote areas. He also described the other measures that the state is taking to improve services but accepted that the needs and gaps are large and it would take much more to close them.

Jharkhand

Cases presented:

1. **Jharkhand Case 1 : High cost of care in private facility and Failure to get sickness benefit in time. Binod Kumar Dutta;Topchanchi Dhandbad,-Jharkhand.**

2. JH 2. Non availability of care in PHC and exorbitant charge in private sector forcing patient into debt for treatment for malaria. Kamarina Jojo; Murud; Murhu , Ranchi.
3. JH- 11: Lack of drugs for kala-azar in distric hospital, and exorbitant costs in purchasing drugs pushing testifier to selling assets and getting indebted.Ajit Kumar Murmu, Godda. Kala-azar.
4. JH- 13: Same as case 11. Even at district hospital has to buy drugs from ouside at large costs for the treatment of kala- azar. Hopenmoy Soren, Godda
5. JH- 14: Dispensing of expired drugs in panchayat level Camp of Chitmiti in Tantanagar block of Jharkhand. The tablets are sealed and packed in the presence of public and in front of the village head (Punch). This packet was opened , its expiry status verified by the panellists and a signed note of this was made. Mr. Hirday Shankar Bikhava (Social Worker)
6. JH-15: 46 cases of diarrhoea, 2 in coma, 2 deaths in Saliburu village of Balandia panchayat in Jhinkpani blocks of Jharkhand. Nearest functional public health facility was Chaibasa district hospital – about 40 km away and had to go to costly pvt hospital. Presented by Sukhdeo Hembraham

7. JH-16: Name-Mr. Kinkar Singh Village- Sima. Case- Death of wife and Infant during Labour (Maternal Mortality and Infant Mortality) due to obviously very poor quality of care, surgery wihtout anesthesia(? episiotomy) and failure to respond to an emergecny situation and callousness in dealing with the deathsand post mortem situation.Presentation by Kinkar Singh residing in Sima Village,District-Sarikela-Khasawa.

8. JH- 17 –20 In addition a few more cases of Asbestosis were presented. The workers of an Asbestos company could not know or relate even after suffering from occupational health hazards that the problems are due to asbestos dust. Even now there is no preventive measure or compensation available.

Government Response:
Mr. Sharma, Secretary, Health, Jharkhand:
Mr. Sharma expressed regret at hearing the testimonies. He said that in all the cases corrective measures will be taken. He went on to give the following reasons for the state of health services amongst which he emphasised that a large number of CHCs, PHCs and Sub-centers which were supposed to have been built till date, have not been built. Also regarding Kala Azar, till July 2004, the only two factories which make the medicine were on strike and so medicines were not available

He stated that there were some discrepancies in the way some of the cases were presented and what the Government record shows. He requested the NGOs to investigate thoroughly. Mr. Sharma also felt that other than presenting failures of the Government, success stories should also be documented. He called it the 'Drain Inspector's vision' to see only the failures.

He talked about the remarkable success of a catch-up round of vaccination held this year when coverage increased from about 12% to over 60%.. He also talked of collaboration with NGOs and management institutes for training of health workers under the Jharkhand Health Society and the efforts being made to improve health infrastructure.

Session 4:
Public Hearing : Parallel Session: II Bihar, Orissa & West Bengal
Vichar Auditorium ,Coal Field India, Ranchi

Panellists:
Mr P S S Thomas, Secretary General, NHRC, New Delhi
Mr Amitava Guha, Jan Swasthya Abhiyan
Government Representatives:

Dr A K Choudhury, Commissioner cum Secretary, Health & Family Welfare, Govt.of Bihar
Dr P K Senapati, Director of Health Services, Government of Orissa
Dr P K Saha, Asst. Director, Directorate of Health Services, Government of West Bengal

Cases Presented From Bihar:

1. Bihar Case No. 1 – Fluorosis in Rajauli block of Nawada Dist. 43 persons suffering from handicaps and all children (more than 95%) are lame to varying degrees. Older age groups - 40 to 45 years old- also suffer from this disease. They suffer from bone pain and ultimately their backbone becomes abnormally curved. There are 8 handpumps and all are reported to be affected.
2. The same problem is found in Bhupnager village of Aamas block of Gaya Dist. Ongoing problem. Need for preventive measures and rehabiliation programmes and compensation needed for severe crippling. Presented by Dinesh & Dharmender.
3. Bihar Case No. 2 – Failure of sterilisation operation and high costs of next child delivery in private sector:Chinta Devi from Manpur block of Gaya Dist. (There are two similar cases of failed vasectomy in Ganjas in Gaya.)
4. Bihar Case No. 3 – Poor quality and outreach of antenatal Care in Jehanabad block of Jehanabad Dist: Sarita Kumari
5. Bihar Case No. 4. – Over ten deaths in 6 months in kinjer village of Karpi block of Arwal dt. from kala- azar and tuberculosis –Lack of care and public health response: Tinharhi Majhi.
6. Bihar Case No. 5 – High prevalence (over 27 cases) of Tuberculosis in one village of Manpur Block of Gaya Dist. Still no outreach of services for tuberculosis and perhaps an untouchability related deinal of basic public health services to this village: Barki Devi and Vinod.
7. Bihar Case No. 6 – Tuberculosis-Lack of affordable care: Illegal fees in public facility. Yogendra Paswan from Vikram block from Patna Dist.
8. Bihar Case No.9- Failure of sterilisation due to poor quality services: Village Tulsi Vigaha Post- Sohepur Bhaya- Buniyad Ganj Thana- Mufsil District-Gaya from Umesh Yadav: 18 cases of failure.

Government Response :
Mr A K Choudhury, Commissioner cum Secretary Health, in response to the presented cases, elaborated a vivid scenario of health care services and underlined the limitations of the machinery. He said Bihar has a population of 8,000 per Sub-centre, 2,08,000 per PHC and 8,20,000 per CHC. He committed that the health department will certainly address to the Fluorosis issue immediately.

Cases Presented from West Bengal:
Only ActionAid had responded to the NHRC notice. Though there had been many other submissions accepted in writing – they all pertained to general observations or third person accounts of denial.

Ms Sunny Sinha from Action Aid, presented a case study and drew the attention of the representatives to the limitation of healthcare services at tertiary level hospitals like Chittaranjan Hospital and Chittaranjan Institute for Cancer. She also stressed on a case of HIV/AIDS where confidentiality was completely lost.

Government response*:*
In response, Dr P K Saha, Asst. Director, Health revealed that Lok-Adalat is in practice in West Bengal and people can share about their grievances or any type of health denial directly in the health directorate. He also assured that he will draw the attention of the health department to the issues raised here.

Cases from Orissa:
Ms Usharani Behera of Orissa summarised a list of some 29 cases. She highlighted on failures of sterilization operation and related to negligence of medical team members and discrimination of women at all levels. Ms Jayanti Jena elaborated her plight after having the post sterilization third child. Mr Shantiranjan Behera of Martin Luther King Centre for Democracy & Human Rights in Bhubaneshwar reflected on the paper clippings of several local dailies and underlined the negligence and apathy of the government machinery in the field of health.

Government Response:
Dr P K Senapati, Director of Health Services, Government of Orissa, expressed his concern over the issues highlighted and assured thorough investigation of these cases. He also appreciated the intention and spirit behind having a public hearing and informed the participants about the recent initiatives undertaken by the health department of Orissa.

SESSION 5

Panel presentations and recommendations on common recurrent denial issues:

Presentation 1: Medically underserved areas with focus on tribal areas and their problems (Sulakshana Nandi, ActionAid Koriya Initiative, Chhatttisgarh)

Issues:

- Area is usually remote, hilly and forested, spread over large distances
- Doctors and ANM not willing to serve in such areas
- There is minimum health infrastructure
- The is also usually no private sector

Recommendations:

1. Recognition of an area by administration and local bodies as medically underserved where
   - There has been no Doctor for the last one year
   - There has been no paramedical staff for the last one year
2. Sanctioning of special packages to strengthen public health infrastructure
3. Alternative arrangements made in consultations with local bodies. Can choose amongst-
   - Special terms for Doctors willing to serve if such areas
   - Training and accrediting nurse/paramedical practitioners to provide basic medical services
   - Mobile hospital sent to such areas
   - Collaboration with NGOs who can provide health services
4. Transfer policy should be such that
   - Long serving Doctors and paramedics in remote areas who want to go to other areas, should be shifted out and fresh set of Doctors brought in
   - Any Doctor/paramedic transferred should be promptly replaced
5. Facilities for accommodation of Doctors and paramedics should be seen as a priority.
6. Each sub-centre should have two ANMs in tribal and hilly areas

Presentation 2: Private practice in public facilities and Denial of Health Care due to Corruption (Shalini, Jan Swasthya Abhiyan Chhattisgarh and Fellow, CHC Bangalore.)

Issues:

- Private practice by public facility doctors causes serious neglecting of the poor who are not able to pay illegal fees
- Other than this, corruption spread in all levels of the facility is further marginalising the needy

Recommendations:

1. A Proactive Vigilance Mechanism at all levels of state health department with assistance of and in coordination with the police department. This should not only responding to complaints, but should prevent illegal charges in public health facilities, and private practice inside public health facilities or in public hours.

2. All public health facilities should have display boards that state what are the legal user fees if any, declare that payments other than these are illegal and inform where to register a complaint in this regard.
3. Vigilance also needs to be exercised against unnecessary referrals to nursing homes, clinics and diagnostic services. To be effective on this, the state governments have to issue appropriate orders disallowing public health staff from such referrals.
4. Monitoring structures for health programmes:
    a. At the district and block levels with panchayat representatives/civil society partners active in advocacy work.
    b. For CHCs, civil hospitals and district hospitals by either strengthening existing patient welfare societies or creating them, including vigilance functions.
    c. An independent grievance redressal mechanism where those who have been denied quality care- in the private or public sector- can go to for registering their grievance and seeking relief.

Presentation 3: Better Regulation of Private Sector (by Dr Binayak Sen, PUCL)
In a set of brief comments Dr Binayak Sen asked for better regulation of the private sector and the implementation of a drug policy.

Presentation 4: The provisioning, prescription and regulation of drugs and supplies in both public and private facilities (by Editor, HT, Ranchi)

In his vast experience of studying health issues, he has seen that resolving local level issues make all the difference. Jharkhand government had made a rule that Doctors would be placed in their own villages. But this never materialized. The movement from sub-centre to the PHC and then to the CHC is not happening. This should be operationalised. At all the hospitals, availability of drugs should be displayed and it should be ensured that only generic drugs are given. He talked about how many people are dying of drug toxicity in kala azar. This needs to be looked into.

Presentation 5: Other suggestions from Jan Swasthya Abhiyan (By Dr T Sundararaman, JSA)
Dr Sundararaman then placed a summary of the recommendations for action required by the state and the centers to provide a systemic redressal of the instances of the denial of the right to health care that had been documented in the hearing . The National human rights commission would need to consider these recommendations and after seeking response from the states finalise these recommendations. **These recommendations, which constitute one of the main immediate outcomes of the public hearing, are elaborated as annexure 1.** These recommendations would be circulated to the five state governments to seek their response.

Concluding remarks by Mr. PSS Thomas, Secretary General, NHRC

Mr. Thomas explained the purpose of the NHRC and advised all to learn more about human rights and the work NHRC is doing. He then congratulated JSA and associated NGOs and the people who had come forward to talk about their denials. He said that the individual cases lent much value to the proceedings and their level of awareness regarding their rights was commendable.

Mr. Thomas insisted that even though much of the responsibility for proper working of the public health system lay with the government, the people also need to demand their rights. According to him it is very important to organize such Jan Sunwais at the local (PHC) level where villagers come together to talk of their denials in front of government officials. He admitted that there would be some bitterness, but it is an essential tool for demanding accountability at the local level. He expressed the need for a grievance redresssal system at the local level.

Mr. Thomas maintained that everything was due to a problem of governance. Raising awareness level of the people and giving them space to assert their rights can only redress this. He stressed that people need to 'assert the right to assert their rights'.

Vote of thanks
Gurjeet of JSA, Jharkhand, gave vote of thanks.

Reccommendations of Eastern Zone Public Hearing. (Submitted by the Jan Swasthya abhiyan)

The public hearing on the denial of right to health care that was held in Ranchi on the 11th of October, heard a number of cases of denial from the five states of Bihar, Jharakhand, Chhattisgarh, Orissa and West Bengal.

Of the over 70 cases presented orally and the about 150 cases submitted in writing there were a few recurrent themes.These included

a. High degrees of illegal fees and denial of treatment if these are not paid – in public health facilities.
b. Poor quality of service in many public health facilites.
c. Absence of any services in remote tribal areas.
d. Denial of right to safe drinking water.
e. Lack of food security and malnutrition related illness.
f. Expensive, irrational drug prescription along with lack of availability of essential drugs in public health facilites.
g. Lack of emergency obstetric care services and safe abortion services
h. Lack of emergecny services for a wide variety of emergencies – notably accidents, burns, snake bites.
i. Lack of referral transport system to access emergency services.
j. Poor access to sterilisation services and poor quality of sterilisation services.
k. Weak public health response to epidemics and sudden increase in infectious deaths in certain areas.

After listening to the testimonies the panel has decided to take cognizance of only a small part of them as individual human rights cases . Though the other individual cases are also heart-rending the panel thought it more useful to pursue the systemic causes behind these failures. For these systemic issues that underlie the denial of the right to health care the panel makes the following 15 recommendations, which are forwarded to the state governments for implementation.

1. A Vigilance Mechanism must be build up in each state health department with assistance and in coordination with the police department. This vigilance should be proactive and not only responding to complaints. Its focus should be to prevent illegal charges in public health facilities, and private practice inside public health facilities or in public hours.
2. All public health facilities should have display boards that state what are the legal user fees if any, declare that payments other than these are illegal and inform where to register a complaint in this regard.
3. Vigilance also needs to be exercised against unnecessary referrals to nursing homes, clinics, diagnostic services. To be effective on this the state governments have to issue orders disallowing public health staff from referring to nursing

homes, clinics or diagnostic services where they have a monetary advantage or commission.

4. Monitoring structures for health programmes should be established/strengthened at the district and block levels with the inclusion of panchayat representatives and civil society partners who are active in advocacy work.
5. Monitoring structures for CHCs, civil hospitals and district hospitals should be established by either strengthening existing patient welfare societies or creating them. These would also have vigilance functions.
6. Independent of the above two there should be a grievances redressal mechanism where those who have been denied quality care- in the private or public sector- can go to for registering their grievance and seeking relief.
7. All areas which have had no doctor for over an year and all those areas which have had no nurse/midwife over an year should be publicly notified as medically and paramedically underserved and a special package of measures must be undertaken to provide some temporary relief and access to care for these areas. (eg visiting doctor- private or public, mobile clinic, NGO, etc). This special package adopted my be made in consultation with all interested parties especially the elected panchayats.
8. States should have a transparent non-discriminatory transfer policy such that doctors and other paramedical staff serve by rotation in difficult areas. During such service in difficult areas a special package of measures including financial incentives to support such doctors should be adopted. These two steps are critical to address the problem of lack of doctors in difficult rural areas.
9. States should have a state drug policy and /or adopt a state drug action plan which ensures that the states formulate an essential drug list and all the drugs on this list are available at all public health facilites without interruption, and that the prescription and use of irrational,expensive drugs and the use of hazardous and banned drugs is curbed in both the private and public sector. This would also need to specify better drug information to both the patient and the prescribers.
10. The state should adopt a time bound action plan/road map by which the critical gaps in the provision of good quality emergecny obstetric services,sterilisation services, safe abortion services, and basic surgical emergency services(burns , accidents) can be provided in a network of referral centers such that there is at least one such center per every 100000 population. This action plan should be a detailed publicly stated commitment and should have an year by year milestone, so that even if the entire plan would take ten years to implement , the monitoring committees and the public would know whether each year that year's goals are being achieved.
11. The most immediate measure for closing specialist gaps in referral center would be transferring of surgeons and gynecologists and anesthetists so that this norm for the provision of emergency and referral level care is met in as many facilities as possible. In the absence of a transfer policy well qualified specialists languish in peripheral centers losing their skills while key facilites which needs their services go without them.

12. The governments may publicly notify what are the services it would be providing at the level of the habitation, at the level of subcneters,at the level of PHCs, CHCs and district hospitals along with quality indicators. This should be accompanied by similarly graded standard treatment protocols. This is essential for public knowledge and for monitoring .This will also help prevent unreasonable expectations from the public – for certain services may be available only at the district or block level and not at every PHC as may be expected. But this needs to be publicly notified.
13. The governments should set up a medical services regulatory authority- analagous to the telecom regulatory authority- which sanction what consitutes ethical practice and sets and monitors quality standards and prices of services – both in the public and even more important in the private sector.
14. A Public health and health services act that defines the rights of food security, safe drinking water, and other determinants of health and the citizens rights to enjoy them along with the rights to medical services that are accessible, safe, affordable needs to worked out. This act would make mandatory many of the recommendations laid down above and would make more justiciable the denial of health care arising from systemic failures as had been witnessed during the public hearing.
15. Implementation of the supreme court order regarding food security and the need to universalise ICDS programmes and mid day school meal programmes remains a priority that this panel also endorses.

(Recommendations regarding health rights of people with disabilites and urban homeless and marginalised sections are being addressed in a separate annexure)

Eastern Region Public Hearing On Right To Health Care, Ranchi
List of Participants

Testimony:

1. Smt. Bhuneshwari Sahu, Rupanter,Dhamtari(Chhattisgarh)
2. Smt. Heera Bai., Srijan Kendra, Janjgir-Champa (Chhattisgarh)
3. Smt. Lalita Bai, Adiwasi Adhikar Samiti Korai, (Chhattisgarh)
4. Smt. Sonkunwer, Adiwasi Adhikar Samiti Korai (Chhattisgarh)
5. Smt. Chhindkunwer, , Adiwasi Adhikar Samiti Korai (Chhattisgarh)
6. Ku. Sureta Nand, Action Aid India, Raigarh (Chhattisgarh)
7. Shri Pravin, Action Aid India Raipur (Chhattisgarh)
8. Ku. Gangi Markam Pragya Seva Sansthan, Dantewada (Chhattisgarh)
9. Shri Dharmendra Kumar, GVS, Nawada, (Bihar)
10. Bhrti Devi GVS,Gaya (Bihar)
11. Shanker Yadav GVS, Gaya (Bihar)
12. Tineri Manghi, GVS,Arwal (Bihar)
13. Mohan Prasad Yadav, Manav Adhikar Sanrakchan Samiti,Gaya (Bihar)
14. Sibodh Kumar, Manav Adhikar Sanrakchan Samiti,Gaya (Bihar)
15. Miss Usha Rani Behra, BGVS, BBSR (Orissa)
16. Jayanti Jena, BGVS, BBSR (Orissa).
17. Shanti Ranjan, Martin Luther King Centre For Democract & Human - Rights,Khurda,BBSR (Orissa)
18. Kinkar Singh, Grame Saroj Abhiyan, Kharsowan (Jharkhand)
19. Abdul Latif Anari, SLADS, Singh(Jharkhand)
20. Hirday Shanker W.Singhbhan (Chhattisgarh)
21. Binah Datta, BGVS, Dhaubad (Jharkhand)
22. Bina Koehhal,AAI, Ranchi (Jharkhand)

Delegates and Observers:

1. Ku. Meena Chelak, Rupantar, Dhamtari (Chhattisgarh)
2. Shri Bhagat Ram Gayakwad, Rupantar, Dhamtari (Chhattisgarh)
3. Shri Makhan Aarle, Rupantar, Dhamtari, Raipur (Chhattisgarh)
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5. Ku. Parwati Pragya Seva SanSthan, Bhailawada, Danetewada (Chhattisgarh)
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7. Subren Singh Kissan Majdur Andolan, Sarguja (Chhattisgarh)
8. Kamlesh Singh, Utkarsh Samiti Sarguja (Chhattisgarh)
9. Shyam Chandra, Srijan Kendra Janjgir (Chhattisgarh)
10. Kamlesh Thakhur, Vanvasi Chetna Asharam, Dantewada (Chhattisgarh)
11. Shri Laluram Kunjam, Vanvasi Chetna Asharam, Dantewada (Chhattisgarh)
12. Baldew Hota, Lokshakti, Raigarh (Chhattisgarh)
13. Ramprasad Lokshakti, Raigarh (Chhattisgarh
14. Budhram Lokshakti, Raigarh (Chhattisgarh)

15. Manoj Kumar Lokshakti, Raigarh (Chhattisgarh)
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25. Jayant Kumar Bag, SHRC, Raipur (Chhattisgarh)
26. Santosh Patel, SHRC, Raipur (Chhattisgarh)
27. Jeetendra Kumar, SHRC, Raipur (Chhattisgarh)
28. Makrand Purohit, SHRC, Raipur (Chhattisgarh)
29. Ku. Gangi, Dantewada (Chhattisgarh)
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31. Dr. Kamlesh Jain, JSA (Chhattisgarh)
32. Naresh Chandra Sharma, JSA/GVS, Jehanabad (Bihar)
33. Pushpa Kumari, GVS, Nawada (Bihar)
34. Sarita Kumari, GVS, Jehanabad (Bihar)
35. Daljeet Singh, GVS, Arwal (Chhattisgarh)
36. Binod kumar, GVS, Gaya (BIhar)
37. Dinesh Prasad, GVS, Nawada (Bihar)
38. Awadesh Kumar, GVS, Madhapara (Bihar)
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40. Sanjay kumar Singh, BGVS,Patna (Bihar)
41. RaJharkhandumar Kda, BGVS, Gaya (Bihar)
42. Rakesh Kumar, VSKS, Vaishali (Bihari)
43. Anita Chaudhari, Aparn Gramin Vikash Samiti, Patna (Bihar)
44. Anita Devi Aparn Gramin Vikash Samiti, Patna (Bihar)
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47. Vinod Jena, BGVS, BBSR (Orissa)
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49. Baishali Chattargee, Aid India, Kolkata (WEST BENGAL)
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51. Umesh Kumar, Pragati Gramin Vikash, Patna (Bihar)
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61. Lalbehari Nayak, SLADS, East Singhbhan (JHARKHAND)
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66. Awadhesh Kumar, Gram swasthay Ariyan, Latehar (JHARKHAND)
67. Sushil Kumar,SATHEE,Goda (JHARKHAND)
68. Ramakant, FXB,Ranchi (JHARKHAND)
69. Sister Saly Sob, Kuru Jharkhand (JHARKHAND)
70. Rudolf Toppo,AGVS,
71. Sister Annamma, HC, Lathehar (JHARKHAND)
72. Sister Rosi Mary, Gumla (JHARKHAND)
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83. Baleshwar Bara, Chabi,Mandair(JHARKHAND)
84. Prakash Chandra Beg,B.G.V.S,Koderma
85. Nirmala Dung,Chabi,Gumla(JHARKHAND)
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101. Sm. Sushma Kaja, Gooda (JHARKHAND)
102. Sr. Mzegga, Simdega (JHARKHAND)
103. Dr. P.K. Roy, Jharkhand (JHARKHAND)
104. J.K.Chaorha, Ranchi (JHARKHAND)
105. A.P. Sinha, Ranchi (JHARKHAND)
106. Shyam Sunder JOHAR(JHARKHAND)

107. Sarjan Doraiburu, JOHAR(JHARKHAND)
108. Buran Singh, JOHAR(JHARKHAND)
109. Saroj Doraibona, JOHAR(JHARKHAND)
110. Birendre Kumar Paswan BGVS Palamau(JHARKHAND)
111. Gita Sinha, BGVS Latahar (JHARKHAND)
112. Sr Clarna, Jharkhand (JHARKHAND)
113. Sr. Jacinta, Jharkhand (JHARKHAND)
114. Shyam Bihari Bhart AID Palamau(JHARKHAND)
115. Nagendra Nath AID Palamau (JHARKHAND)
116. Dr. P R. Bpd OSD Health Dep.(JHARKHAND)
117. P.P.Sharma , MPHFW
118. Jonis CHABIJ Ranchi (JHARKHAND)
119. Sanjeev Kumar Bhagat, Lok kalyan Seva Kendra,Pakur (JHARKHAND)
120. Ms. Tushara Shonker, KGVK Ranchi (JHARKHAND)
121. T. rahaa BVM Ranchi (JHARKHAND)
122. Kisan Sanbhav Ranchi (JHARKHAND)
123. Dr. P.K. Singh Ranchi (JHARKHAND)
124. Sr. Basanti Besrp, Zila Mahila Samiti Chaibasa (JHARKHAND)
125. Jtoti lakra, Maitri project (JHARKHAND)
126. Sharwani, JUDAV(JHARKHAND)
127. Cordula Kujue Abhiyan (JHARKHAND)
128. Sunil Minnj AKHRA (JHARKHAND)
129. Amulyanidhi, Indore (MP)
130. MD.Sanjar Alam Amliedker welfare Society, Ranchi (JHARKHAND)
131. Kalim Ansari, Amliedker welfare Society Ranchi (JHARKHAND)
132. Barsha Gori, Bhathia Malahi Shamti (JHARKHAND)
133. Pawra oroam Bhathia Malahi Shamti (JHARKHAND)
134. Chandramani Oranam Bhathia Malahi Shamti (JHARKHAND)
135. Rosalia Tirkey, ABHIYAN, Ranchi (JHARKHAND)
136. Binay Prasad, Lok Astha (PRESS) Ranchi (JHARKHAND)
137. Sr. Geanila saw, CCF Project Ranchi (JHARKHAND)
138. Ar. Lema CCF Project Ranchi (JHARKHAND)
139. Ravi Sagar, Drishti Ranchi (JHARKHAND)
140. Yogesh Kiralay, India TV. Ranchi (JHARKHAND)
141. Pandw Pradhan (JHARKHAND)
142. Dr. Kalyani K. Meena, Prerana Bharti Ranchi (JHARKHAND)
143. Dr. Sunita Gupta, AAI Ranchi (JHARKHAND)
144. Preeilla Lopes, ASK Bokaro (JHARKHAND)
145. ManoJharkhandalo, CHABI ranchi (JHARKHAND)

State Government Officials/Representatives:

1. Mr A K Choudhury, Commissioner cum Secretary, Health & Family Welfare, Govt.of Bihar
2. Mr Sharma, Secretary Health, Jharkhand.
3. Dr. P.K.Senapali, DHS, Dept of health, Govt. (Orissa)
4. Dr PK Saha, Asst Director, Health, West Bengal.
5. Dr Jayaprakash, Deputy Director, Health Services, Chhattiasgarh.
6. Md.Mozaffer, Govt. of Jharkhand, Ranchi (JHARKHAND)
7. Dr. Syed Iqbal Hussain Govt RCH Officer Ranchi (JHARKHAND)
8. Binay Mohan Prasad, Govt. Ranchi (JHARKHAND)
9. Dr. S.Panda, Govt. Ranchi (JHARKHAND)
10. Dr. S.K. Verma, Govt. PHC V. Hunti Ranchi (JHARKHAND)
11. S.N. Jha, Govt. Dy. Secretory Ranchi (JHARKHAND)
12. Dr. J.Uamar, Govt. Civil Surgen Godda, Ranchi (JHARKHAND)
13. Dr. S.S.Hanjan Govt.Distt. T.B. Officer Godda, Ranchi (JHARKHAND)
14. Dr. H. Hansdan, Govt I/CMO Godda, Ranchi, (JHARKHAND)
15. Dr. S.Yanmoo , Deprt Super. SH.Godda (JHARKHAND)
16. Dr. A.K. Singh, Health Dep. ACMO, Ranchi (JHARKHAND)
17. Dr. Neelam Chaudhary Health Dep. DS , Ranchi (JHARKHAND)
18. Dr. Raghandra Health Dep. DSP, Ranchi (JHARKHAND)
19. Dr. Om Prakash Shrivastawa, PHC Musha Ranchi (JHARKHAND)
20. Dr. D.B. Sargl Dep. Health East Singhbhan (JHARKHAND)
21. M.M.Prasad, Dept. of Health East Singhbhan (JHARKHAND)
22. Dr. Raj Mohan, Dept of Health, Ranchi (JHARKHAND)
23. Dr. N. D., TB officer (JHARKHAND)
24. Khushica Rahia, IEC Health Co-Ordinator Govt. Ranchi (JHARKHAND)
25. A.X.Kaushal, CHCRavagoda/Orissa (Orissa)
26. Dr. Rajan Patel, UNDP, BBSR (Orissa)

Annexure-3

CASES OF DENIAL OF HEALTH CARE

PRESENTED /SUBMITTED FROM PARTICIPANT STATES OF EASTERN ZONE.

Cases From Chhattisgarh(Most of them were identified or the identification was supported as part of the study)**:**

CH-1
Gendhibhai, Gedhali Village, Charama, District Kanker

Type of Case: Obstetric case with complications- Malaria leading to maternal death.

Description:
Gendhibai, from a village Gedhali of Kanker district was suffering from high fever with shivering. It was her fifth month of pregnancy. The Mitanin and local ANM helped get a blood smear examination done. This we found malarial positive. Recognising the seriousness of the case the ANM took personal initiative to rush the patient on her moped to the CHC Charama – over 20 km away. There she was attended to and given 500 ml i.v. fluid. But patient continued to worsen and was having convulsions. The doctor then referred her to the Mission hospital at Dhamtari stating to her husband, the attendant of the patient, that the CHC was not equipped to manage this case. The drips were stopped the patient was discharged . The attendants/relatives did not have money to arrange a vehicle to take the patient immediately to Dhamtari. They had to get her back to home. It took 3 days for her husband, to arrange the required amount of money and by the time they managed to hire a jeep and reached the village to take the patient to Dhamtari, she had passed away.

Denial and related issues:
Inadequate emergency obstetric care facilities. No referral system , Non-availability of ambulance/ referral service. Note: pressures to keep blame of maternal mortality away may also contribute to inappropriate referral.
Consequence: Loss of life

CH-2
Smt. Hiradevi, village Navapara, Block Dabhra, District Janjgir.

Type of Case: MTP failure and adverse effect (Congenital deformity) of drugs induced.

Description: Smt. Hiradevi, w/o Deenbandhum yadav of Village Navapara, Block Dabhra, District Janjgir, went to CHC Dabhra to terminate the undesired pregnancy of one month, as it was only 7 months after she gave birth to a boy child. She met the doctor there and the doctor gave her a 15-day course of oral pills and asked her to report after completing the course. She reported the doctor that these tablets had no effect, and then the doctor gave her two injections and told that the termination would occur within 15 days. No results were there and she met the doctor again at fourth month of

pregnancy, and the doctor advised to carry the child saying an abortion would be risky both because there are no proper facilities at CHC if some complications occur and the period was not safe.

At the time of delivery she was admitted in CHC Dabhra where she delivered a girl child under the supervision of the doctor there. After giving birth the parents found that the newborn baby had congenital deformity in the left eye. The doctor then referred the child to district hospital where the doctor examined the child and told the mother that it is the drugs induced during pregnancy period for MTP, which caused disability to the child.

Denial and Related Issues:

- Lack of proper attention and adequate precautions from doctor
- No clinical facility for MTP at the CHC
- Improper and illegal technique of inducing abortion used.

Consequence: Baby born disabled.

CH-3

Bilasabai, Chainpur Village, Koria.

Type of Case: Dysfunctional Uterine Bleeding (DUB/Gynae) needing specialist treatment

Description: Bilasabai 50 years of age of Chainpur village in Koria district. Due to heavy bleeding, she reported at a CHC on 08-11-03. Doctor advised her further investigation like sonography, x-ray and blood test and charged Rs.100 as consultancy fees. All those investigations were done in private pathology lab where she had to pay Rs. 500 for sonography, Rs.100 for x-ray and Rs.110 for blood test. Going through the reports, the doctor told her that she should undergo a uterus surgery but she should take supporting drugs for three months as a preparatory measure for operation, as she is severely anaemic. These medicines she had to buy from private medical shops. Then after she was admitted in the CHC on 31-1-04 for 12 days and was operated only after payment of Rs.15,000 to doctor who did the surgery. In addition, she had to pay Rs.500 to the nurse. Part of drugs was made available from the hospital but most of the medicines were purchased from private medical store. The expenses total was above 20,000. Finally, to manage the expenses, she was compelled to sell off the land she had. However, she is still suffering from some pain in abdomen but has not visited the CHC because she has pay Rs.100 as consultancy fees that she cannot afford.

Denial and related issues:

All investigations done outside the CHC, Medicines were not available, Treatment was appropriate but at prohibitive costs and that too charged in a public health facility. Eventually excluded from further medical service because of her inability to pay.

Consequences: Loss of productive assets of land, to meet the illegal costs of care.

CH-4.

Rani Patel, Jaimuda Village, Kharsia, Dist Raigarh.

Type of Case: Chronic Fever with severe weakness.
Description: Rani is a girl child of five and half years, daughter of Than Singh Patel, in Jaimuda village of Kharsia block in Raigarh district. She is very weak and suffering from chronic fever. Her mother took her to the government district hospital initially on 11th March 2004, and they continued treatment in the months of April and June 2004. Initially she was advised for an x-ray and prescribed some medicine by the doctor and on the same day after the x-rays done, she was taken to the same doctor, but at his private nursing home. Also to note that they had to get the x-ray done and to buy medicines at their own. The medicines were so costly that they have already spent more than Rs.5000 on it since March 2004 (prescription enclosed, which is self explanatory). In the meanwhile, they failed to arrange money to buy medicines and the patient had to discontinue medicine. Till now, the mother or others has not been informed about the disease that the child suffers.

Denial and related issues:
Irrational and wasteful prescriptions; High cost private profits from public health facility while failing to use public facilities (Xrays/drugs which are provided and available free of cost).

Consequence: loss of money, interrupted medication and continuing illness

CH-5
Lalita, Rokda village, Kachhod, Manendragarh Block, Koriya District, Chhattisgarh
Type of Case: Pregnancy care

Description: Lalita of Rokda village was four months pregnant in May 2004. She hadn't been registered either by the ANM and nor by the AWW. She hadn't been given TT injection or Iron Folic acid tablets. She hadn't undergone the requisite examinations (weight, urine, BP, abdominal). She started vomiting and had high fever for 3 days. Her husband went to the sub-centre on 7th May and requested the ANM to visit his wife as she was too ill to be moved. The ANM said that she will visit shortly. But she did not come and Lalita's situation became serious. On the 19th, the husband again went to the ANM and requested her to come. She refused to go with him and the husband went back home, not knowing what to do next. The family did not take her to PHC, Biharpur (15 km away) the PHC does not have provision for any admission nor any facility for treating illnesses during pregnancy. Meanwhile, on the 22nd of May, the ANM's husband came to their house and gave Lalita some injections and charged Rs.100. The ANM's husband did not even give any advice regarding referring her to the PHC/CHC. On the 26th of May, she had a miscarriage.

Nature of Denial

- No antenatal care provided by ANM including homevisits, TT, iron tablets, examinations
- Refusal of the ANM to make any home visits during emergency in pregnancy and linkage to private profiteering through informal care.
- Neither Sub center nor PHC provided any services for illness during pregnancy
- No referral service provided by sub-centre or PHC
- PHC does not provide services for illness during pregnancy

Consequence
Miscarriage
Physical and mental pain to the mother and the family

CH-6
Amarsai, Chharcha village, sector Biharpur, Manendragarh block, Koriya district
Type of Case : Epidemic Gastroenteritis

Description:
There was an outbreak of gastroenteritis in Chharcha village in May2004. Amarsai, his wife and daughter fell seriously ill. The PHC Doctor and peon visited his house and gave intravenous fluids along with some injections to all three. The Doctor demanded Rs.700 in return. Amarsai could give only Rs.200 and promised to give the rest later. Even after 5 days, when their condition deteriorated, they sent a message to the PHC Doctor on 20th May to come again and also informed him of other serious patients in the village. The doctor did not visit the village. Amarsai and his wife's condition became so serious that on the 22nd, at 4 am they had to be carried on two charpais by eight men, to PHC Biharpur, 8kms away, through densely forested and hilly tracts. As there was no Doctor present when they reached at 9 am, the peon gave IV fluids. The Doctor came at 12 'o' clock and told them to go to the CHC. But no transport was available and neither is there an ambulance in the PHC. So the patients were carried back to their village in the charpais.
The demand for money stopped with a complaint to the SDM .
In the same village, Ramsunder's son fell ill in May 2004. The PHC Doctor and the peon visited and gave IV fluids and injections and charged them Rs.250.

Nature of Denial
- PHC Doctor charging money for public functions
- Basic illness not treated at PHC level but referred.
- No ambulance/referral facilities in the PHC

Consequence
Financial loss
8 people's labour and time spent in carrying the patients on their shoulders to the PHC and back
Prolonged illness leading to physical and mental trauma and loss of livelihood

CH-7

Sunita, Chharcha village, sector Bhiharpur and CHC Manendragarh . District Koriya

Type of case: tuberculosis

Description:

Sunita of Chharcha village fell ill with high fever and cough in February 2004. This continued for more than a month. At that time she went to her mother's house and showed to a quack who gave her injections and tablets and charged her Rs.40. When her illness continued, she got injections and medicines from a MPW of another sub-centre who comes to her village for private practice. He charged her Rs.80. When even after that her fever and cough continued for two more months, her husband took her to the PHC in Biharpur. At Biharpur the Doctor gave her two injections and iron folic acid tablets and told her to come back every week for three more weeks. She had to pay up Rs.10 at the PHC. So, she went back to the PHC for three more weeks, having to pay up Rs.10 every time as fees. By this time she had become very weak and could hardly walk the distance of 8kms of hilly and forested tract to the PHC, but she did so in the belief that the PHC Doctor will cure her. She had stopped doing any economic activity through the whole season of *tendu* leaf and *mahua* collection. Even simple household tasks were impossible for her to perform and she spent most of her time in bed. Even after going to the PHC, her condition did not improve, as it was very obviously a case of TB which the PHC Doctor chose to ignore deliberately.

A social activist met her and immediately told her to go to the CHC to test for TB. Sunita, along with her husband and social activist went to CHC, Manendragarh, on the 30th of June, 2004. From here starts the next part of her harrowing ordeal.

At the CHC, she was told that she could have TB and that she had to get an X-Ray and blood and urine test done from private to confirm. There was no facility to test for TB in the CHC. They had to spend Rs.180 on the X-Ray and blood test. When they came back to the CHC Doctor, he told them to come to his house to show the results, but they would have to pay up Rs100 as fees. Sunita and her husband had already depleted the money they had brought so they told the Doctor that they will show to him only once he comes to the CHC in the second half. When the X-Ray results came, the Doctor confirmed that she had TB. He wrote the prescribed TB drugs and told them to buy them from the drug store. Sunita and her husband were baffled. They had no money and they had heard that TB drugs were available free of cost. They were informed that the TB drugs were not available at the CHC. They had no other choice but to go back home, without any treatment. The social activist intervened and suggested that Sunita could be admitted under the Ayushmati Yojna as she had a Antodaya card and TB drugs could be provided to her for a few days till the CHC starts the DOTS programme. The BMO agreed and Sunita was admitted for seven days and then given TB drugs from a private store, for a total of 25 days. The clerk took Rs 50 from them for admission under Ayushmati Yojna. Sunita was too weak to walk back to her village so she stayed in her mother's house which was near the road. After twenty days, when few doses were left, Sunita's husband went to the CHC to get rest of the TB drugs. He was told that they are still not available and that he would have to buy them. He came back disheartened as he realized that the dose Sunita had earlier taken was of no use as it got interrupted.

At the time this case was written, Sunita is back in her house, but she is too weak to even get out of her bed. They can't figure out what they have done wrong. Having a disease

like TB, for which the Government claims to have a programme for detection and treatment, inspite of going to the PHC and the CHC, she hasn't been provided with any respite and her condition is deteriorating everyday.

Nature of Denial

- No identification, let alone referral of TB patient at the PHC level
- Forced to pay up more than the requisite Rs 2 at the PHC
- No TB investigation at the CHC and the PHC levels
- Non-availability of TB medicines at the CHC and PHC levels
- Victim to private practice of Government servant
- Money had to be spent on services the Government claims to be free

Consequence

Continued physical and mental trauma of the patient and family
Major loss of livelihood
Inability to do even household work
Incomplete TB drug doses may have led to drug resistance
Financial loss

CH-8

Roopsai, Salwa, Manendragarh, District Koriya

Type of case : tuberculosis

Description:

Roopsai of Salwa village had fever and cough for a couple of months. He went to the CHC, Manendragarh in June 2003. The CHC Doctor told him that he might have TB and told him to get X-Ray done from private. Roopsai spent Rs150 and the results showed that he had TB. The Doctor then wrote him the TB drugs which he had to buy from a private drug store. Since the last one year, he has been taking the prescribed medicines, but irregularly, as per money availability. Till now he has had to spend about Rs.3500 and has incurred heavy debts. There has been no improvement in his condition and he has stopped buying the drugs.

Nature of Denial

- TB investigation not done at the CHC
- Non-availability of TB medicines at the CHC
- Money had to be spent on services and medicines the Government claims to be free
- Forced to take incomplete dosage due to financial crises

Consequence

Getting incomplete TB drug dose led to drug resistance
Heavy financial losses
Patient still suffering from TB
Continued physical and mental trauma of the patient
Major loss of livelihood due to continued illness

CH-9

Hirasai, Salwa, Manendragarh,Koriya district
Type of Case: Tuberculosis:

Hirasai of Salwa village was having fever and cough for a long time. He went to the CHC, Manendragarh and was told to get X-Ray done from private shop. Then he was diagnosed with TB and told to buy the drugs from the private store. He did so but when he did not get well, he went to a private hospital in Manendragarh. During the entire length of his illness, he had to spend more than Rs.10, 000. As a result, he had to sell all his livestock. Finally in July2003, he died.

Nature of Denial

- TB investigation not done at the CHC but linkage with private sector.
- Non-availability of TB medicines at the CHC
- Money had to be spent on services and medicines the Government claims to be free.
- High cost of private health care.

Consequence
Heavy financial losses
Death of the patient

CH-10
Smt. Prabha Kunjam, Vill Kodoli, Bijapur, Dantewada
Type of Case: Emergency Obstetric Care
Description: Prabha Kunjam, 28 years, a tribal from Bijapur, a remote block of Dantewada was pregnant and the local ANMs Tara Meshram and Smt Jyoti Pandey were giving ANC and assistance. There was a regular vaginal discharge, which was reported to BMO Bijapur who told that the discharge may affect normal delivery and it may need a caesarean session. From there, the case was referred to a private hospital in Jagdalpur on 13.09.2004 and a caesarean session was done at Manorama nursing home on 15.09.2004. As the baby was premature and of 2 Kg weight, service of a paediatrician (who actually is a medical officer at Maharani Hospital (District Hospital-Bastar, Jagdalpur). They had to pay a total of Rs 20170 (Operation 8700, accommodation 1600, treatment/service charges 1600, baby treatment charges/paediatrician charges 700, Medicine 5170, and transportation 2400) where most of these services were supposed to be given free of cost from district hospital. On the other hand, the heavy burden of costs charged by the private hospital is evident from the rates, where no proper receipt but a slip of paper on the handwriting of the doctor was given against these payments.

Denial and Related Issues:
Lack of emergency Obstetric care facilities at block CHC
Case referred to Private hospital where a full-fledged govt dist hospital was available
Lack of transportation assistance

Consequences:
Family in debt (Rs 25000 was taken under loan from local lender)

CH-11
Rambati, Village Masodi, Block Geedam, District Dantevada

Type of case: Abdomen and waist pain after tubectomy operation

Description: Rambati 40 years of age had a tubectomy operation operation 6 years before at PHC Geedam. After some month she had a problem of abdomen and waist pain. Till now she spent 3000 thousand rupees in treatment, but have no improvement.

CH-12
Purseti Kasyap, Village Chitalanka
Type of case: Leprosy

Description: Shri Purseti Kashyap 56 years of age, approached supervisor, Ashaniketan (leprosy home) for treatment and dressing on the wound. The doctor was not available and the supervisor attended him but refused to do anything. When asked for dressing of wound, he said to go to PHC Dantewada. As Purseti's position was not good to travel, he could not go to Dantewada and get treated. After 6 months, the Ashaniketan supervisor gave him some ointment. Many of the dependants in Ashaniketan are facing the similar sort of issue. So far Purseti is concerned, his health problems have deepened and the disability due to disease also has increased.

Denial and Related Issues:
Denial of medical care to marginalised sector- already leprosy affected and age old
No proper attendance or assistance
Non-availability of medicines
Lack of proper systems for redressal
A different sort of stigma

Consequences:
Further isolation of already isolated leprosy patients and deepened physical and mental crisis

Supplementary Case Study of Ashaniketan and Rehabilitation of Leprosy affected in Dantewada:
Ashaniketan is the leprosy home run by the government in District Dantewada. Management and facilities inside the leprosy home is visibly poor. Currently, there are only 2 inpatients in Ashaniketan. They have got no proper treatment facilities. There is a supervisor and a dresser posted- but the dresser does not do any assistance for patients. 17 patients recently declared fully cured, got discharged from Ashaniketan and sent to rehabilitation home, where 5 out of them (Kamalsingh, Konda, Samlu, Rajendra &

Purseti) are actually not cured but living with severe wounds. Current Situation of the Ashaniketan is as follows, as studied by Chetna Ashram, an NGO working in rural Dantewada:

- No doctors service attended at least for the last one year
- No Health checkups during the last 2 years
- No regular drugs/supplies available
- There is a dresser posted but he does not turn up regularly, thus the patients themselves has to assist their problem
- The centre is located some 1.5 KMs far from Dantewada, no proper transport facilities or road available
- Nobody is there to listen individual problems of the patients

So far the rehabilitation arrangements are concerned for the cured patients, the government has established a colony, but with poorest basic amenities. No responsibilities given to either government or voluntary organisations regarding taking care of these isolated lives.

CH-13
Arti Bekh and her son Pooren, village Barsoor, Gidham, Dantewara.

Type of Case: Comprehensive Obstetric Care and neonatal care

Description: Arti Bekh is 30 years old, was pregnent and going through regular ANCs. On 10th December 2001, she was taken to CHC Dantewada with labor pain and the doctor (Dr Mrs Tirkey) checked her up took delivery at the hospital. The child was silent, and thus given Oxygen. The doctor was in a hurry to go to Bhopal or somewhere, thus she was not giving proper attention to the mother and child. She referred the case of the child to Dr Daharia, a paediatrician in department, who diagnosed the case as cerebral palsy and referred the case to Apollo Nursing Home, Bacheli, for the CHC has no adequate facilities to take care of the child. The child then was taken to another private nursing home, Jagdalpur and then at Seven hills hospital, Vishakha Patnam, AP. About half a lakh rupees or more have been spent on the child's treatment but no impact yet.

Denial and Related Issues:

Improper facilities in CHC for neonatal care
Improper ANC
Inadequate diagnosis and assistance during pain and labor
The complication could have been timely identified if the ANC and diagnosis during pregnancy and labor was proper.

Consequences:
Mental stress of parents, child borne with problems, loss of money

CH-14:

This is a set of issues related to CHC functioning – as regards quality of care, cost of care in a public facility, and nexus between private practice and public facility and above all about high costs due to irrational prescription.

Cases of white discharge: Inadequate treatment /drugs at CHC leading to high cost private prescriptions: All cases Referring to CHC Magarlod.

1. Kavita Bai Age- 35 yearsVillage- Bhaismudi.
Case- White Discharge-(PID)
For these complaints she went to the CHC hospital but she got medicine for fever only at the hospital. For her main complaint she was prescribed drugs by the doctor she had has to purchase from outside, she is a poor patients, can not afford such type of medicine.

2. Dhan bai sahu Age 41 years Bhaismudi.
Case- Irregular bleeding (DUB)
For the same complaint she went to the CHC hospital where Dr. prescribed a medicine which was very costly for her that means one tablet cost 18/- rupees, she could not purchase that medicine.

3. Kewada bai-age 35 years Village- Bhaismudi.
Case- White Discharge (PID)
Whenever she went to the govt hospital she got a costly prescribed drugs, which has to be purchased from outside.

Cases Related to Public Doctor's Private Practice :

1. Savitri Rao (magarload) age- 26 years
Case – Complaints of body ache, Headache, Giddiness, some time fainted.
For the same complaints she had been gone to the CHC hospital magarload since one year, even approximately 20 times in a one year. She has always been prescribed medicine from out side . The cost of drugs made her drop out of treatment
2. Rajani Bai Soni age 30 years village Magarload.
Case-Dog bite.
Her son was bitten by dog, when she went to CHC hospital for the same complaint where he received TT injection and referred to other hospital, then she came to the Raipur along with her son, there was spent approximately 4000/- rupees for his treatment.

3. A case of pregnant lady of village Motimpur,where she went to the CHC hospital for ANC check up and routine blood examination but there was dr.was referred to Private lab, where she has to be spent 150/-rupees.

CH-15

Amar Sai, Tunga village, Gram panchayat Poudi, Laxmangarh, District Sarguja
Type of case- Hydrocoel operation

Description- Amar Sai, 18 years, went to district hospital on 27 July 04. Doctor examined him and asked to do blood and urine test and admitted the patient. After studying the report doctor advised the patient for hydrocoel operation. For this surgery, the doctor charged rupees 3775 and the patient had to spent further Rs 500 to buy medicines. The patient against managed to borrow the amount to meet the expenses. On the other hand, he is not feeling well even after the surgery.

Denial and Related Issues: Medicine was not available and charging of illegal money.

Consequence- Family in debt, and the patient is not cured till now.

CH-16
Shri Subran Singh, Manoharpur village,Udaipur, Dist. Sarguja

Type of case-Animal bite

Description-Shri Subran Singh, 45 years, belongs to tribal community of Manoharpur village, Udaipur block in district Sarguja. After an animal (bear) bite in his left hand, he hired a vehicle and went to district hospital, Sarguja on 06 June 04. The duty doctor admitted the patient and put stitches on the wound and dressed it and asked for an x-ray investigation. A fracture was identified and the doctor told him that it needs immediate admission and a necessary surgery. To do the surgery, the doctor demanded some illegal payment and told he would not do the surgery unless the money is paid. The poor man had no money, nor he had somebody to go and arrange the money. As told by the doctor, the nurse marked leave for 2 days on his prescription and told him that he can come back with the desired amount of money within 2 days. As he could not manage the money within two days, he went back to the hospital again and requested the doctor but he refused to take the case. Finally, He had no other way than mortgaging his land for Rs. 5000. After arranging this amount, he reported to the doctor again on 17 June 04 and 25 June 2004 respectively, but the doctor did not attend the patient both the times, nor he got any kind of treatment.

He had spent Rs. 100 for x-ray, Rs.110 for blood and urine test, Rs.1800 to buy medicines from private medical store and Rs. 1300 to hire the jeep. As he is the only earning member of his family, he had to look after the family as well. At this point of time, he has no money and he is unable to complete the treatment. He is still suffering and his left hand is developing a total handicap.

As the Doctor did not issue his admit card or medical certificate, he is also not able to get any proper compensation than Rs 500 from the department of forest.

Denial and Related Issues:

- Patient not treated at district hospital due to inability to pay illegal money
- Doctor demanded bribe
- Delay in treatment and lack of proper care
- Essential medicines were not available
- Doctor did not issue admit card or any other treatment records

Consequences- Disability od left hand of the only earning member of a family, financial loss and the patient was compelled to mortgage his land.

Ch-17
Somaru, Village Khandabari, Block Premnagar, District Sarguja.

Type of case: Outbreak of Diarrhoea

Description: In first week of July 2004, there was a disease outbreak in Khandabari, Premnagar, Sarguja, and the health department set up a special health camp to redress this. Somaru, 55 years was admitted in the health camp on 5 July 04. Where he got treatment till 12 hours but his condition had not improved. From there he was taken to CHC Surajpur. He was kept there for four days. Dr Sharma of the CHC treated him and their loose motion and vomiting could be controlled. The patients became severely weak, thus the doctor referred him to district hospital Sarguja, where he was kept for three days. No proper care was given to him at the district hospital. There was no money with him to buy medicines, and medicines were not provided from the hospital as well. After 3 days of treatment in the district hospital, fell dead. The dead body was kept in the mortuary.

The story continues. No assistance was provided by hospital to the relatives of Somaru to take the body home. They were also not aware about the facility at the hospital level for dead body transportation, thus the poor tribal family had to arrange a private vehicle at a cost of 3 goats and Rs.700.

Another 3 people were already into the mouth of death, in the above epidemic outbreak, before Somaru.

Denial and Related Issues:
- Lack of proper care at district hospital
- Essential medicines were not made available from the hospital and the patient was not able two buy medicines from outside.

Consequence:
Loss of life of the patient, and the Poor Pando tribal family had to pay Rs 700 three goat and to take the dead body home.

Ch-18
Roopsai, Village Khandabari, Block Premnagar, District Sarguja.

Type of case: Outbreak of Diarrhoea

Description: This case also pertains to the same epidemic outbreak mentioned in CH-13. Roopsai, 43 years was admitted in the health camp on 5 July 04. He got treatment over there but his condition had not improved. From there Roopsai was taken to PHC Premnagar and then to CHC Surajpur. The patient became severely weak, so he also was referred the district hospital.

In the district hospital, he did not get proper care, doctor gave him intravenous fluids once but did not turn back to see the situation of the patient again. Nurses were also not there to attend not only them, but also some other patients admitted there. Feeling that he would not get proper attention or treatment, he left the hospital.

Roopsai is still continuing ill and he has become very weak, and he is remaining on bed. He is the head and only earning member of the family, so his family is near to starvation. He had to pay about Rs.2000 in the district hospital. He spent another 700 rupees to buy the medicines. All these expenditures were met by mortgaging his two-acre of agricultural land for 2000 rupees and selling his goat.

Roopsai belongs to Pando primitive tribal group, who lives in hilly forest area of Sarguja. Mostly all the Pando community is illiterate, they are not aware about their rights and the facilities provided by the government. In the village, there is no hand pump in working condition to provide safe drinking water and people drink the water from the nala and dodi. The epidemic spread out due to infectious water too.

Denial and Related Issues:

- Lack of proper care at district hospital
- Essential medicines were not made available from the hospital
- Charged extra money in the hospital
- Not got proper care, doctor not attended him seriously

Consequence:
The family is struggling for food, The patient is still suffering and not able to do any job, and he had to mortgage his land.

CH-19
Smt. Jhengobai, Village Salka, Udaipur, District Sarguja

Type of case: Severe Weakness, undiagnosed and ineffective treatment.

Description: Smt. Jhengobai is of 30 years belongs to a primitive tribal community. As she was suffering from headache, chest pain and shivering, she went to PHC Lakhanpur in July and August 2004. Doctor (Dr Manoj) examined her and prescribed some medicines, and asked for blood examination. Doctor told her that she had no disease, and the pain and shivering is due to weakness. She purchased the prescribed medicines from private medical store, and completed the course of medicines but there was no improvement. After 8 days she went again to district hospital Sarguja, where the doctor

was not available. Then she went to doctor's residence, where the doctor examined her, prescribed medicines and took 50 rupees as consultation fees. All drugs were purchased from private medical shop, she completed the course but still there had no improvement. Total 210 rupees spent in drugs. She is not in a position to spend more money on treatment. What she feel is that the doctor did not examine or attended her case seriously.

Denial and related issues:
Drugs was not given from PHC and District hospital
Doctor not examined properly

Consequence: The health is deteriorate day by day

Ch-20
Km. Rajni Yadav,Bagbuda village,Tamnar block,District Raigarh

Type of case: Post-Fever severe weakness.

Description: Km. Rajni Yadav (12 years, D/o Dhansingh Yadav) was taken to PHC Gharghoda by her parents on 1st September 2004, for she was severely weak. She had fever before somw 3 months. Seeing the patient, the doctor referred her immediately to district hospital Raigarh but they could go there only after some days. She was admitted in the hospital for two days. Even after showing the BPL card and requesting the doctors, no medicines or facilities provided from the district hospital, hence her father took her to a private paediatrician in Raigarh. There, blood examination was done in a private pathology laboratory and they had to spend 100 rupees. All prescribed medicines were purchased from private medical stores. They had to spend 3000 rupees till date on this. The BPL family had to borrow money on 5% interest to meet various expenses. Even now, Rajni has not recovered completely and her treatment is on.

Denial and Related issues:
- Medicines were not given from the hospital.
- Investigation was not done in the hospital
- No proper advise given.

Consequences: Family in debt.

CH-21
Harimati Yadav, Village Gadgoan, Tamnar, District Raigarh

Type of case: Heavy bleeding during periods

Description: Harimati Yadav, 45 years got heavy bleeding during periods. In June 2003, she suddenly fell unconscious and her son took her immediately to district hospital Raigarh. She was admitted and kept in the hospital from 23-6-03 to 30-6-03. She is from a BPL family; total expenditure on treatment was rupees 5000.All drugs were purchased

from private medical shop and two bottles of blood also was to be arranged- which they did purchase. She borrowed money on 5% interest to meet the expenditure

Denial and related issues: Non-availability of essential drugs.

Consequence: Family in debt.

CH-22
Kunto Prasad Kuwar, Village Givri, Tamnar,District Raigarh

Type of case: Emergency care related to injury during road accident

Description: Kunto Prasad Kuwar 18 years, Budhram 25 years, Manoj 20 years of age of village Givri were carried to district hospital Raigarh by police after a truck accident with their cycles at 10:30 am on 30th August 2003. In the hospital, no one attended them till 9:30 pm. in the night- till the identification of patients and information from police on accomplishment of legal formalities and filing a case under IPC 279 and 337 against truck driver. Their relatives also could not be informed as the patients were unconscious till night. When Ramprasad, one of the patients' relative went to the hospital, all three were kept on the floor with bleeding bodies, without given either bed and other facilities, or proper care. They were admitted and the treatments were given after 12 hours, and were kept in the hospital for three days.

All the prescribed drugs were purchased from private medical shop outside the hospital.100 rupees were spent on x-ray. Total expenditure was 8500 rupees, which was arranged borrowing 5000 rupees on 5% interest and mortgaged mother's jewellary for 3500 rupees. Two of their cycles were damaged too, at the time of accident.

Denial and related issues:
Delay in treatment and no provision of emergency care, which is common with most of the cases where legal formalities are desired
No proper facilities provided or the facilities in the hospital improper
All drugs were to be purchased from outside.

Consequence: Family in debt
Ch-23
Namebai, Village Kusmul, Block Dabhra, District Janjgir
Type of case: Severe Burn Injury

Description: On (date) August 2004, Namebai, 30 years got severe burn during cooking and she was taken to CHC Dabhra, at about 3.30 PM. Dr Miri admitted her and gave first aids kept the patient till night. Then she told the husband that there are no facilities in the CHC for further treatment and referred the case to district hospital Raigarh. In the night,

he arranged a Marshal Taxi and took her to Dist hospital Raigarh. She got treatment over there for 3 days, but developed serious troubles on third day and dead.
All the medicines were purchased from out side and the family had to spent about Rs 13000 on this.

Denial and Related Issues:
No Proper facilities at CHC for emergency care
No referral facilities provided
Drugs purchased from outside
Life could have been saved if timely care was provided at CHC

Consequence: Loss of life, loss of money and loss of mother for 2 small children

CH-24
Surang(1.5 years), Vill Karoundi, Salka, Udaipur, District Sarguja

Type of Case: Suspect case of severe malnutrition and anaemia.
Description: on 6th August 2004, Surang was taken by his father Jaisingh to PHC Salka for severe weakness. There was no doctor but the compounder attended the case and told the problem is weakness due to anaemia. They went to PHC for further two times and met Dr Jain. He prescribed B-complex, Sickwill and Relaxol syrups, and given some injections. All the prescribed medicines were purchased from private medical shop. No improvement recorded after completion of the course and the family is unable to continue treatment due to lack of money. They already have spent about Rs 1000.

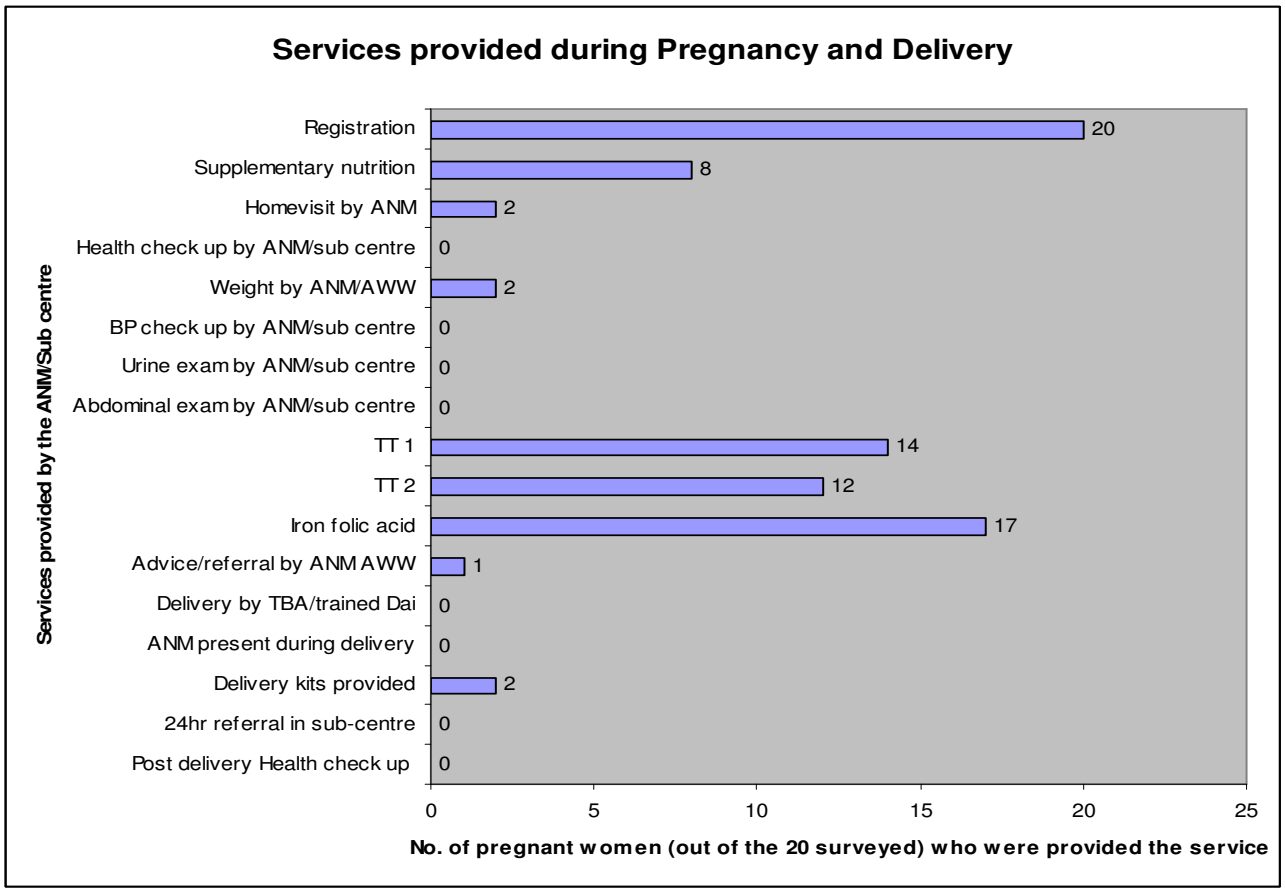
Denial and Related Issues:
Non availability of doctor for two times
Lack of proper diagnosis(no weighing of child done or any further diagnostic tests)
Suspect case of irrational prescription and improper treatment
No drugs were provided from public facility
Consequence: Treatment incomplete

CH-25
Gajendra, Bilaspur Village, Kharsia, District Raigarh.
Type of Case: Dog Bite seeking immediate relief.

Description:
Gajendra , four and half years old child , belongs to a BPL family of Bilaspur village of Kharsia block in Raigarh district. After a dog bite, he was taken to the district hospital, Raigarh, on 15 April 2004.
Doctor attended and advised him to buy anti rabies' injection from outside informing that the specific injection is not available in the hospital.
The patient had to buy the injection from a private medical store paying rupees 260 per injection for 6 injections. His father, Jaleshwar who is a small farmer and labourer had to borrow money from relatives for fulfilling this.

Denial and related issues: Anti rabies injection is supposed to be available at every PHC, was not available in the district hospital. The cost of care for this very common problem works out to Rs1560 on the injections alone- a sum that only borrowing can bring forth at such short notice. The essential drug list of Chhattisgarh mandates its availabiliy on every PHC.
Consequences: Family in debt

CH Background Note 1 : Linked to CH2 and CH5:
Topic: Services related to Pregnancy and Delivery
Survey of Outreach Services related to Pregnancy and Delivery in the sector Biharpur in Block- Manendragarh; District- Koriya; Chhattisgarh:
Place- Contiguous villages of Biharpur Panchayat (Nawadih, Sonhari, Nagwa, Hanspur and Padhewa) coming under PHC Biharpur
Total number of women surveyed – 20 (who had delivered from December 2003 to August 2004): Selection of women: visted above villages and asked for women who had recently given birth to children. 20 consecutive respondents recorded.
Total number of births- 22 (two pairs of twins included)
Total number of infant deaths within 4 days of birth - 10 (including two pairs of twins)
All 20 had been registered ,but none had visited sub-center and only two had a check up where weight was taken. 17 of them had got iron and folic acid drugs and 14 had got TT injections and only 8 had got supplementary nutrition. No one had their BP taken or blood examined or urine examined or had an abdominal examination as is mandatory for antenatal check up. Only two had received disposable delivery kits.



Nature of Denial

- Supplementary nutrition not available for a large number of pregnant women due to absence of ICDS centre in their village
- Requisite home visits not made by ANM/AWW
- ANM/ Sub centre and even PHC not equipped/not undertaking basic examinations like, measuring weight, checking BP, urine examination, Hb examination, hence not able to identify complications and treat/refer accordingly.
- ANM not trained to carry out abdominal examination, hence not able to recognize complications
- Proper health checkups and necessary referral/advice not given by the ANM. There were two women who had previous miscarriages, and one who had been treated recently for ulcers in the uterus, but they were not given any kind of advice.
- PHC and Sub centre not equipped to handle any kind of delivery
- No infrastructure available at the Sub-centre
- No 24 hr service referral in Sub-centre or PHC
- No provision for admissions in PHC
- All pregnancy related cases referred to CHC, without proper referral services like ambulance, leading to very high expenses. One family spent more than Rs.3000 on admission in the CHC for 15 days, even though the woman was covered under

the Ayushmati Yojna. The family was already in heavy debts, so was not able to admit her again during delivery. The woman died of complications one month later.

- Not a single delivery done by TBA/trained dai
- ANM not present during a single delivery
- No post natal check ups, even in case of child deaths and so the woman and future pregnancies continue to be at a risk.

Consequence
10 out of 22 children dead
Mental trauma for mother and family
Health risk of mother continues also leading to loss of livelihood.
Risk in future pregnancies

Backgound Note –2 : linked to cases CH-1,CH-8

Topic: PHC services and functionality.
Primary Health Centre, Biharpur
PHC, Biharpur is in a tribal area which is hilly and heavily forested. It covers a population of about 14,000. It epitomizes the denial of health rights of the tribals living in that area. The register shows that in a six month period (January to June 2004), the PHC has handled 540 patients. This means that there is a measly average of 3 patients per day. This is because of the Doctor's irregularity, absence of basic infrastructure and non supply of critical medicines.

As per the checklist for PHC and discussions with villagers, the following data was collected:
Availability of Staff

- There is only one Doctor and a peon in the PHC. The Doctor stays in the district headquarters, 59kms away and comes to the PHC only 3-4 days a week and most often after 12 pm. The peon stays in the PHC premises and handles most of the cases.
- There is no staff nurse or lab technician
- No other doctors, including woman doctor, ever visit the PHC

Availability of Infrastructure

- There is no water supply, no electricity connection and no toilet
- There has never been any admission ever in the PHC
- No kind of minor surgery like draining of abscess has ever been attempted in the PHC
- There is no microscope, BP machine or Hb meter
- There is no refrigerator which poses problem in ensuring potency of vaccination
- There is no ambulance

Availability of Medicines/OPD charges

- There is no Anti- snake venom or Anti- rabies vaccine available
- Any patient coming to the PHC has to pay up Rs.10 (instead of the government norm of Rupees 2 for an OPD patient and none for the patients having BPL status). Further the doctor does not give the receipt of *Rogi Kalyan Samiti* and this amount is never deposited in *Rogi Kalyan Samiti.*

Availability of Reproductive and Child health services

- Antenatal clinics have never been organized by the PHC- this is seen as sub-center function.
- There no facility for delivery at the PHC
- Any pregnant woman who goes to the PHC is referred to the CHC in the Block
- There is no facility for internal examination for gynecological conditions nor treatment
- Pregnant women don't go to the PHC as there are no services available for them
- There is no facility for measuring weight, checking BP, checking Hb, Urine examination or Abdominal examination
- There is no facility for measuring weight of babies at the PHC, or for giving them any treatment- at least this has never been done.

Availability of laboratory services

- There is no facility for Hb, Malaria, and TB testing or urine examination

CH-Background Note- 3; Linked to cases CH-7, 8,9.

Topic: Non availability of TB medicines in Koriya district and the linkage with private practice as major factor in costs and denial of care:

Description:

Survey of one village, Sonhari, shows that there are seven TB afflicted patients. In all the cases, visits had been made to the CHC, but all the investigations had to be done from private shops. Also, the TB medicines were prescribed to be bought from private drug store. In most cases, the patients gave up going to the CHC as they were not getting much of service there and instead went to private doctors/quacks. They had spent an average of Rs.4000 per patient. This has resulted in incurring heavy debts, and loss of land and livestock. Due to incomplete dosage and improper medicines, none of the patients have recovered.

Nature of Denial

- TB investigation not done at the CHC
- Non-availability of TB medicines at the CHC
- Money had to be spent on services and medicines the Government claims to be free
- Forced to take incomplete dosage due to financial crises

Consequence

Incomplete TB drug doses leading to drug resistance
Heavy financial losses
Patient still suffering from TB
Continued physical and mental trauma of the patient
Major loss of livelihood
1. Meena bai sahu (nawagarh-Khisora)

2. Ganga bai dhruve- (magarload): Operation done in Bhilai . Again sterilization has been done at govt. district hospital Dhamtari where she has to spend approximately 1000/- rupees for this even she has BPL card. Even in spite of she has a BPL card, she has not free medicine from hospital.

Cases of white discharge: Inadequate treatment /drugs at CHC leading to high cost private prescriptions: All cases Referring to CHC Magarlod>.

1. Kavita Bai Age- 35 yearsVillage- Bhaismudi.
Case- White Discharge-(PID)
For these complaints she went to the CHC hospital but she got medicine for fever only at the hospital. For her main complaint she was prescribed drugs by the doctor she had has to purchase from outside, she is a poor patients, can not afford such type of medicine.

2. Dhan bai sahu Age 41 years Bhaismudi.
Case- Irregular bleeding (DUB)
For the same complaint she went to the CHC hospital where Dr. prescribed a medicine which was very costly for her that means one tablet cost 18/- rupees, she could not purchase that medicine.

3. Kewada bai-age 35 years Village- Bhaismudi.
Case- White Discharge (PID)
Whenever she went to the govt hospital she got a costly prescribed drugs, which has to be purchased from outside.

Ch-26
Shanti Bareth , vill Patelpali, Dist- Raigarh

Type of case: Typhoid
Description: Shanti is a 16 year old girl, she was admitted to the district hospital on 6th August, 2004 till 13th August, 2004 for treatment of typhoid. The patient belongs to a BPL family, and after showing the BPL card, only one injection was provided free of cost by the hospital authorities. The rest of the medicines and injections had to be bought in her seven days stay in the hospital. Even the blood had to be bought and was charged for transfusion and investigation by the hospital. About 3000 Rs had to be spent for the medicines. In all the family had to spend Rs 10,000/- for the treatment. For this they had to borrow Rs 12,000/- at an interest rate of Rs 5 per month.

Denial: unavailability of medicines inspite of being BPL patient.
Consequences: family in debt

Ch-27
Leelambar Banjara, Village Karpipali, Kharsia, District Raigarh
Type of case: T.B.
Description: Leelambar Banjara 28 years of age went to a private doctor with the complaint of blood vomiting. The doctor examined and investigated his sputum, study the x-ray, told that it is TB. He spent 2000 rupees on treatment. One day when a social worker came to know of this, she advised him that TB drugs are available in government hospital free of cost. He went to CHC Chaple on may 2004, doctor told him after investigation that it is not TB, so he can't give TB medicines, if he would use these drugs, would die. There is no improvement, he had chest pain and sometimes blood vomiting.

Denial: No proper advice given
No drugs were given

Consequence: He is suffering with disease

Ch-28
Ganesi Yadav, village Dumarbhata, Kharsia, District Raigarh
Type of case: Delivery facility
Description: Ganesi Yadav visited CHC Kharsia for delivery. She delivered the child normally but no supplies were provided by the CHC.All medicines were purchased from private medical shop, even the blade to cut the cord, soap, dettol is also bought. She paid 400 rupees for delivery.
Denial: Charged money for delivery.
Essential things were not provided for delivery at CHC
Consequence: People do not have believe in institutional delivery.

CH-29
Late Meena Rathore
Date of Marriage- 2002

Socioeconomic status- BPL

Type of Case – Death after Delivery- Maternal Mortality with severe anemia.

Description- Mrs. Meena Rathore was died 12 hours after delivery on 18.06.04.She was a 10 month pregnant lady and had a good antenatal checkup She was regularly going to the checkup and she was diagnosed has having severe anemia and doctor advised to her for blood transfusion.In spite of this, she was hesitant and her family members also discouraged a blood transfusion.After some time she had been suffering from severe backache and she could not walk even for short distance.In such a condition her family members did a "Jhad phook" for this problem by a neighbor. After 7 days, a "normal delivery" was conducted by Dai and MPW and for this 1100/-was given to the MPW and

Dai. After two hours placenta did not come out. She was then referred to the hospital but due to the lack of availability of transport, ANM was called by MPW and placenta was removed with traction and she was asked to drink a cup of hot tea and eat two slices of bread. She has some relief but over all situation did not improve. After 3-4 hours general condition was deteriorating. After this transport was organised and she went to the hospital.When they reached the hospital, Meena expired.

The doctor in the hospital told them they had erred both by delay in coming to the hospital and by seeking treatment from an unqualified person and that the way the placental removal had been managed was criminally wrong.

Denial-- lack of proper referral system, Unqualified practice by MPW.

Consequence- Loss of Life.

CH Background Note: Denial of health rights of persons with disabilities :
(By Praveen Kumar with 5 cases of denial at the end)

Introduction.
Estimates of incidents of disability in India vary greatly depending on definitions used and the mode of survey. Although WHO estimates that 7 per cent of the population in developing countries like India is disabled, in Indian context the moderate and the severe disability which calls for rehabilitation effort is 3%, which would mean around 3 crore people. Even though the number is high this community is quite invisible. The invisibility is mainly because they are frequently hidden behind the walls of homes or institutions. As they struggle to achieve their potential of a fulfilled, dignified and useful life, most frequently they become victims of extreme social prejudice and ostracism.

In Chhattisgarh, the issues of the persons with disability are as ostracized as anywhere else. There is no proper estimate of number of disabled persons. A rapid one day state wide survey conducted by the Department of Social Welfare in June 2002 reveals that around 1.8 percent of the people are disabled, which would mean around 6.5 lakh persons that calls for rehabilitation effort. This number could be much higher considering the magnitude of invisibility of the persons with disability. The invisibility further deprives them of their basic rights, the right to lead a dignified life including right to education, right to livelihood, right to participate in political and social discourse, right to have access to basic facilities like health, right to be mobile, right to lead a life as normal as other citizens, right to childhood, play, and right to life.

The primary reason for the high incidence of disability is that health rights are denied to the majority of the population. The major causes of preventable disabilities are :

- Malnutrition.
- Lack of effective Immunization.
- In effective prenatal, neonatal and postnatal care.
- Unsafe delivery practices.
- Unsafe drinking water.
- Crowded living conditions.
- Poor sanitation.
- Exposure to chemicals and pesticides.
- Inadequate period of rest during advanced pregnancy and after delivery.
- Child marriage.
- Consanguinous marriage.
- Neglect of minor injuries and unhealthy conditions e.g. running nose, running ear.
- Unhealthy traditional practices.

The inebiquous disability act of 1995 prescribes that people with disability of more than 40% are entitled to the provisions of the act. This in itself if a gross violation of the human rights of disabled people who have, in the eyes of the act, less than 40% disability. This segment of the disabled population however are subjected to the same level of

discrimination by their family, community and civil society. To add to this malady, the professionals who are authorized to certify the degree of disability are non-existent in many district hospitals.
Access to health :

Disabled people, in the first place, do not know that they have rights. This is because their life experience is limited on account of exclusion. Disabled people are denied of basic health facilities as the PHC's are situated far off from the village (10-15 kilometers) and are unaccessible to them. Moreover in the PHC's there are no facilities to cater to the needs of disabled persons like therapy, occupational therapy, and for the severe disabled there is no hope as even for a CT scan or a surgery they have to go to the district hospitals. Further there is no preventive machinery for prevention of disabilities. Chapter IV of the persons with disabilities act 1995 clearly states : Every state government within the limits of their economic capacity and development, with a view to preventing the occurrence of disabilities, shall -

(a) Undertake or cause to be undertaken surveys, investigations and research concerning the cause of occurrence of disabilities;
(b) Promote various methods of preventing disabilities ;
(c) Screen all the children at least once in a year for the purpose of identifying "at-risk" cases ;
(d) Provide facilities for training to the staff at the primary health centers ;
(e) Sponsor or cause to be sponsor awareness campaigns and disseminate or cause to be disseminated information for general hygiene health and sanitation ;
(f) Take measures for pre-natal, prenatal and post-natal care of mother and child ;
(g) Educate the public through the pre-schools, primary health centers, village level workers and anganwadi workers ;
(h) Create awareness amongst the masses through television, radio and other mass media on the causes of disabilities and the preventive measures to be adopted.

Chapter XIII (Social security) of the persons with disabilities act (1995) provides for :

The appropriate Government and the local authorities shall within the limits of their economic capacity and development undertakes or causes to be undertaken rehabilitation of all persons with disabilities.

A study conducted with a sample size of 89 persons with disabilities in Bharamkela block of Raigarh district Chhattisgarh shows that only 9% have access to rehab aids and only 49% have even visited the hospital.

The health infrastructure :

The health infrastructure is so inadequate that even for a simple reason of certification one has to travel for more than 100 kilometers to visit the district medical board especially in places like Dantewada where there is no district hospital. Further no PHC's have the machinery to provide assistance in surgery. Personnel either in the primary health care structure or in the Integrated Child Development Scheme do not have even the basic knowledge of early identification of disability, leave alone assessment, early basic intervention. Even the doctor's are not aware of how much more damage an ordinary injection can do to a child with polio. They do not know the difference between for e.g. mental retardation and cerebral palsy. The front line health workers interface with this population is very minimal. Their knowledge of causes of disability is rudimentary. Even this knowledge is not passed on to this population. Causes and prevention of disability is not part of their job description. There is no synergy between the district rehabilitation centers and the public health system. After care and preventive measures are far from question. This is a total violation of the persons with disabilities act chapter IX which clearly provides for research and manpower development :

The appropriate Government and local authorities shall promote and sponsor researches, inter alia, in the following areas: -

(a) prevention of disability;
(b) rehabilitation including community based rehabilitation;
(c) development of assistive devices including their psycho-social aspects;

Though the government conducts disability camps they are limited to identification and distribution of aids and appliances. More over these camps are not accessible by all persons with disabilities and there is no frequent follow-up.

Attitude :

Much of the population is still shrouded in superstitious beliefs about causes of disability. People even now have strong faith in traditional methods of cure hence tend to visit the local traditional healer rather than visiting the doctor hence aggravating their disability in many cases. I.e. Identification of polio in the earlier and provision of appropriate treatment can reduce contractures. This is more so as they do not find immediate relief or cure in the hospitals. The health system considers a disabled person as one who needs welfare services and concentrates on provision of aids and appliance as an end to the problem of disability. Rehabilitation are mostly institutional where in the disabled is subjected to the four walls of the institutions this is more so in mental health problems where the mental ill or mental retarded person is subjected to institutionalization. Women with disabilities are not treated properly due to the belief that she is the housekeeper and not much importance is given for health needs even during pregnancy. The pre and postnatal care is very poor in rural areas as the auxiliary nurse midwife (ANM's) visits are very limited (supposedly to be once in a week but hardly visits the area). This apart from health care and treatment are of high cost as even for a check-up and delivery the

local doctors charge some where between 500-1000 rupees which is unaffordable by the family when they have a hand to mouth existence. Even the dai's improper or unsafe delivery also results in disability.

Poverty :
UN statistics shows that 20% of impairment is due to mal nurishment and further 20% of impairment is due to infectious diseases. Around 600 million world wide are disabled with 2/3rds of them in the poor countries. The process of vicious cycle of poverty is another cause of disability as even getting clean drinking water is a major problem. In rural India people have no access to safe drinking water one has to travel for 2 -5 kilometers to fetch water and boiling it is a problem as the family would have collected only few head load of wood (fuel) for cooking and the family cannot afford more wood for boiling water. Lack of nutritious intake of food also leads to disability mainly due to lack of vitamin A.

Recommendations :

1. Prevention of disability should be recognized as a fundamental human rights in the disability act of 1995.
2. Entitlement of rights of disabled people should be determined not on percentage but on their functional ability. The act should be amended appropriately.
3. The ICDS and the PHC staff should be trained on early identification, assessment and intervention of disability.
4. All health staff to be sensitized on disability aspects.
5. It should be part of their job description to provide the services listed in item (2) above.
6. To promote CBR (community based rehabilitation) and discourage institutionalization.
7. Appropriate amendments to be made in the public health structure to ensure certification of persons with disabilities at the village or PHC level.
8. Emphasis should be on access to safe drinking water, improved sanitation, and improved nutrition, better MCH including immunization.
9. Basic rehabilitation facilities in services should be in place in all district hospitals - physiotherapy, Occupational therapy, speech therapy, besides orthotic and prosthotic workshops.
10. The health structure to link up with other local organizations in catering to the specific socio-psychological needs of women with disabilities and people with mental health problems.
11. To promote establishment of mental health centers to cater to the treatment and psychosocial counseling of mentally ill and mentally retarded.
12. Discimination of basic health information to persons with disabilities so as to enable them to understand the importance of health services and the need for prevention.
13. Prevention, early detection, assessment, intervention and referral should also be the responsibility of the panchayat raj institutions.

14. It should also be the responsibility of the panchayat raj institutions to protect the human rights of disabled children and adults in the family and in the community by ensuring their inclusion in age appropriate activities.
15. Training for the civil servants on disability, manual should be available with the ministry of justice and empowerment
16. There should be linkages established between the existing DRC's and PHC's in all programs including identification and rehabilitation of persons with disabilities.
17. The implementation of the disability act of 1995 should be the responsibility not just of the ministry of justice and empowerment but of all appropriate ministries with adequate resource allocation and capacity building on disability.

CH- Case study : 30
Village Gont.(District Raipur)

Suratram Sonwani lives with his wife and 5 children. The eldest child Ishwar who is disabled aged 12, Veena aged 8, Daneshwar 5 years, Hukumdass 3 years and Dageshwar 7 months old. When Ishwar was one year he fell ill and his leg began to swell. He was taken to the hospital where the doctor gave him an injection and tied up the leg, he opened the bandage after a week to see that the leg was shortened. The family blames the doctor for giving wrong injection. He was taken to the Raipur hospital but it was not helpful. Now the family has to take care of the disabled child, lame in one leg. Ishwar is in class six now and has to go to the neighboring village as there is only a primary school in his village. During the rainy season he has to walk for five kilometers across the stream to go to school. The parents cannot drop him to school every day as this would mean losing one day of work. Loosing a day's work means that their whole family including the children would have to starve. They are hoping for a better future for the child.

CH Case study 31:
Nera, Village Gotiyardi (District Raipur)

Description: Naresh Kumar gritlehara lives in village Gotiyardi with his wife and three children, Neera 17 years, Dickeshwar aged 12 and Dogeshwari 9 years. Naresh owns half an acre of land and also works in other's field and earns Rs. 25 per day. Neera was not sent to school from the beginning but the other two children were sent to school. 4 years ago Neera had severe fever and was taken to the hospital at Raipur. She was suffering from sickle cell anaemia, she could not eat much or do anything after that. Thereafter she developed mental illness and she started beating up her parents and abusing all those who spoke to her with foul language. The family sought to locking her up in a room of the house as a remedy of silencing her. Her father said that she cannot be treated anywhere as the family had no money to take her to the hospital in Durg.

CH Case study 32:
Vicky, Village Kesla (district Janjgir Chapa)

Description: Kesla a village in Pamgarh block of Janjgir district has a population of 2004 with 322 house holds. The village has a majority of SC's. Ganesh Ram lives in this village with his mother Mandakani and wife. He has 4 children, Sanjita the eldest daughter Vicky is the second son, then Suman and Sukvindar is the youngest. Due to lack of work Ganeshram and his wife Mandakini used to go to Shivpuri in M.P. for livelihood where they used to work on the construction sites. Vicky was born in Shivpuri. After three months he fell ill and Ganeshram after seeking permission from the contractor went to Shivpuri hospital which was around 20 kilometers away for which he had to spend Rs. 30 while his income per day was only Rs. 20. The doctor gave him some medicines and the treatment went on for two months where Vicky was taken to the doctor once a week. After a few months Ganesh returned back to the village. Vicki's fever subsided but his leg would not grow straight. He was affected by polio. After this he was given polio drops three times in the camps held in the village but nothing happened. Polio had left a mark on him. He was sent to school and now is in the sixth standard. He likes going to school and does not like his friends from the harijan hamlet teasing him. The family owns 2 acres of land and it is difficult for Ganeshram, the family head to support the family. Vicky is not getting the scholarship. He was taken to the Bilaspur hospital where he had to wait for a long time to meet the doctor. He asked Ganesh to come later and told him that nothing can be done for the child. The second time he went there was no doctor he waited the whole day but just to return back in the evening. The third time he went the doctor told him to get Rs. five hundred for the caliper next time. The fourth time he went he got the caliper after paying the Rs. 500, which he had borrowed from his relatives. The caliper became small after using it for a few years and Ganesh returned back the caliper to the hospital.

CH-33
Sureta, Village Banhar, Block Bharamkela, District Raigarh.

Description: Sureta lives in village Banhar with her parents. Kapilo is a landless labour and has a hand to mouth existence. The family after a strong desire for a male child bore only three girl children Sureta being the youngest one. When Sureta was still young (1 year old) she had a leg injury in her right leg. The parents had to forgo their daily work (depriving them of their daily income) and took the daughter to Tharakela traditional doctor Soukilal which is three kilometers away. Soukilal after examination gave some medicines which costed a lot to the family. The PHC was 12 kilometers away and each time they went they had to spend Rs. 20 per person which the family was not able to afford. The mother took Sureta frequently to Soukilal hoping for relief but nothing much happened (The family had spent Rs. 300 on the fees and medicines which is a big amount for the family) Pus began to grow on the wound and Soukilal decided to operate it. The operation was not successful as according to the family the doctor cut the wrong place. Soukilal said that the girl cannot walk independently but can walk with the help of the stick. With all the difficulties the parents sent Sureta to school where she was able to study only till the class 8. Sureta got no disability scholarship when she was in school.

Two years ago the family decided to get a disability certificate. For this the family had to travel for around 80 kilometers which would cost 50 rupees per person for one side. They reached Raigarh hospital on a Monday (The medical board authorized to certify disability sits on every Monday) They had to buy a form for 20 rupees and after filling it up they had to get it signed by a chief doctor who was not available on that day hence they had to stay in a Dharmshala and got it signed the next day. Totally they had spend Rs. 500 for getting the certificate. Then the family applied for the disability pension. For this also they had to run around, Sureta herself had visited the gram panchayat at Tharakela three kilometers away more than 5 times to meet the Sarpanch and Sachiv, in each of her visit they would either not be there or assure her it would be done. Finally Sureta's paternal uncle who is a Sarpanch of another village influenced the sarpanch to give the pension. Now Sureta receives her pension after struggling for nearly 6 months. Sureta says that, without money and influence it is difficult to get anything.

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Ch-34
Panwarabai Viswakarma, Vill.- Mudpar, Po – Sarona, Dist. Kanker

Description : Panwarabai, 38 years of age was suffering from bleeding per vagina. On the advice of the health worker she went to the district hospital (on 9th June 2003) by a private jeep for which they had to pay Rs 500/-. In fact she visited the doctor at his residence who advised her attendants to admit her in the hospital but in the hospital the nurse and compounder refused to admit her. Later on, on doctor's persuasion over phone she got admitted in the hospital. On 13th June 2003 she was released and advised to go to Raipur for further treatment but they could not arrange the needed amount of money and got back to their native village and opted for treatment from baiga since they had already spent about Rs 7000/- on medicine food and travel. Without proper treatment she was succumbed to death in Frebruary 2004.

Denial : failure of referral system
Consequance : Loss of life
Two children orphaned

Ch-35
Rupeshwari Sori, Vill- Singhanpur, P.O.- Sarona, Dist. – Kanker

Type of Case : Burn Case

Description : Rupeshwari D/o Mr Bihariram Sori, age- 14 yrs was a student of 7th standard. On the morning of 19/02/2004 Rupeshwar I was looking for a book just before going to school. It was dark enough so she lighted a lamp but somehow her dress cut fire from the lamp and she was burnt to a large extent. The case was reported at Sarona PHC but no proper treatment was made available. The ambulance was also away on a trip to drop some patient. The accompanying attendants applied mashed potatoes as paste over the burns.

Rupehwari was shifted to district hospital at Kanker and got admitted where she was put on a general bed at 02.10 pm. In the hospital a bottle of saline was given and all other medicines were purchased by her parents from out side.
The case was referred to Christian Hospital, Dhamtari ant she was admitted there at 03.00 pm on 20/02/2004. Shewas shifted by the district hospital ambulance but they had to bear the fuel cost of Rs 600/-. They had to pay Rs500/- in advance as admission fee at Christian Hospital, Dhamtari.
The patient died on 12/03/2004. The family members had to pay Rs 1000/- for transportation of the dead body. On the whole her par parents had to borrow about Rs 35,000/- out of which Rs 10,000/- was a loan from the local panchayat.

Denial : No burn unit at district hoaspital, Kanker
Consequence : Patient died
Debt load of Rs 35,000/-

Ch-36
Devkumar Patel, S/o Pattarlal Patel, Vill- Sakarri, PO- Sakara, Tahsil-Malkhoroda, Dist.-Janjgir-Champa

Type of Case :
Description: Devkumar Patel, 24,yrs, was having Gall stone, who reported at Apollo Hospitals, Bilaspur and was operated on 29/11/03 and was released on the following day. Since the operation was not successful the asked them to report again for the second operation on 03/12/03. Accordingly the patient was admitted and operated but it was also an unsuccessful operation and bleeding was continuing. The patient was also complaining of pain on whole body. When enquired the doctor avoided about referral of the case and released the patient on07/12/03 at 11.00 pm. The doctor was out on leave and his contact phone number was also not made available after repeated request.

The patient was shifted to Raigarh and Dr Rupendar Patel was contacted. The patient was serious hence the doctor referred the patient to Bhilai-Sector -9 Hospital where the patient died on the following day. The patient, excluding all other expenses, had to spend Rs22,000/- in Apollo Hospitals only.

Denial : Adequate provision for treating this kind of case is lacking even in apex institute like Apollo Hospitals.

Consequences : Loss of life
Had to spend Rs22,000/- which was of no use.

Annexure-4

CASES OF DENIAL OF HEALTH CARE

PRESENTED /SUBMITTED FROM PARTICIPANT STATES OF EASTERN ZONE.

Cases from Jharkhand.

Jharkhand Case 1

Name of patirent- Binod Kumar Dutta
Age- 40 Years
Vill- Topchanchi , Bloc – Topchanchi
Dhandbad- Jharkhand.

The patient who was a BPL cardholder was suffering from renal disease since last six months and undergoing treatment at Dhanbad on the advice of a private doctor.

The doctor finally suggested him to go to Apollo hospital Ranchi for treatment, as his was a complicated case and could be treated there only. As he was a poor person the village community collected donations from the fellow villages and sent him to Apollo hospital in a car. He was admitted on 22/7/04. His family deposited Rs. 2.500/ for initial checkups. His application for help [in treatment for BPL families under government scheme was submitted in the Medical Board at Ranchi on 30/7/04. The Board staff asked the hospital for estimate in treatment and the hospital sent that on 4/8/04 to the Board.
In the meantime the dialysis was done and the hospital management asked for more money. His family again came back to the village and collected some money and deposited Rs.5000/- in the hospital on 28/7/04.

The Medical Board did jot sit and gave him financial help. The hospital management kept on asking for the dues (which they said will be reimbursed if it gets sanctioned), which finally grew to 27,000 on 3/8/04. The family was asked to take back the patient and come home only after they get sanction information. The family facing insults and guilt finally managed to collect Rs 2,000 for the car and brought Binod home in a pathetic condition.

They kept on inquiring about the Medical Boards sanction but it did not happen. The condition of Binod deteriorated day by day and finally died on 2/9/04 at 10:30 PM.

On 22/9/04, the family came to know through newspapers – that after his death the money for his treatment has been sanctioned ie .Rs 1,50,000/. But for what use! As the only bread winner of the family was gone.
Denial Issues: High cost of care: difficulty in accessing schemes meant for covering such high cost care under special circumstances.

Jharkhand Case 2.

Name of the Patient- Kamarina Jojo
Age- 38 Years
Vill- Murud
Block- Murhu , Ranchi.

The patient suffered from Malaria and was feeling fever with cold. She went to the PHC Murhu. The doctor was not available. The health worker refused to admit them saying he can not manage it, so come next day, she was then taken to St Barnabas hospital at Barnabas and treated.
She was not admitted nor her blood was taken for examination. She had to spend Rs 4509 for treatment for which she took loan from moneylender and had to sell her goat to pay him back.
Denial Issues:
Lack of care in public facility:
Quality of care and cost of care in private facility.

Jharkhand Case 3.

Name of the Patient- Phoolmani Hassa Purthi
Age- 30 Years
Murhu- Ranchi.

She went for treatment in PHC Murhu for malaria on 9th Aug –2004. When she reached there at 2:45 afternoon. The doctor was not available. The Health worker present there scolded him and said that " Don't you know the timings" and refused to give any medicine.
Feeling helpless she had to get treatment from private doctor and got treated at Sarvada Mission and had to spent Rs 1,500/, which she had to borrow from moneylender.
Denial Issues:
Lack of care in public facility:
Quality of care and cost of care in private facility.

Jharkhand Case 4.

Name of the Patient- Kajal Kumari
Age – 38 Years
Khunti Block.

The patient was taken to local hospital and then a referral hospital after dog – bite. She went there three times but could not get any treatment she was examined and referred to Ranchi. The hospital staff said they did not have any medicine.
She was then taken to Kanke hospital, where she was (RINPAS) charged Rs 50/ and got treated. She finally had to spend Rs 800/- on her treatment.
Denial Issues:
Lack of care in public facility:
Quality of care and cost of care in private facility.

Jharkhand Case 5.

Name of the Patient-Rarsi Munda
Age- 8 Years
At - Murhu - Ranchi.

The patient got injured in an accident and was taken in critical condition to PHC, Khunti on June 2004.He was examined by the doctor there.
But due to non-availability of medicines and facilities he was taken to Ranchi for treatment and had to spent Rs 9,000/- on treatment. Which the family managed after much hardship!
Denial Issues: Inadequate level of care at PHC with no arrangements for referral.High cost of care.

Jharkhand Case 6.
Name of the Patient – Late. Suyu Dodray.
Age. – 45 Years.
Angancha, Ranchi.

The patient fractured his bones and went to District hospital, Ranchi on June 2003. He was put on the waiting list and waited for operations. All the medicines was purchased from outside. The care was not good and was examined for the first time after five hours after he reached the hospital. The regular examination was erratic.
The patient spent Rs 20,000 on treatment but finally died due to paralytic attack.
Denial Issues:
Poor quality of care in secondary health facility. – death in such circumstances is otherwise unusual.
High cost of care in public facility

Jharkhand Case 7.
Name of the Patient- Kanchan Kumari; Age- 3 Years; Mohanpurhat;Dist. Deoghar.

Kanchan a 3-year girl has had recurrent respiratory tract infections for which her parents took her to the PHC were she was seen by a doctor and compounder.
She was prescribed medicines and some were dispensed at the PHC. They had to also buy Rs 650 /- worth of medicines from the private pharmacy.
When she did not show signs of improvement they were referred to a higher centre and since no government run centre was nearby went to a private hospital were she was treated and spent Rs 3,600/-. Her parents have taken a loan for the expenses.

Jharkhand Case 8.
Name of the Patient - Arun Kumar
Age. - 3 Months. Boy.
Mohampurhat, Dist. Devgar.

Arun Kumar a 3month old boy was taken to the hospital with complaints of weakness in both hands and Right leg. He visited the PHC and was seen by a doctor. They were prescribed medicine worth Rs. 200/-, which they had to borrow from a private Pharmacy. They were not

referred to a Government centre but instead went to a private nursing home in Patna where they incurred a cost of Rs 10,000/- for the treatment. All bills are with the patient.
They had taken a loan to pay up the medical bills.

Jharkhand –Case 9.

Name: Dharma Paharia ;Village: Langodih,Post: Chandana;Dist: Godda; Pin 814156

Aged 49 years he has been suffering from a wound in right hand which affected his wrist joint and he is unable to move the hand or work. Since two years he has this disease and as result is not able to work and therefore even find money for food for the family. Nor is he able to afford treatment. The local doctors say that it can be bone T.B. But the government hospital here do not provide T.B. medicines on a regular basis. The expenditure involved in Xrays and proper diagnosis and treatment has been beyond him and now he is helplesly watching the disease progress.

Denial of Health care:
Unable due to poverty to acces higher level care. Local facilties are inadequate.

Jharkhand Case 10.;
Name Dharmi Malto;Village Kotbitta (Kotley);PO Chandana 814156; Dist Godda

Dharmi Malto is a girl from Kotley Paharia village. She has a few wounds around her neck, which are deep seated. They have not healed for over a year. As the village is located in the hills and there is no hospital nearby, she could not get treatment earlier. now the wound is getting worse. Therefore with the help of a volunteer she was taken to the Sundarpahari PHC on 25/9/2004. (A Referral Hospital building has existed for over 4 years an it was completed 2 years ago. It has been used for some operation camps- but offically it has not been inaugrated. No OPD exists at the Referral Hospital building. Ex CM Babulal Marandi who visited on 28th September, 2004 commented on the absence of doctors at the PHC at 2 pm).
The doctor at the PHC who saw Dharmi referred her to Godda District Hospital. Dharmi lives 7 km from Sundarpahari. This 7 km is on the hills-where no bus or transport is available.Godda is another 18 km from Sundarpahari.Dharmi is an orphan and could not afford the bus fare. She lost hope and returned to her house with a few medicines.

Denial Issue: Even where PHC exists the desired set of services that the PHC should provide does not exist.

Jharkhand Case 11
Ajit Kumar Murmu, Godda.
Type of case**:** Kala-azar

Description: Ajit, a 32 year male has been suffering from Kala-azar since three years. Went he went to the district hospital in Godda, this August, he was prescribed Sodium Stibogluconate

Injection I.P. but since this drug was not available in the district he was asked to get the medicine from outside. Later the patient also went to Medical Hospital, Kolkata, where he had to spent about 8,000/-. In all he had to spent about 50,000/- for his treatment. He could manage this much of money only after selling off his cattle and jewellery, and taking loan.

Denial and related issues: Godda district hospital should have the medicines for Kala-azar, more so as this disease is quite prevalent over there.

Consequences: Financial loss, assets sold off, debt.

Jharkhand Case 12
Sujit Hembram, Godda
Type of case: Pneumonia

Description: Sujit, a three month old baby was taken to the district hospital in Godda after he developed difficulty in breathing, fever, pneumonia. The patient was treated and drugs were prescribed but no drugs were available from the hospital. The drugs that were prescribed were, Taziol injection 250ml;Derlphyllin inj; Zincovit drugs;Tixylix Cough Linctus;Malaria P.F/P.V.
All the drugs had to be bought from private medical stores. The test had to be done in a private lab.

Denial and related issues: Drugs for such basic diseases should be available in the district hospital.

Consequences: Family in debt.

Jharkhand Case 13
Hopenmoy Soren, Godda

Type of case: Kala-azar

Description: Hopenmoy a 22yrs female went to the district hospital for treatment of Kala-azar. She was seen by the doctor and Sodium Stibogluconmate injection I.P was prescribed to her. The drug was not available in the hospital and had to be bought from outside. She had to spent about 20,000/- for the treatment and she had to sell off her land for it.
Denial and related issues: Drugs for this disease should be available in the hospital in this Kala-azar prone area.

Consequences: land sold off.

JH- 14
Name- Mr. Hirday Shankar Bikhava (Social Worker)

Case- Dispensing of expired drugs in panchayat level Camp of Chitmiti in Tantanagar block of Jharkhand.

Description- On 9th October 2004, one health camp was organized by govt. at Chitmiti village of Tantanagar block. There, many patients were examined and free treatment was provided to the public where Iron Folic Acid tablets were provided to the pregnant ladies of the village by the medical officer. Manufacturing date of that medicine was July 2000 and expiry date was June 2004. Till now tablets are sealed packed. It was packed and sealed in the presence of public and in front of the village head (Punch). This packet would be presented in the public hearing of eastern zone. I would like to say that essential heath services should be given regularly in public sector up to the grass roots level. However, this service is provided by the govt. personnel in the form of health camps and supply of expired medicine which is complete denial of health services, health rights and human rights. It is certainly a big cheating by the govt. to the innocent public.

Denial- Negligence and cheating.
Consequences- Might be harmful to the pregnant ladies and their foetus as well as other beneficiaries.

JH-15
Name-Sukhdeo Hembraham
Case- 46 cases of diarrhoea, 2 in coma, 2 deaths in Saliburu village of Balandia panchayat in Jhinkpani blocks of Jharkhand.

Description- According to Sukhdeo in Saliburu village, an outbreak of diarrhoea was there. It started on 26th September 2004 and is continuing up till date. All patients of that village belong to people Below Poverty Line. Having no local facility they have to go to Chaibasa which is 30-40 km away from this village and not inconvenient to reach. However, we have to take one coma patient with the help of villagers and went to the Sadar hospital of Chaibasa, where they refused to provide treatment because they had no medicine or other technical facilities, and referred the case to Tata MGM hospital but there was costly treatment so that we requested to "AJSU" for some help. They provided medicine and met all other expenditure. However, the patient's condition has not improved till now. We would like to say that Malnutrition, Starvation, Diarrhoea will be a cause of death amongst poorer section then is it denial of health and human rights or not.

Denial : Quality of Health Services and even essential treatment not available in public sector facility.

Consequence: Death, Disability, Unnecessary financial loss.

JH-16
Mr. Kinkar Singh Village- Sima

Case- Death of wife and Infant during Labour (Maternal Mortality and Infant Mortality)

Description-
Myself kinkar Singh residing in Sima Village, Post-Sima Gunda, Thana –Nimdiha, District-Sarikela-Khasawa, state- Jharkhand, I am a tribal person. My wife late Ramani 27 years, was full term pregnant and on 22nd June 2004, when pain started, we went to the primary health centre where doctor A.P. Singh took Rs5000/- in advance and referred the case to his clinic at his govt. quarters. Place of delivery was bathroom of his residence and without anaesthesia he did operation by simple instruments. Sir, my wife was crying with top of her voice and after 3-4 hours ultimately my wife and my infant were no more. Doctor asked me to take the dead body of my wife, and mean while he threw the dead to out side with the help of some other fellows. When I saw my wife's dead body I informed the matter at police station. On the following day villagers agitated against doctor and the doctor was arrested. In MGM hospital post-mortem was done having the case no. - 578/04 but when I asked for report they didn't give. Sir, I was denied of facility and have not received any compensation. I have lost my child and my wife.

Denial- Bribe for health services by the public sector doctor.
Poor quality of service.

Consequences- Maternal Mortality with Infant death.
Un necessary loss of Money.

Cases From Orissa

Orissa 30
Ms Maheswari Mishra
D/o Mr Bichitrananda Mishra, retired head clerk of Social Forestry Division Office, Berhampur, Orissa

Type of case: CEREBRAL PALSY

Description : Ms Maheswari Mishra' D/o Mr Bichitrananda Mishra, retired head clerk of Social Forestry Division Office, Berhampur, Orissa is an unmarried lady of 36yrs.
The Professor and Head of the department of Psychiatry, MKCG Medical College, Berhampur certifies that Maheswari is a case of CEREBRAL PALSY with complete physical handicap and mental retardation and that she needs nursing and medicines for day to day living. The doctor has also advised to admit her to any Govt. / NGO run facility because the mother of Maheswari is also suffering from Schizophrenia.
Maheswari's father Mr Bichitrananda Mishra sought for support and financial assistance from his department for treatment and rehabilitation of her daughter because of inadequate facilities of services for this kind of a case in the said medical college hospital.He has received Rs 3,000/-up till date as medical advance and nothing more than that.

Denial: Inadequate provision for physically handicap individuals.
Departmental apathy towards Mr Mishra's repeated appeals.

Consequences: Fate of Maheswari after the demise of her parents.

Orissa- 31

Ms Kalyani Maharana
D/o Mr Subash Chandra Maharana
C/o BGVS, Nayagarh

Type of Case : Malaria

On 20.08.2004, Mr Maharana reported Odogaon government hospital with his daughter who was suffering from malaria and waited there for the doctor to come from 7.00 am to 9.30 am. The doctor was at his quarter but did not turn in. There were no other staffs. Since the patient was under delirium he took her to the nearest private clinic for primary health care and got back to the government hospital again at 10.30 am and wanted to have doctor's advice for furtherance of treatment and claimed free treatment under *panchabyadhi* scheme. He also commented that because there was no one in the hospital he had to go to a private clinic and spend money on that. The doctor got irritated and got up from his chair and said, "Do whatever you can but go away from here". He also said to the people that he will not see any patient unless he vacates from the premises. Hence Mr Maharana had to leave the place with his daughter.
On 23rd he had to take her daughter to the district headquarter hospital and on the following day at noon the case was referred to the Medical College Hospital at Cuttack. By then she was administered with oxygen.
Since the ambulance of the district headquarters hospital was not in running condition for a period of more than one year the ambulance of Saranakul CHC was in service at the district hospital. It took more than an hour just to obtain permission from the CMO to use the ambulance but at last the driver denied taking the vehicle out because of some problem in the wheel. Thereafter he had to run from pillars to posts for arranging oxygen cylinder in a private vehicle but failed and had to carry the patient without oxygen.
However, the patient recovered from malaria and was relieved from the medical college hospital on 30th August 2004. All together he spent more than Rs10,000.00.

Denial: Literally denied of treatment

Consequences: Got more severe and had to run to Medical College Hospital and finally had to spend Rs 10,000.00.

Cases of Denial of Right to Health : Bihar

Bihar Case No. 1 – Fluorosis in Rajauli block of Nawada Dist.

In the village Kachahariya dih, G.P – Hardiya, 43 listed persons (mostly less then 10 years of age) are suffering from handicaps due to fluorosis due to high fluoride content in water. .After 3 years a child gets abnormal deformity of bones in his legs below the knee(genu valgum and genu varum deformities). This can be severe enough to make them lame. In this village all children (more than 95%) are lame to varying degrees. Older age groups - 40 to 45 years old- also suffer from this disease. They suffer from bone pain and ultimately their backbone becomes abnormally curved. There are 8 handpumps and all are reported to be affected. This disease was detected in 1985 but there is no treatment offerred in PHC or in the hospitals. Some relief work was done 2 years ago but it was not sustained and alternate drinking water is still not available. At persent they are still helpless.

The same problem is found in Bhupnager village of Aamas block of Gaya Dist.

Denial : lack of safe drinking water.
Lack of a public health response to major public health problem.
Denial of rehabiliation programmes and compensation needed for severe crippling.
Ongoing tragedy – Needs urgent response still.

Bihar Case No. 2 -- Chinta Devi from Manpur block of Gaya Dist.
30 years old young lady Chinta Devi, village -–Baradih, Panchyat – Baragandhar got tubectomy (family planning) operation in Lady Elgin hospital, Gaya. Doctor did't test her for pregnancy and operate her. She has already 4 daughters and two sons. She was delivered her 7th baby on 26.9.04 in private clinic by surgical operation and spent more than 10 thousands rupees. This has left her physically and mentally traumatised.

Denial: Poor quality of care in public facility. High cost of care in private facility.

(There are two similar cases of failed vasectomy in Ganjas in Gaya.).

Bihar Case No. 3 -- Antenatal Care in Jehanabad block of Jehanabad Dist.
A small survey was conducted of 20 women who had delivered a baby in this year in Chakiya/ Larsa Panchayat. All these women are selected from one hamlet. The survey showed that none of the women had been registered either in ANM register nor in ICDS worker's registers. 3 women got T.T Vaccine and this too from the market. Only 4 women went to a PHC for check-up but no lady doctor was present there. The women who went for checkup were neither talked to on maternal care nor about anemia. No blood test was done. However due to higher awareness many of them went and got treatment from district hospital. One woman got 30 iron tablets and one woman got 100 iron tablets. Of the 20 babies, 5 have been immunised in the dist hospital.

Bihar Case No. 4. – Tuberculosis –Lack of care:
Late Suresh Manjhi from Karpi Block of Arwal dist.
Suresh Manjhi of Village- Kinjer- was suffering from T.B and did not get proper treatment in the village or in nearby PHC.. Ultimately he died. In this village 10 persons have died in last 6 months from T.B and Kala-Azar including ward member of gram panchyat and the son of persent ward member. The health facilities to service this area are the sub-center at kinjer, the PHC at Karpi and Dist. Hospital . All three have been informed but there have been no disease control measures nor any improvement in facilties provided.. The list of names of those who died is available.
Denial: Lack of TB or kala –azar control programme.High death rate evokes no public health response.

Bihar Case No. 5 – Tuberculosis in one village of Manpur Block of Gaya Dist.
In the village Pahartalli/Abgila, Rubi Khatun (25) wife of Mokhatar (40) daughter of Samim (05 month) Anbar Khan (40) Kashim Miyan (60) and 7 other persons died in last 6 months of tuberculosis. An estimated 27 persons have been diagnosed as having tuberculosis and suffer from it even as of now. Perhaps there are other persons who are also suffering, but who are not detected till now as now proper survey has been done. There are no services that reach them from the PHC and the dist. T.B center. There are complaints that many health sector employess who are rude to them when they insist and this denial is linked in their perception to a caste based discrimination bordering on untouchability..
Denial: Absence of TB control programme and lack of public health response to high death rate. Also exclusion from primary health care services.

Bihar Case No. 6 – Tuberculosis-Lack of affordable care: Illegal fees in public facility.
Yogendra Paswan from Vikram block from Patna Dist.
He is suffering from T.B. He paid Rs. 100/- for a 1 month course of medicines in Vikram additional PHC. After two months, he was adviced check- up. He went to a Red Cross facility on referral from PHC and paid Rs. 750/- for the check-up. He was referred back to PHC for drugs. The compounder there was willig to provide drugs but only on payment. Unable to pay these recurrent sums of money due to poverty, he is not receiving any medicine as of now.
Denial: Illegal Costs of care in public health facility excluding the poor from access to treatment including essential drugs.

Bihar Case No. 7 – Private practice in public health facility
A case from Patarghat block of Saharsa dist.
In PHC doctor remains persent and he gives treatment to the patients in PHC. But he receives fee. He is practicing as private practioner in PHC on the public hospital's beds. He has even hung up a Doctor's signboard also. He does not provide any facilities free of cost.

Bihar -Case - 8 – Private practice in public facility with poor quality of care
Lalita Devi from Chand block of Kaimur dist.

She was suffering from simple skin disease . She went to the PHC where the doctor gave two injections and a prescription for purchasing medicines from market. Docor took Rs. 30/- for this. After one week on 24th July, 04 she went PHC again. Doctor was absent and compounder

repeated the same process. He also took Rs.30/- for injection. But she was not cured and ultimately she went to a private clinic and had to spend even more over there and then only she was cured.

Denial:

Poor quality of care

Charging fees illegally in a public facility:

Name- Village Tulsi Vigaha Post- Sohepur Bhaya- Buniyad Ganj Thana- Mufsil, District-Gaya. **Case- Sterilization Failure: presentaation : Umesh Yadav,**

S..	Block	Name/ Name of the husband	Address	Age	No. of Child before Operation	No. of Children after Operation	Mediator	Place of Operation	Govt/ Non govt	Date of Operation
1	Manpur	Chinta devi/Raghunandan yadav	Tulsi Vigha	35	2-M 2-F	1-M 2-F	ANM	PHC,Manpur	Govt.	12 years before
2	Bodhgaya	Budhani devi/Dukhan Banjhi	Pathalgarh	45	3-F	1-alive 1-died	Self	PHC, Guruwa	Govt.	1970
3	Bodhgaya	Kaili devi/Biphan manjhi	Pathalgarh	50	3-M 1-F	1-M	Self	PHC, Bodhgaya	Govt.	15 years before
4	Bodhgaya	Jageshwari devi/Suraj Manjhi	Pathalgarh	50	4-alive 3-died	1-M	Self	PHC, Bodhgaya	Govt.	----
5	Bodhgaya	Savita devi/Lala yadav	Pathalgarh	33	2-M 2-F	1-M	Doctor	Private Nurshing home	Non Govt.	27/12/2002
6	Bodhgaya	Phulava devi/Gauri Yadav	Pathalgarh	45	2-M 3-F	1-F	ANM	PHC, Bodhgaya	Govt.	--------
7	Mohanpur	Chinta devi/Parshuram mistri	Chauri	40	2-M 1-F	2-alive 2-died	ANM	PHC, Bodhgaya	Govt.	---------
8	Bodhgaya	Sukari devi/Ganauri mistri	Shekwara	48	3-M	2-M 1-F	AWW	PHC, Bodhgaya	Govt.	----------
9	Bodhgaya	Puniya devi/Jethan Manjhi	Shekwara	-	1-M 2-F	1-alive 2-died	Compounder	PHC, Bodhgaya	Govt.	Feb2004(Reoperation Done)
10	Bodhgaya	Koshmi devi/Mundrika Manjhi	Shekwara	-	2-M 4-F	1-F	-------	Lady Elgin Hospital	Govt.	---------
11	Bodhgaya	Kamla devi/Sahade thakur	Shekwara	-	2-M 1-F	1-M	Compounder	PHC, Bodhgaya	Govt.	----------
12	Bodhgaya	Sanjudevi/ Shankar Yadav	Shekwara	-	2-M	1-F	ANM	PHCBodhgaya	Govt.	3 years before
13	Bodhgaya	Wife of Baijnath Mistri	Shekwara	-	4-M 1-F	1-F	-------	-------	Govt.	----------
14	Dobhi	Wife of Viseshwar Yadav	Dariaura	-	6-M 3-F	She is Pregnant	Doctor	PHC,Sherghati	Govt.	One year before
15	Dobhi	Rohani devi/Sakul Yadav	Habibpur	45	3-M 1-F	1-M	Doctor	PHC,Serghati	Govt.	----------
16	Manpur	Wife of DilipYadav	Bahora Vigha	-	3-M	1-F	-------	LadyElgin hospital	Govt.	1998
17	Manpur	Wife of Ramchandrayadav	Murkatta	-	1-M 3-F	1--F	-------	----------	Govt.	----------
18	Fatehapur	Ramtaj devi/Birju Manjhi	Kadiaundh	-	2-M 2-F	1-F	-------	----------	Govt.	----------

Denial- Poor Sterilization Services., **Consequences--- Failure of sterilization ,Increase Family Size , Poor financial Condition**

Cases from West Bengal:
WB- 1. Representation from Deepak Talukdar Choudhary

This is to inform you that , I Sri Deepak Talukdar Chowdhury s/o Sri Digendranath Talukdar Chowdhury of village Pandua Telipara, P.O& P.S. Pandua, Dist- Hooghly, 712149, had an 1"-11/2" accidental glass cut injury over frontal aspect of right forcarm just below wrist joint on medial side, on 2 October 2003. For that reason I was admitted in Orthopaedic Department, Calcutta Medical College & Hospital under Dr. P.Roy (unit no. III). I heard from the conversation of attending Doctors that my right ulnar nerve was injured I had an operation on 2 October 2003 in between 3 pm. to 8 pm. under general anaesthesia. I was informed that operation was successful. But after 14 days when the bandage was opened, I was astonished to see that operation was made by extending the cut injury over wrist. After repeated enquiry about why the extention of cut injury was made no attending doctor bothered to answer my question. They prescribed a lot of medicine and they assured me and my relatives & fried that I could move my right hand as before.

After long time when the condition of my right hand was gradually deterioting, I consulted many doctor from many deptt. of Peerless Hospital, Apollo M.C.G., Suraksha Poly Clinic, CMC Vellore & Chennai Apollo Hospital. They had done a lot of medical investigation and informed me that the operation done on Medical College & Hospital was totally wrong. They wanted case history and operation note from Medical College & Hospital. Having no such case history and operation note, I contacted Dr. Sandipan Gupta, Head of Deptt. of Plastic Surgery Calcutta Medical College & Hospital. Dr. Gupta told me that the operation was totally wrong and it was not the domain of orthapaedic surgeon. Then I contacted Dr P Roy, head of unit no.3 of ortho surgery but he behaved rudely with me. after harassing me, 4 months he compelled to give the operation note.

After getting the operation note, I went to Apollo Hospitals, Chennai, for better treatment with the financial assistance from my friends and reltives. They operated and repaired my ulner nerve but now my right hand is 70% disabled.

Hope you will enquire and find out the truth to ascertain who is negligent and help me to get the compensation for my disability, now I am under heavy debt for my medical expenses and unable to bear my livelihood.

WB 2: Case study of hand rickshaw puller;Bhan behari naiya;Age- 67;Ballygunge station

Bhan Behari Naiya pulls a hand rickshaw in Ballygunge Station. He stays in his owner's house in Garia. Everyday he travels up and down by train. His owner's name is Mr.Kalachand Shah. Bhan Behari Naiya's hometown is Dhankhiya of 24-Parganas in Kashinagar. He has a wife and two daughters. One daughter has already passed her MBA exams and she has just finished her teachers training course. She has applied for a job in a school. She is still awaiting her results. Another daughter has just finished her madhaymik exams this year. His wife looks after both of them in the village.

In his childhood Bhan Behari Naiya used to go to school but he studied up to class seven only. After that because of shortage of income, he joined hands with his father in agriculture. Inspite of working together there was still scarcity of money. One day his relative Mr Anando Mondal told him that he pulls ricksahw in Kolkata . He thought over and decided to do the same.

Now Bhan Behari Naiya pulls hand rickshaw in Ballygange Station. He begins his work at 6 o'clock in the morning and finishes at 9 o'clock in the night. He earns rupees 100 per day. Out of this 100 rupees he has to give 20 rupees to his owner everyday.He spends 30 to 35 rupees on his food. He has three meals a day, though not at fixed timings. So at the end of the day he sees 40 rupees saved in his pocket. But there are days he doesn't get passengers at all. Yet he has to some how pay 20 rupees to his owner and that money he borrows from his friends. He also generously extends his help to his friends, when they need him. Bhan Behari Naiya gets different kind of passengers. Some of them are so much intoxicated that they don't even bother to give him the right fare. And sometimes he gets good people who converse with him and ask him about his family, wife, children and so on and so forth. And at the end of the journey they willingly give him some extra money for his family. For entertainment he tells passengers ",babu aaj kya bazar kiya, aaj kal har cheese ka dam bar giya" This is how he starts his conversation with the people.

Bhan Behari Naiya feels really homesick but he can't do anything about it. His wife also keeps worrying about him. Neither he writes letters nor his wife writes to him. He gets news about his family from friends.

Bhan Behari Naiya feels that in this world there has to be some place for hand rickshaw pullers. He likes his job over here. He told me that, there are many people in this world who are highly learned but still unemployed so pulling hand rickshaw did not embarrass him . He also said that, whatever job people do, they do it for the stomach. So in the rat race, some are more priviledged some are not. But basically , we all need to slog.

Bhan Behari Naiya goes to his house at the month end and stays there for 10 to 15 days only. Before he comes to his house he has to give his rickshaw to his owner's hand and only then can he take off from his job .Whenever Bhan Behari Naiya goes to his house he always takes something for his daughters, not expensive things but cheap ones , and he hands over some of his savings to his wife. He pays back debts with the rest of the money .Bhan Behari Naiya and his family has a good relationship with the local people in his village and because of that Bhan Behari Naiya does not worry about his family when he is in Kolkata.

Bhan Behari Naiya has two close friends over here, Mr Lakhan Dey and Mr Sirdarsar Ghosh who always help him in need. They told me, that sometimes police forcefully catch their rickshaw and demand for bribe. If they revolt , the police just drags their rickshaw to the police station keeps it for the entire day. But not earning for a day is a huge loss for them.
Further Bhan Behari Naiya told me that when police catches 25 rickshaw then they

make only five rickshaw cases and rest they ask for bribe from each of them and whoever fails to do so loses his rickshaw for the whole day. Bhan Behari Naiya thinks that these policemen takes bribe even from those who make small forgivable mistakes. They do this inspite of getting regular salary from the government.

Bhan Behari Naiya and all his friends told me that they are not satisfied with their rate of the rickshaw fare.They work so hard, give in so much of their labour and energy to pull and carry people from one place to another. Hence they should also be pulled from their present status of poverty and misery .They should be liberated from the shackle of exploitation so that they can lead a comfortable life. If their problems are ignored and neglected they will raise their voice and do something for it themselves and do it very soon .

Annexure-5

These are sent by post separately.

Annexure-6
These are sent by post separately.