Fact Finding Report

Indian Public Health Standards

&

Right to Health

A Case Study of

Raga Primary Health Centre

Lower Subansiri District, Arunachal Pradesh

March 2016

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List of Abbreviations

- ANM Auxiliary Nurse Midwifery
- ARP Arunachal Pradesh
- ASHA Accredited Social Health Activist
- AWC Anganwadi Centre
- BPL Women Below Poverty Line Women
- CD Block Community Development Block
- CHC Community Health Center
- DH District Hospital
- DLHS District Level Household and Facility Survey
- ENT Ear, Nose & Throat
- HDI Human Development Index
- HMIS Health Management Information System
- IIPS International Institute for Population Sciences
- IPD In Patient Department
- IPHS Indian Public Health Standards
- JSSK Janani Shishu Suraksha Karyakarm
- JSY Janani Suraksha Yojna
- NFHS National Family Health Survey
- NHM National Health Mission
- NRHM National Rural Health Mission
- NUHM National Urban Health Mission
- OKDISCD Omeo Kumar Das Institute of Social Change and Development
- OPD Out Patient Department
- PHC Primary Health Center
- PIP (State) Programme Implementation Plan
- RMNCH+A Reproductive, Maternal, Newborn, Child, and Adolescent Health
- RRCNES Regional Resource Centre for North Eastern States
- SBA Skilled Birth Attendant
- SC Sub Center
- UNFPA United Nations Population Fund
- UNICEF United Nations Children's Emergency Fund
- WHO World Health Organization

List of Figures

[1] Arunachal Pradesh State Government. n.d. "Map of Arunachal Pradesh." *Official Website of the State of Arunachal Pradesh.* http://www.mdoner.gov.in/content/arunachal-pradesh-1# .

[2] Sacchidananda Mukherjee et al. *Three Decades of Human Development across Indian States: Inclusive Growth or Perpetual Disparity?* (p.16).

[3] Health Management Information System. *HMIS State Factsheet Arunachal Pradesh: Year 2013-14 & 2014-15*.

[4] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. "RRCNES State Profile: Arunachal Pradesh."

[5] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. *RMNCH+A Index: State Dashboard Arunachal Pradesh.* Statistics Wing, Ministry of Health & Family Welfare.

[6] *Ibid.*

[7] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. "RRCNES Arunachal Pradesh District wise Health Score Card."

[8] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16.

[9] Directorate General of Health Services, Ministry of Health & Family Welfare. *Indian Public Health Standards (IPHS): Guidelines for District Hospitals (101 to 500 Bedded)* (p.33).

[10] Census of India 2011. 2011. *District Census Handbook: Lower Subansiri.* Series-13 Part XII-B, Directorate of Census Operations Arunachal Pradesh (p.133).

[11] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Lower Subansiri."

[12] Figure is based on Raga Primary Health Centre's administrative files.

[13] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Lower Subansiri."

[14] *Ibid.*

[15] *Ibid.*

"For a middle-income country
of its stature and level of development,
the rate of maternal deaths in India is shocking,
raising multiple human rights issues."[16]

[16] Human Rights Council. 2010. *Annex to the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Paul Hunt: Mission to India (22 November to 3 December 2007).* United Nations General Assembly (p.20).

1. Introduction

In 2016, India continues to face numerous structural public health problems all throughout the nation, in spite of the considerable progress that has been made in recent years, partly attributable to the successes of newly introduced government programmes and schemes. Amongst the various persisting health problems in India, one of the most pressing – both as a public health and as a human rights issue – is the lack of equal access to basic healthcare facilities. "In India, inequalities in the availability of health care due to socio-economic status, geography and gender persist."[17] In other words, although public health problems are prevalent and worrisome nationwide, their intensity and frequency is often significantly higher for certain groups of people in this country. The respect, protection, and fulfilment of the human right to health in India is thus limited towards some people and thereby exclusive towards others. This fact finding report seeks to examine these inequalities in the enjoyment of public health and the underlying human rights violations. The object of study for this report can be narrowed down in the following three ways.

Firstly, with regard to inequality based on geography, this fact finding report investigates access to and quality of healthcare in a highly disadvantaged region of the country: the sub-district/circle of Raga, within the Lower Subansiri District, which is in turn part of the state of Arunachal Pradesh (hereinafter "ARP"). ARP is the least densely populated state in India and also one of the country's most remote states, due to various geographical features which inhibit the easy movement of people, services, and goods.[18] Within the state of Arunachal Pradesh, the district of Lower Subansiri is one of the worst performing districts, in terms of maternal and child mortality and morbidity, according to the state's most recent Health Management Information System (hereinafter "HMIS") data.[19] Based on the same dataset, the sub-district of Raga performs lowest of all sub-districts within Lower Subansiri District, in terms of key maternal and child health indexes.[20]

"Inhospitable terrain and low population density make rendering of health services rather difficult in Arunachal Pradesh. Though there has been a perceptible improvement in the public health facilities, most of the health care facilities are not well equipped with basic infrastructure like building[s], trained

[17] Santosh Mehrota, Neha Kumra, en Ankita Gandhi. 2014. *India's Fragmented Social Protection System: Three Rights Are in Place; Two Are Still Missing.* Working Paper 2014-18, United Nations Research Institute for Social Development (UNRISD) (p.15).

[18] Indian Census 2011. 2011. "List of states with Population, Sex Ratio and Literacy Census 2011." *Census 2011.* http://www.census2011.co.in/states.php.

[19] Health Management Information System (HMIS). 2015. "Performance of Key HMIS Indicators for Arunachal Pradesh."

[20] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Lower Subansiri."

man power, equipment and lifesaving drugs. The existing District Hospitals […] require upgradation in terms of physical infrastructure and essential supply."[21]

Secondly, regarding inequality based on gender, this fact finding report specifically looks into the quality, availability, and accessibility of maternal healthcare facilities in Lower Subansiri District, with a particular focus on the Raga Sub-District. With an approximate 45,000 maternal deaths per year, the country of India accounts for 15% of maternal deaths globally.[22] This clear indication of gender-based inequality to access in healthcare warrants a thematic focus on maternal health.

Thirdly, relating to inequality based on socio-economic status, this fact finding report scrutinises public healthcare facilities, in the form of the Primary Health Centre (hereinafter "PHC") in Raga. Primary health centres constitute the second-most decentralised form of public healthcare facilities in India (only above Sub-Centres). They play a vital role in people's access to healthcare, as they represent the first point of reference for the vast majority of the population covered. They have a mandate and duty to provide primary healthcare services to all people, independent of any individual's socio-economic status. The Primary Health Centre in Raga thus provides a good object of study to inspect the enjoyment of maternal healthcare care for women across socio-economic strata.

In short, this fact finding report will research people's enjoyment of the right to health within a geographically, thematically and institutionally challenging context:

- Geographical focus: Raga Sub-District, Lower Subansiri District, Arunachal Pradesh
- Thematic focus: maternal and child health
- Institutional focus: Raga Primary Health Centre (public healthcare facilities)

[21] Department of Planning, Government of Arunachal Pradesh. n.d. *A Development Profile of Arunachal Pradesh.* Itanagar: Department of Planning, Government of Arunachal Pradesh (p.18).

[22] World Health Organization. 2015. *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.* Geneva: World Health Organization (p.xi).

1.1 State Profile: Arunachal Pradesh

One of India's most remote States, Arunachal Pradesh is also one of the country's most sparsely populated States. ARP lies for a large part in the Himalayas, covering a total area as big as 83,743 sq. km and an estimated population of 1,441,716[23]. Almost three-quarters of households in the State reside in rural rather than urban areas[24]. The rugged and undulating terrain in combination with the innumerable rivers and streams make physical transport and communication largely difficult.[25] Infrastructural options are likewise very limited, as ARP does not have an airport and only a minimal connection to the Indian Railway.[26]

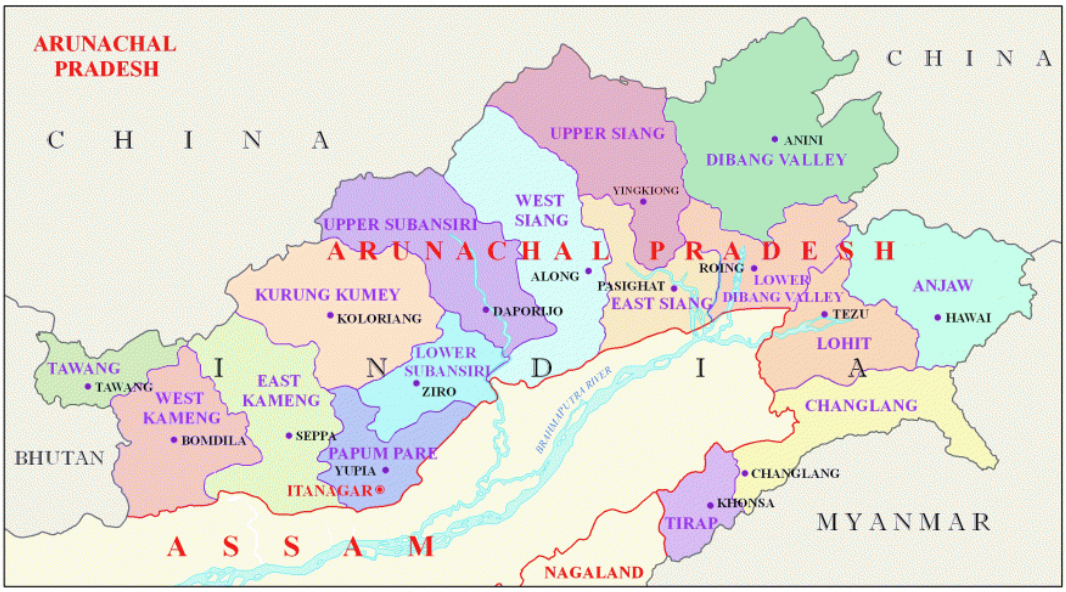


Figure 1 – Map of the State of Arunachal Pradesh

These natural features of ARP determine the State's socio-economic development dilemmas. With its large rural population, agriculture is the primary driver of the economy. Disparities in urban and rural development are significant. Figure 2 demonstrates how ARP has one of the lowest Rural Human Development Indexes (HDI) of all Indian States. Even more worrisome is the indication that rural human

[23] Health Management Information System. 2015. *HMIS State Factsheet Arunachal Pradesh: Year 2013-14 & 2014-15.* Health Management Information System.

[24] International Institute for Population Sciences (IIPS) and Macro International. 2009. *National Family Health Survey (NFHS-3), India, 2005-06: Arunachal Pradesh.* Mumbai: IIPS (p.2).

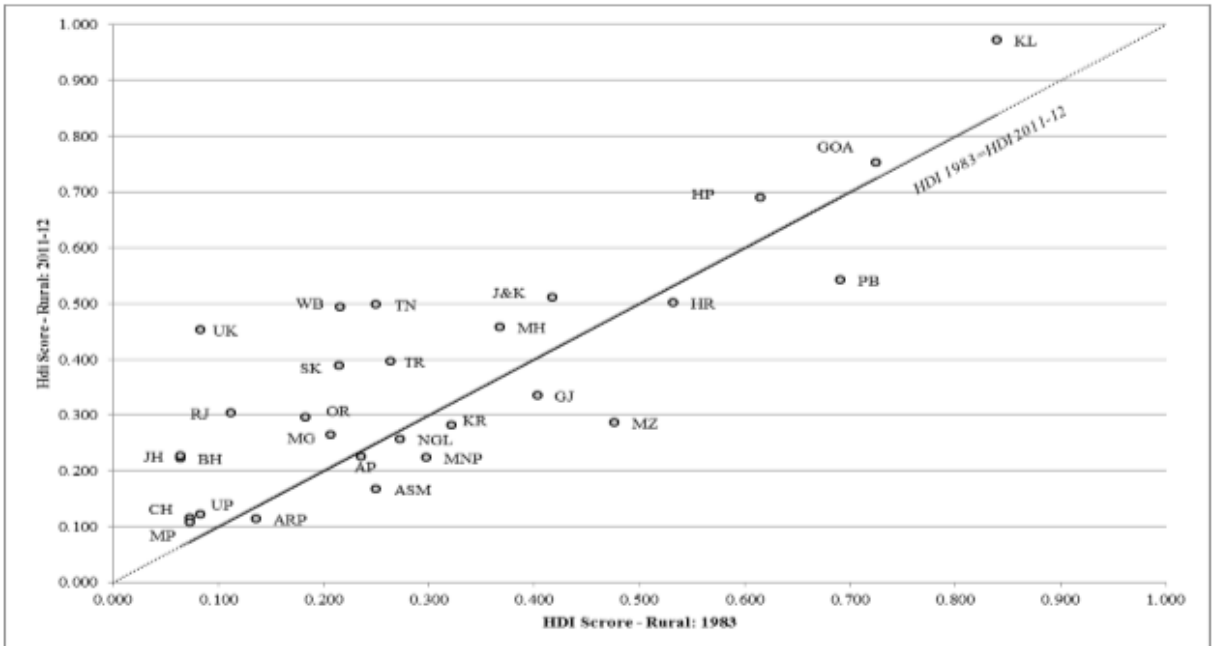
[25] Department of Planning, Government of Arunachal Pradesh. *A Development Profile of Arunachal Pradesh* (p.2).

[26] State Programme Management Unit (NUHM) O/o MD (NHM), Government of Arunachal Pradesh. 2016. *National Urban Health Mission Programme Implementation Plan 2015-2016.* Naharlagun: Government of Arunachal Pradesh (p.6).

development has seen little progress since 1983.[27] Furthermore, ARP has the lowest literacy rate of all North-eastern States, especially amongst rural populations.[28]

For 83% of households in ARP, the public medical sector is the main source of health care (88% of rural households). Among households that do not use government health facilities, the principal reasons given for not doing so are lack of a nearby facility (50%) and poor quality of care (37%). There is a strong correlation between wealth and the use of private facilities, indicating that wealthier people are more likely to access nearby private healthcare facilities, which offer a good quality of care.[29] Widespread access to wealth, education, and most notably health all contribute to ARP's low performance in terms of human development.

Figure 2: Rural HDI performance of the Indian states (comparison between 1983 and 2011-12)



[27] Sacchidananda Mukherjee, Debashis Chakraborty, and Satadru Sikdar. 2014. *Three Decades of Human Development across Indian States: Inclusive Growth or Perpetual Disparity?* Working Paper No. 2014-139, New Delhi: National Institute of Public Finance and Policy (p.13).

[28] Ministry of Development of North Eastern Region. 2011. "Literacy Rates 2001, 2011 - by gender." *Ministry of Development of North Eastern Region.* http://www.mdoner.gov.in/content/literacy-rates-2001-2011-%E2%80%93-gender.

[29] International Institute for Population Sciences (IIPS) and Macro International. *National Family Health Survey (NFHS-3)* (p.24).

From the State level to the local level, the healthcare infrastructure in ARP is organised as follows: State Hospital, District Hospitals (DHs), Community Health Centers (CHCs), Primary Health Centers (PHCs), and Sub Centers (SCs). The table below gives an overview of the quantities of each type.

Figure 3 – Public healthcare facilities in Arunachal Pradesh	
Type of healthcare facility	**Number of facilities**
State Hospital	1
District Hospital	14
Community Health Centers	52
Primary Health Centers	117
Sub Centers	286

1.2 District Profile: Lower Subansiri

Arunachal Pradesh is made up of 16 districts. The district of Lower Subansiri is comparatively close to the State capital Itanagar. The topography of the district is mostly mountainous terrain, where the Hill Ranges vary approximately from 1000 to 1600 metres above sea level.[30] The District Headquarter is in the town of Ziro (Hapoli), which ought not to be confused with Old Ziro (located in the same district). Lower Subansiri has a total estimated population of 86,510.[31]

The table below gives an overview of the different health care facilities that exist (and are operational) in Lower Subansiri District.

Figure 4 – Public healthcare facilities in Lower Subansiri	
Type of healthcare facility	**Number of facilities**
State Hospital	0
District Hospital	1
Community Health Centers	2
Primary Health Centers	7
Sub Centers	18

[30] National Informatics Centre, Lower Subansiri Unit, Ziro. n.d. "Physiography." *Official Website of Lower Subansiri District.* http://lowersubansiri.nic.in/html/physiography.htm.

[31] Health Management Information System (HMIS). 2015. *District Factsheet: Maternal and Child Health Indicator (2013-14 & 2014-15): Arunachal Pradesh, Lower Subansiri.* Health Management Information System.

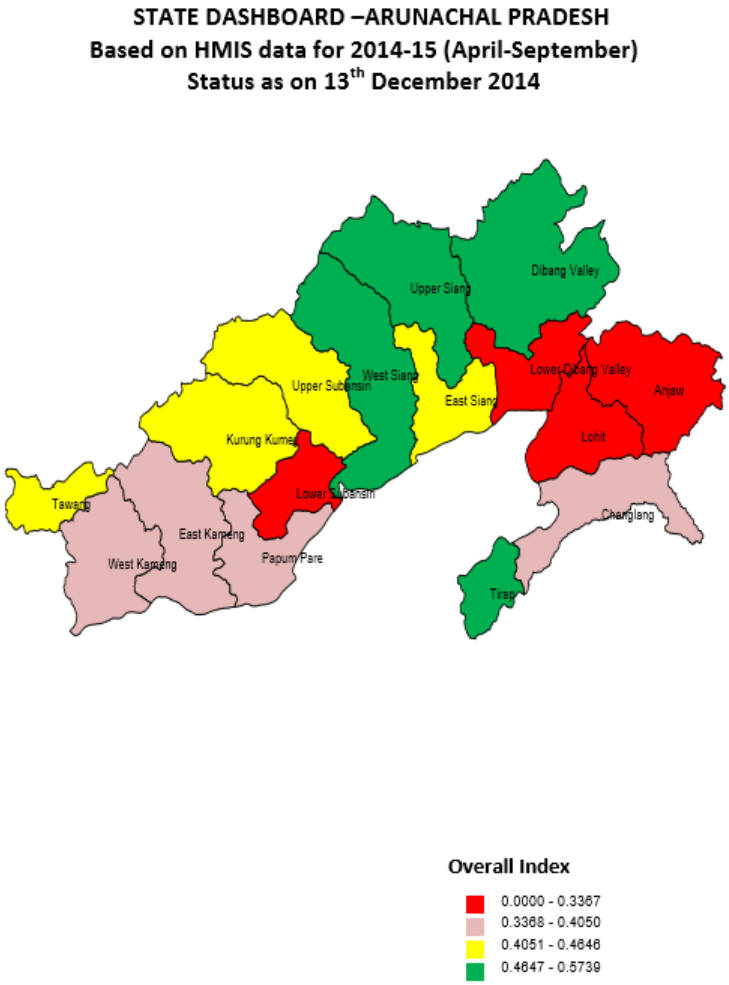
In spite of its relative vicinity to Itanagar, Lower Subansiri is one of the worst performing district in terms of maternal and child healthcare performance. Figures 5 and 6, which are based on the most recent HMIS data, show that Lower Subansiri belongs to the bottom two districts in the Overall Index rankings.

When taking a closer look at the performance in the different categories that make up this composite index, it becomes apparent that Lower Subansiri scores worst in providing adequate postnatal maternal and new born care to its citizens. Figure 7 gives a quantification of this performance.

Figure 5 – Table of Overall HMIS Index per ARP District

District	Overall Index	
	2014-15 (Apr-Sep)	2013-14 (Apr-Sep)
Dibang Valley	0.5581	0.5611
Tirap	0.4754	0.544
Upper Siang#	0.5739	0.5333
West Siang	0.4819	0.5032
Tawang	0.4363	0.5008
Upper Subansiri#	0.4259	0.4108
East Siang	0.4538	0.3912
Kurung Kumey#	0.4465	0.5331
Changlang#	0.3841	0.4236
East Kameng#	0.3594	0.3166
Papum Pare	0.3429	0.4772
West Kameng	0.3796	0.4157
Lohit#	0.330	0.4567
Lower Dibang Valley	0.3227	0.5152
Lower Subansiri#	0.1648	0.2743
Anjaw	0.3304	0.3157

Figure 6



Rank	District	Composite Index (April 2014-September 2014)				
		Overall Index	Pregnancy care	Child Birth	Postnatal maternal & new born care	Pre Pregnancy/ Reproductive age group
1	Dibang Valley	0.5581	0.3055	0.1487	0.4626	0.3333
2	Tirap	0.4754	0.3729	0.2626	0.4986	0.3333
3	Upper Siang#	0.5739	0.6886	0.5015	0.5963	0.3333
4	West Siang	0.4819	0.5201	0.2382	0.2872	0.3333
5	Tawang	0.4363	0.5059	0.8423	0.2277	0.3551
6	Upper Subansiri#	0.4259	0.5832	0.1557	0.5522	0.3333
7	East Siang	0.4538	0.2995	0.2161	0.4296	0.3285
8	Kurung Kumey#	0.4465	0.2815	0.4429	0.3958	0.1495
9	Changlang#	0.3841	0.0317	0.0306	0.3153	0.2697
10	East Kameng#	0.3594	0.2603	0.6071	0.3963	0.1274
11	Papum Pare	0.3429	0.5553	0.1783	0.5395	0.3238
12	West Kameng	0.3796	0.5539	0.195	0.6504	0.3333
13	Lohit#	0.33	0.6522	0.4672	0.7243	0.2995
14	Lower Dibang Valley	0.3227	0.3157	0.3585	0.5759	0.4267
15	Lower Subansiri#	0.1648	0.4891	0.3582	0.3106	0.3333
16	Anjaw	0.3304	0.5171	0.6457	0.4873	0.2505

Figure 7 – HMIS Composite Index (April 2014-September 2014 per ARP district

1.3 Sub-District Profile: Raga

Lower Subansiri District is divided into eight administrative sub-districts (also called circles).[32] One of these is Raga Sub-District. This sub-district is made up of 39 villages (the cities has no towns or cities) and covers a total number of 80 9 households, of which 1,281 persons live in the main village of Raga (H.Q.).[33] The entire community development block (CD Block) of Tame-Raga, which encompasses Raga Sub-District, comprises a total—entirely rural—population of 15,279.[34]

The medical infrastructure of the sub-district of Raga is made up of solely one Primary Health Centre, as well as various Anganwadi Centres (hereinafter "AWCs)". The Raga PHC is the first point of medical reference, both for emergency and non-emergency needs, for the entire population of the sub-district. The closest other public healthcare facilities are Ziro District Hospital in Ziro (Hapoli) and the Community Health Centre in Old Ziro, which are both at considerable distance from Raga PHC.

[32] Census of India 2011. 2011. *District Census Handbook: Lower Subansiri.* Series-13 Part XII-B, Directorate of Census Operations Arunachal Pradesh (p.9).

[33] *Ibid.* (p.102; p.122).

[34] *Ibid.* (p.22).

The most recent HMIS data give a clear indication of the worrisome maternal health situation in Raga Sub-District. Statistics on three key maternal health topics in the sub-district of Raga suffice to demonstrate this. Firstly, only 39.4% of the total antenatal care (ANC) registrations happen during pregnant women's first trimester. Secondly, of all the ANC-registered pregnant women, solely 8.00% opts for an institutional delivery. Thirdly, a mere 36.1% of women receive post-partum check-ups (PNC) within the first 48 hours after delivery.[35] These statistics on ANC, institutional delivery, and PNC all specify the substandard nature of access to maternal healthcare in Raga Sub-District.

Based on the abovementioned statistics, it becomes apparent that Raga Sub-District is a critical area of concern in Lower Subansiri. In turn, Lower Subansiri is one of the worst performing districts in terms of (maternal and child) healthcare facilities, within what might be India's most remote and infrastructure-wise underdeveloped States. These indications strongly warrant further research about the district's current state of public health facility, as well as an analysis of the key shortcomings in this facilitation from a human rights-based approach.

[35] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Lower Subansiri."

2. Methodology

In light of the statistical data about both Arunachal Pradesh and Lower Subansiri, which have been presented in the introduction, this fact finding report seeks to investigate the fulfilment of the right to health, in the form of the Indian Public Health Standards, in Raga Sub-District, Lower Subansiri District, ARP.

Seeing as the IPHS are very extensive and encompass a broad range of health-related themes, this fact finding report focuses thematically on maternal health, the rationale for which has been elaborated on in the introduction. Both on the national and international level, maternal health is often referred to as a key component of public health, particularly in the context of developing countries. The reduction of the Maternal Mortality Rate and the Infant Mortality Rate across India is one of the primary goals of the National Rural Health Mission.[36] Various other national health programmes hold the reduction of maternal health-related problems as a central objective.

In addition to a geographical and thematic focus, this fact finding report will institutionally focus on the Primary Health centre in Raga. This hospital constitutes the principal public health facility in Raga Sub-District and thus plays a crucial role in providing adequate decentralised healthcare and in respecting the IPHS Guidelines. For this reason, any fact finding research on maternal healthcare in Raga Sub-District should first of all focus on Raga Primary Health Centre.

After having explained the rationales behind the focus points of the fact finding, this report will now elaborate on the Indian Public Health Standards. These standards constitute the central methodological framework for this research, which will be used to assess people's enjoyment of the right to health.

2.1 Indian Public Health Standards

The Indian Public Health Standards were created to improve the quality of healthcare under the National Rural Health Mission (NRHM) throughout India. The performance of healthcare facilities are assessed against set standards. The IPHS thus serves as a framework which seeks to enhance uniformity and monitoring of the minimum quality level of care that is necessary for public health facilities on all levels. Under IPHS, Indian health care delivery is organised at three levels, namely primary, secondary and tertiary, i.e. in the form of PHCs, CHCs and DHs, which also includes sub-centres and sub-district hospitals. IPHS lays down minimum requirements such as healthcare services, staffing, furniture, equipment, infrastructure, medicines, and hygiene, which every single health institution in the country should provide for.

[36] National Rural Health Mission (NRHM). n.d. "National Rural Health Mission: Mission Document (2005-2012)."

"[The] Primary Health Centre is the cornerstone of rural health services, a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report [to] or [are] referred from Sub-Centres for curative, preventive and promotive health care."[37]

A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas. Primary Health Centres act as a referral unit for 6 Sub-Centres and refer out cases to CHCs (30-bedded hospitals), as well as District Hospitals, if the medical conditions of a patient so require. [38] PHCs can be divided into two types: Type A and Type B. Type A PHCs have an annual delivery load of less than 20 deliveries, whereas Type B PHCs have a higher delivery load.

According to the IPHS Guidelines, PHCs should provide for all "Minimum Assured Services" (or "Essential Services"), which is necessary to bring the PHC to a minimum acceptable grade. "Desirable Services" are elements for further improvement of service delivery. The main essential medical care services are OPD services, 24 hours emergency services, referral services, and in-patient services (6 hospital beds).[39] When it comes to maternal and child health the IPHS require PHCs to arrange for antenatal care, intra-natal care, basic first aid treatment for PH, eclampsia, sepsis and prompt referral, postnatal care, new born care, care of the child, and family welfare.[40] Additional essential medical services are also included in the IPHS Guidelines for PHCs.

In addition to medical services requirements, the IPHS obliges PHCs to follow essential services in the domains of infrastructure, manpower, drugs, transport facilities, laundry services, dietary facilities for indoor patients, waste management, quality assurance, monitoring of PHC functioning, accountability, and statuary and regulatory compliance.

In conclusion, the Primary Health Centre has three main objectives under the Indian Public Health Standards:

- To provide comprehensive primary health care to the community through the Primary Health Centres
- To achieve and maintain an acceptable standard of quality of care.
- To make the services more responsive and sensitive to the needs of the community.[41]

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[37] Directorate General of Health Services, Ministry of Health & Family Welfare. 2012. *Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres (Revised 2012).* Directorate General of Health Services, Ministry of Health & Family Welfare (p.1).

[38] *Ibid.* (p.1).

[39] *Ibid.* (p.4).

[40] *Ibid.* (p.5-7).

[41] *Ibid.* (p.4).

2.2 Fact Finding Research

The research for this fact finding report was conducted by a team of lawyers and social activists of the Human Rights Law Network (HRLN), who visited Raga Primary Health Centre in February 2016. In addition, other health facilities in the Lower Subansiri District were visited during the same fact finding mission The findings of these other visits however fall outside of the scope of this fact finding report and will therefore not be discussed here.

The visit to Ziro District Hospital consisted of three main methodological approaches:

- A physical inspection of the district hospital's premises in their current state
- Interviews with healthcare workers at Raga Primary Health Centre, including but not limited to doctors, nurses, specialists, and administrative staff
- Interviews with patients who are sitting in the designated waiting areas and are awaiting medical treatment or consultancy

The identities nor the specific designations are disclosed in the fact finding report for reasons of privacy.

3. Results and Discussion

The fact finding research was carried out in accordance to the methodology, as described in the previous chapter. Firstly, some general observations of Raga Primary Health Centre can be made. The health centre has 10 beds and delivers an average of 223 OPD (Out Patient Department) services per month and an average of 2 IPD (In Patient Department) services per month.[42] Furthermore, only 2 normal institutional deliveries took place at Raga PHC in the period 2014/2015 (12 months).[43] This makes Raga PHC a Type A PHC, in accordance with the IPHS Guidelines.[44] This type determines the specific IPHS provisions that Raga PHC falls under, particularly when it comes to staff capacity. Officially, the PHC is a 24/7 operational healthcare facility, but in reality no emergency infrastructure is available. The total fund proposal for the year 2014/2015 was 2,400,000 rupees (24 lac).[45]

Figure 8 gives an overview of all the medical staff employed at Raga PHC, based on the information provided during the fact finding research, in combination with the 2015/2016 Arunachal Pradesh State Programme Implementation Plan (hereinafter "PIP") data.

Figure 8 – Medical Staff at Raga Primary Health Centre (as per February 2016)

Medical staff function	**Current number of staff**	**IPHS Guidelines minimal essential manpower requirements**
Medical Officer (MBBS)	2	1
Homoeopathist	1	1 (Pharmacist)
General Nursing Midwife (GNM)	3	3
• *Regular*	*1*	
• *Contractual*	*2*	
Auxiliary Nurse Midwife (ANM)	1	1
Laboratory Technician (LT)	1	1

[42] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015.

[43] *Ibid.*

[44] Directorate General of Health Services, Ministry of Health & Family Welfare. *Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres (Revised 2012)* (p.4).

[45] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015.

Based on the main observations and outcomes of the fact finding research, the following five central elements of concern can be identified:

1. Ambulance and mobility
2. Medicines and surgical equipment
3. Antenatal care
4. Institutional delivery
5. Postnatal care

By combining the findings from the fact finding research with an in-depth academic literature and statistical study, a comprehensive account of these six issues can be given. The results and discussion of each central issue will now be presented one by one.

3.1 Ambulance and Mobility

Physical inspection at Raga PHC pointed out that the PHC does not have an ambulance. The medical staff could not indicate with certainty whether an ambulance will become available in the foreseeable future. This Flow Chart of the Emergency Department (Figure 9), based on the IPHS Guidelines for District Hospitals clearly demonstrates the central role played by ambulances in the identification triage of emergencies. The absence of ambulance facilities thus structurally disrupts the working flow of the emergency department, as stipulated by the IPHS Guidelines.[46]

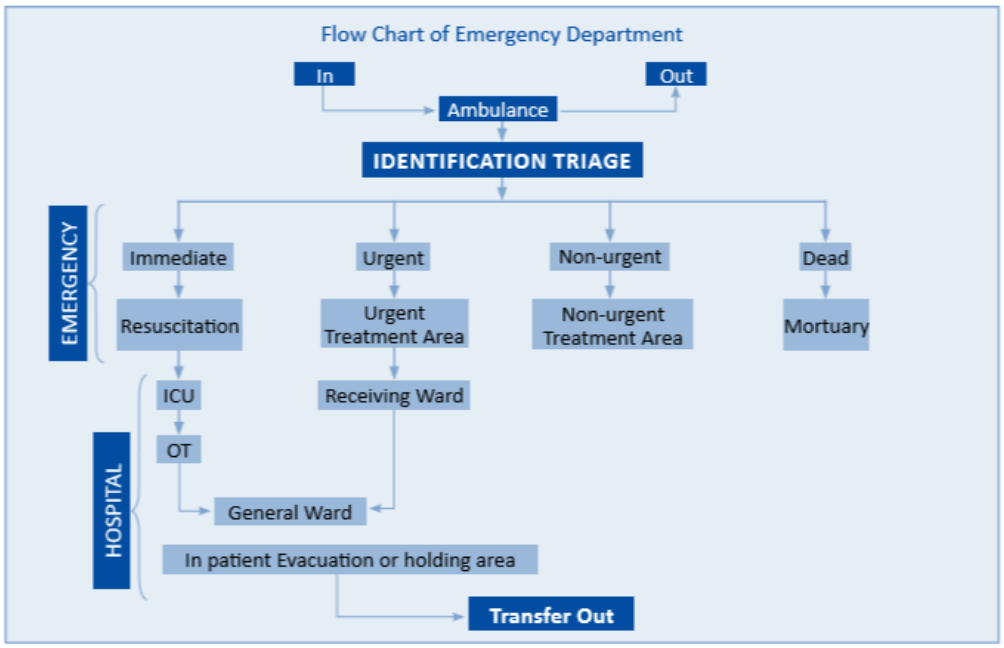


Figure 9

According to the IPHS Guidelines for PHCs on the referral transport facility, *"It is desirable that the PHC has ambulance facilities for transport of patients for timely and assured referral ton functional*

[46] Directorate General of Health Services, Ministry of Health & Family Welfare. *Indian Public Health Standards (IPHS): Guidelines for District Hospitals (101 to 500 Bedded)* (p.33).

FRUs in case of complications during pregnancy and child birth."[47] The lack of an ambulance at Raga PHC is particularly worrisome due to the fact that there has been no ambulance present at the Ziro District Hospital for the last 15 years.[48] In other words, the people who live in Raga Sub-District do not have access to any ambulance services, neither at the sub-district level nor at the district level. The completely lack of ambulances within Raga Sub-District is astounding when one takes into account the fact that as of 30 April 2013 the Government of Arunachal Pradesh has had a total of 142 Government Ambulances, of which 125 are functional.[49] It is not clear why none of these 125 ambulances are deployed in Raga Sub-District or in other parts of the Lower Subansiri District.

Figure 10 – Access to Transportation in Raga Sub-District

	Bicycle	**Scooter/Motor Cycle/Moped**	**Car/Jeep/Van**
Percentage of total Raga Sub-District population with access to transportation type	1.48%	7.79%	7.66%

Figure 10 gives an overview of the three main types of transportation in Raga Sub-District and the percentage of the total population with access to each type. The fact that the great majority of all residents do not have access to any motorised vehicles underscores the importance of public referral transport facilities, in the form of an ambulance. Currently, people who reside in Raga Sub-District are supposed to arrange their own means of travel to Raga PHC or other public healthcare facilities in case of emergency, including child delivery. This constitutes a second obstacle in mobility from and to Raga PHC, in addition to the problematic lack of ambulances.

A third obstacle arises due to the appalling state of most roads. "The State is still quite deficient due to inadequate capacity, poor geometric, poor riding quality, weak and distressed bridges and presence of a number of semi-permanent timber bridges and lack of wayside amenities. […] Out of 3863 villages, only 1743 are connected by road."[50] The vast majority of roads are unsurfaced in Lower Subansiri and there is only a very limited connection between the district and the national highway.[51] Seeing as Raga

[47] Directorate General of Health Services, Ministry of Health & Family Welfare. *Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres (Revised 2012)* (p.17).

[48] This was discovered during the fact finding visit to Ziro District Hospital in February 2016.

[49] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. "RRCNES State Profile: Arunachal Pradesh."

[50] Department of Planning, Government of Arunachal Pradesh. *A Development Profile of Arunachal Pradesh* (p.14).

[51] Omeo Kumar Das Institute of Social Change and Development (OKDISCD): Guwahati. n.d. "Baseline Survey of Minority Concentrated Districts: District Report Lower Subansiri." (p.17).

Primary Health Centre only arranges for basic medical services, patients will need to turn to the Ziro District Hospital for more advanced medical services. However, even the District Hospital in Ziro cannot provide all medical services. For this reason many patients find themselves required to head to the Arunachal State Hospital in Naharlagun, if they require certain medical services not offered at Raga PHC or Ziro DH. The triple obstacle that arises from the absence of ambulances, personal motorised vehicles, and proper infrastructure thus contributes to a myriad of limitations to people's access to health. Above all, it inhibits pregnant women to opt for an institutional delivery, to arrive at Raga PHC quickly in case of pregnancy-related urgencies, or to be referred to other public healthcare facilities in a swift manner.

3.2 Medicines and Surgical Equipment

Through interviews with the medical staff at Raga PHC, it was discovered that one of the main obstacles faced by the health centre is the supply of medicines and proper surgical equipment. Numerous essential medicines were not available at the PHC at the time of the fact finding mission. This is hugely problematic, as it structurally impedes the proper delivery of any type of medical service at the PHC, including ANC, institutional delivery, and PNC. Particularly the deficiencies in the supply of IFA tablets is very worrisome, as this medicines is an important component for ANC.

When it comes to the supply and access to the medicines, a serious discrepancy exists between theory and reality. According to the Arunachal Pradesh State PIP 2015-16, there are no identified obstacles or irregularities in the supply of medicines to Raga PHC. Because of this clearly erroneous representation of reality, it seems unknown to the State government that this problem exists. For this reason, no measures are taken to ameliorate the present situation.

Furthermore, there is a shortage of essential surgical equipment at Raga PHC. Upon physical inspection of the operation rooms, the present surgical equipment is in an unhygienic and overall unsatisfactory state.

Finally, various premises within Raga PHC also proved to be in a highly unhygienic condition. As stated in the ICSSR District Report of Lower Subansiri in 2008 already on the topic of hygienic facilities: "The overall scenario of the district has been marked by unhygienic and unhealthy practices."[52]

The two pictures on the next page were taken during the fact finding visit to Raga PHC and show the state of hygiene of both surgical equipment and waste management. They are a clear demonstration of the fact that the minimum standards for hygiene are currently not being satisfied at Raga PHC.

[52] Omeo Kumar Das Institute of Social Change and Development (OKDISCD). "Baseline Survey of Minority Concentrated Districts: District Report Lower Subansiri." (p.21).

Picture 1 - Surgical Equipment Raga PHC

Picture 2 - Waste Management Raga PHC 1

3.3 Antenatal Care (ANC)

As explained in the introduction chapter, Lower Subansiri is one of the worst performing districts in Arunachal Pradesh, in terms of maternal and child health. Furthermore, Raga Sub-District performs badly in terms of ANC, institutional delivery, and PNC. While discussing the main outcomes of the fact finding research in this regard, it is worth to present some more statistical information to illustrate the current state of maternal healthcare in Raga Sub-District and Lower Subansiri District. Extensive data on the 2015/2016 HMIS Key Indicators on both Sub-District, District, and State Level gives the most relevant and up-to-date statistical information in this regard.

The percentage of women in Lower Subansiri who register for antenatal care during their first trimester is only 37.4%. Furthermore, solely 38.3% of pregnant women receive the recommended total of three ANC check-ups, which constitutes full antenatal care.[53]

Zooming in on Raga Sub-District, the situation is equally troublesome. Based on the most recent HMIS data on Sub-District level, the 175 pregnant women registered for ANC in 2015/2016, only 69 registered during their first trimester.[54] This is the equivalent to 39.4% of all ANC-registered pregnant women (see Figure 11).

[53] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Arunachal Pradesh."

[54] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Lower Subansiri."

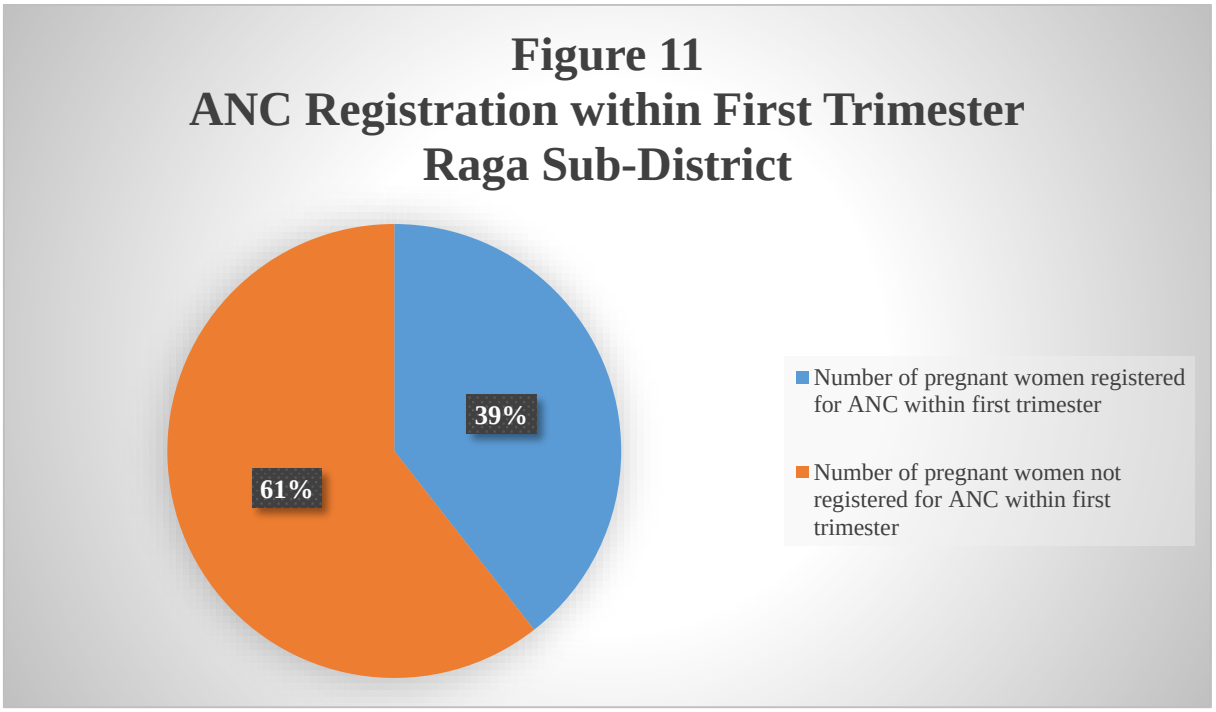


Figure 12 shows the total number of ANC registration at Raga PHC in 2015. This information was collected during the fact finding mission and is based on the health centre's administration. The data indicates that only 43.2% of total ANC-registered pregnant women register at Raga PHC during their first trimester. Due to this delay in registration for the majority of pregnant women, their access to proper ANC is limited.

Figure 12 – Total ANC registration at Raga PHC in 2015

Month	Total ANC registration	1st trimester	2nd trimester	3rd trimester	4th trimester
January	3		2	1	
February	4	2	2		
March	10	7	2	1	
April	2	5			
May	0				
June	1			1	
July	3	3			
August	10	8	2		
September	15	4	9	2	
October	11	2	6	3	1
November	9	1	5	3	
December	6		2	3	1
TOTAL	**74**	**32 (43.2%)**	**30 (40.5%)**	**14 (18.9%)**	**2 (0.03%)**

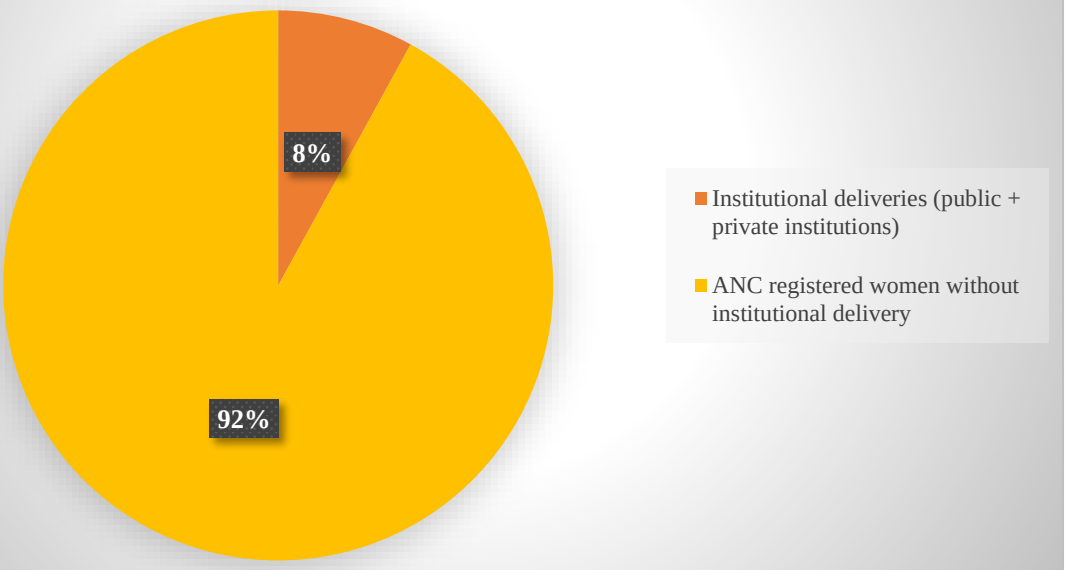
Quality antenatal care is of major importance to improve maternal healthcare and to prevent maternal deaths in India. "Antenatal care (ANC) is the systemic supervision of women during pregnancy to monitor the progress of growth of the baby and to ascertain the well-being of the mother and the child.

A proper antenatal check-up provides necessary care to the mother and helps identify any complications of pregnancy such as anaemia, pre-eclampsia and hypertension etc. in the mother and slow/inadequate growth of the child. Antenatal care allows for the timely management of complications through referral to an appropriate facility for further treatment. It also provides opportunity to prepare a birth plan and identify the facility for delivery and referral in case of complications".[55] Thus, maternal deaths can be prevented if a pregnant woman receives proper antenatal care.

3.4 Institutional Delivery

The ratio of institutional deliveries against the total number of ANC registered pregnant women is only 43% in Lower Subansiri, compared to 59.8% for the whole of Arunachal Pradesh. Of the already undesirably high percentage of home deliveries in Lower Subansiri, only 24.1% is attended by a Skilled Birth Attendant (SBA), compared to a 60.6% State average for Arunachal Pradesh. The percentage of total reported deliveries that can be categorised as safe deliveries is only 85.4% in Lower Subansiri, whereas on the State level this percentage lies much higher at 97.2%.[56] The most common place of delivery is at home, rather than at a public health facility.[57]

Figure 13
Institutional Deliveries to ANC Registration
Raga Sub-District

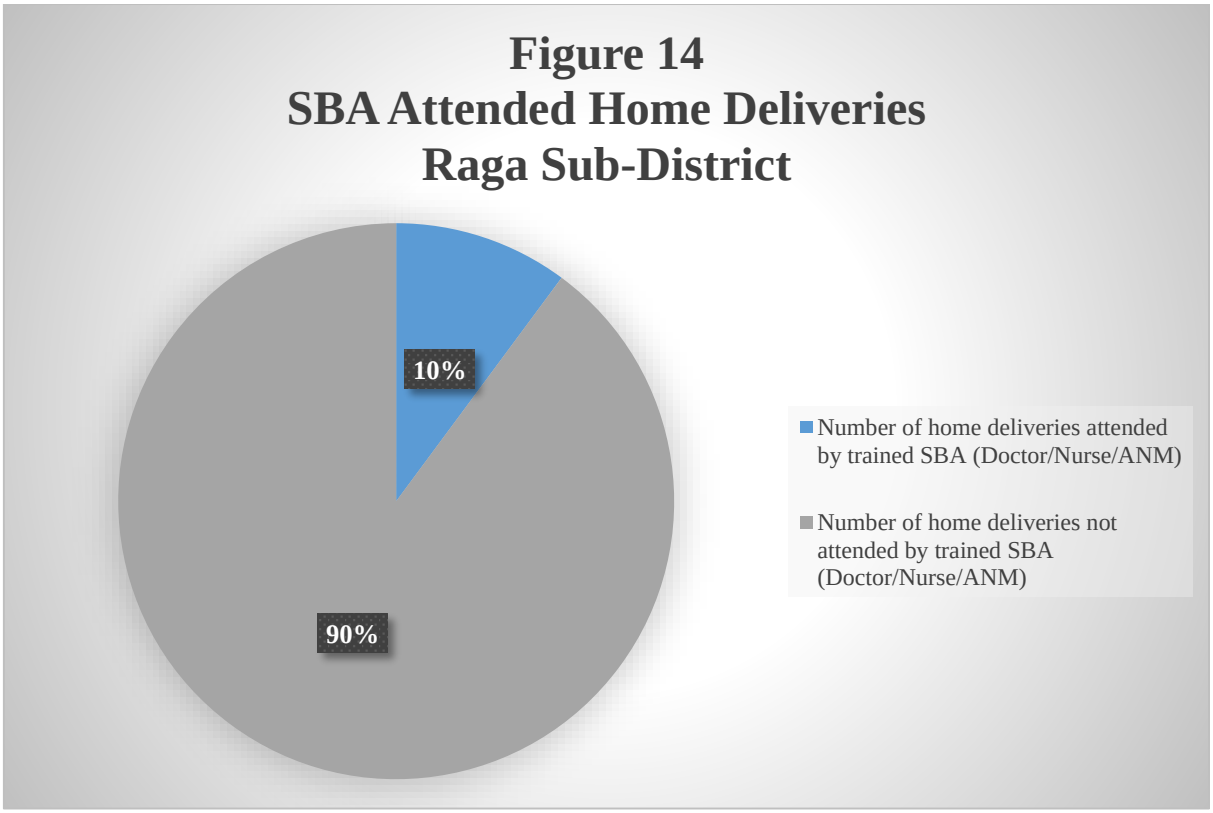


[55] Ministry of Health and Family Welfare. 2010. "Guidelines for Antenatal Care and Skilled Attendance at Brith by ANMs/LHVs/SNs."

[56] *Ibid.*

[57] International Institute for Population Sciences. *District Level Household and Facility Survey (DLHS-4): State Fact Sheet Arunachal Pradesh (2012-2013).*

Within Raga Sub-District the rate of institutional deliveries is terribly low. In 2015/2016, of the 175 ANC-registered women, only 14 delivered their child in an institutional facility. This constitutes only 8% (see Figure 13).



Of the home deliveries, which constitute the great majority of deliveries, only 10% is attended by an SBA. In 2015/2016 (12 months) there were merely two institutional deliveries at Raga PHC, according to the Arunachal Pradesh State PIP 2015-16.[58] It can be concluded that the extreme majority of deliveries in Raga Sub-District take place at home without any professional medical assistance. The position of Raga PHC is essential when it comes to providing institutional delivery care, given the fact that there are no registered private healthcare facilities within Raga Sub-District.[59] In other words, all institutional deliveries will have to take place at public healthcare facilities, most notably Raga PHC.

These highly troublesome statistics clearly indicate underlying causes for maternal mortality. As stated in the 2014-2018 Working Paper by the United Nations Research Institute for Social Development named *India's Fragmented Social Protection System: Three Rights Are in Place: Two Are Still Missing*, "[a]cross India, high maternal mortality rates are attributable to the large number of non-institutional

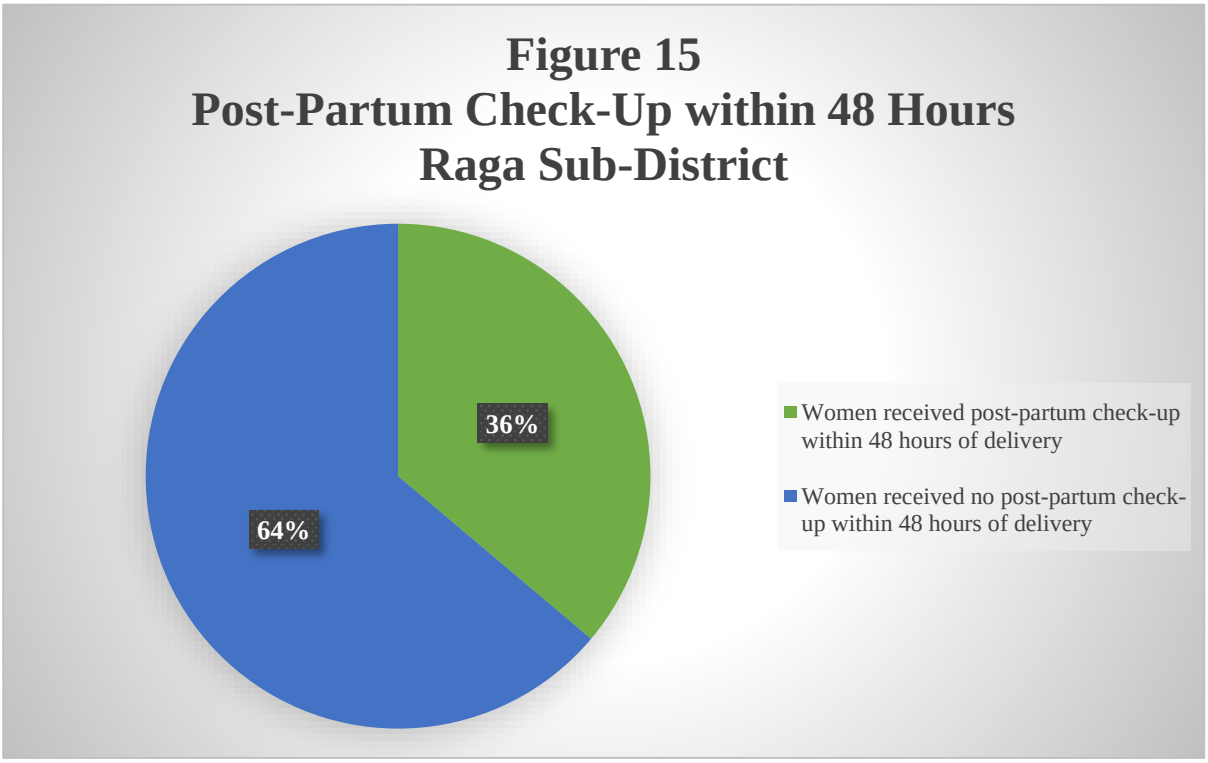
[58] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16.

[59] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Lower Subansiri."

deliveries."[60] Improving women's access to healthcare facilities for institutional delivery therefore constitutes a major step in the struggle against maternal mortality in India.

3.5 Postnatal Care (PNC)

In Lower Subansiri only 47.8% of delivering women receive post-partum check-up within 48 hours of delivery, compared to 56.6% Arunachal Pradesh State average. Moreover, only 31.4% of delivering women in Lower Subansiri get a post-partum check-up between 48 hours and 14 days after delivery.[61] One of Arunachal Pradesh' State targets for 2016/2017 is to receive a total of 220 woman per year post-partum check-up within timespan of 48 hours to 14 days after delivery.[62] However, according to HMIS 2014/2015, this number is still only 114. [63] Within Raga Sub-District, of the 83 reported deliveries in 2015/2016, only 30 women received a post-partum check-up within 48 hours of delivery. This amounts to a mere 36.1% of all delivering women (see Figure 15).



Amongst all essential maternal health services that PHCs should offer, the state of PNC at Raga PHC is undoubtedly the most substandard. During the fact finding visit, it became apparent that the Primary

[60] Santosh Mehrota et al. *India's Fragmented Social Protection System: Three Rights Are in Place; Two Are Still Missing* (p.12).

[61] Health Management Information System (HMIS). "Performance of Key HMIS Indicators for Arunachal Pradesh."

[62] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. "Lower Subansiri Annexures Service Delivery."

[63] *Ibid.*

Health Centre in Raga does not provide any PNC to women. This is an appalling violation of women's access to health, as PNC constitutes a crucial step in ensuring health child delivery for the mother. Instead, women in Raga PHC find themselves to either seek PNC elsewhere (e.g. at Ziro DH or at a private healthcare facility) or not to undergo any PNC at all, which can have medically destructive consequences.

The first 48 hours of the post-partum period, followed by the first one week, are the most crucial period for the health and survival both of the mother and her new-born child. Most of the fatal and near-fatal maternal and neonatal complications occur during this period. Evidence has shown that more than 60% of maternal deaths take place during the post-partum period.

The assessment of these three types of services gives a good overview of the overall state of maternal health: good-quality and accessible ANC, institutional (or assisted home) deliveries, and PNC. According to the State's technical strategies under the 2015/2016 PIP, patients from around the district are supposed to be referred to Ziro DH in case of complications surrounding ANC or other pregnancy-related conditions.[64] However, due to the structural shortcomings in mobility and infrastructure, the quick referral to Ziro DH is very often not feasible (see also Chapter 3.1 on Ambulance and Mobility). For the ostensible lack of alternative public healthcare facilities in the close vicinity of Raga PHC, this Primary Health Centre carries a large burden to provide quality care for the services of ANC, institutional deliveries and PNC. The current reality clearly shows that Raga PHC is the only direct healthcare provider for people in Raga Sub-District. If Raga PHC does not provide for good-quality and accessible medical (emergency) services, no other public health institution will.

3.6 Analysis of Underperforming Maternal Healthcare in Raga Sub-District

As has just been established, the district of Lower Subansiri and particularly the sub-district of Raga underperform in terms of ANC, institutional deliveries, and PNC. Based on the fact finding research, the principal direct cause for this seems to be an overall reluctance amongst pregnant women, women in labour, and mothers of new-borns to get hospitalised at Raga PHC. This is largely based on the flawed IPHS implementation at the health centre. Five main underlying factors can be identified.

Firstly, during interviews with Raga PHC staff members, it became apparent that there are no adequate heating facilities within the centre's premises. Considering the fact that Arunachal Pradesh has a cold climate during the winter, the lack of heating has two major consequences. Firstly, indoor patients with weak immune systems or a fragile health can face serious obstacles in their recovery or even new health problems due to persistent exposure to the cold. Secondly, the lack of heating facilities strongly

[64] Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. "Arunachal Pradesh Annexures Technical Strategies."

discourages people to head to Raga PHC in case of longer hospitalisation. This is especially the case for institutional delivery and postnatal care for women and new-borns. According to the medical staff informants, one of the principal reasons for pregnant women's reluctance to opt for institutional delivery or PNC at Raga PHC is the lack of heating during the cold winter season.

Secondly, the absence of a functional blood bank in the entire district of Lower Subansiri (including Ziro DH) strongly obstructs women's willingness to seek pregnancy-related medical services at the DH. In particular, it dissuades women from opting for institutional delivery at public healthcare facilities within the district, seeing as there are no appropriate structures in place to safely treat emergency situations, e.g. in case of severe anaemia and haemorrhage.

Thirdly, the lack of functional infrastructure and in Lower Subansiri and the long-time absence of an ambulance at Raga PHC (and Ziro DH) strongly inhibit women's mobility to travel to the necessary health facilities, both in case of emergency and in case of general hospital check-up, e.g. ANC.

Fourthly, the lack of essential medicines and surgical equipment dissuade women from going to public healthcare facilities. Many women are afraid that the PHC will not be able to solve pregnancy-related emergency situations in an appropriate manner, due to the shortcomings in medicines and equipment. Particularly the deficiencies in the supply of IFA tablets is very worrisome, as this medicines is an important component for ANC.

Fifthly, many women are not made aware of the importance of ANC, institutional delivery, and PNC for their own health and that of their new-born child. This was one of the main obstacles for successful maternal healthcare service delivery indicated by the medical staff at Raga PHC.

Observations during the fact finding research point out that women can only conceive of three alternatives to overcome the obstacles posed by the lacking health facilities at Raga PHC. However, each of these three alternatives faces new obstacles in return:

- Alternative 1: To opt for home delivery, instead of institutional delivery at Raga PHC
    - *Obstacle: Home deliveries are more susceptible to delivery complications, including maternal mortality and morbidity.*
- Alternative 2: Not to seek any ANC/PNC, for lack of awareness and availability
    - *Obstacle: ANC and PNC are both crucial and essential medical services, which play a key instrument in combatting maternal mortality and morbidity.*
- Alternative 3: To turn to Ziro District Hospital or Arunachal State Hospital in Naharlagun for ANC/PNC and/or institutional delivery
    - *Obstacle: The poor infrastructure between Raga, Ziro, and Naharlagun does not allow for quick movement in case of emergency. When it comes to institutional delivery, this alternative would almost require an anticipation of the time and date of delivery. This is not feasible for most pregnant women.*

4. Relevant Provisions under IPHS Guidelines

After presenting and discussing the five central elements of the fact finding research, it is now necessary to link each elements to its relevant provisions under the IPHS Guidelines. These IPHS provisions demonstrate how all the central elements must be present within Type A Primary Health Centres. All the provisions listed here below only cover essential services, rather than desirable services. In other words, they constitute the minimal threshold for district hospital service delivery. Every Type A Primary Health Centre should provide for these essential services listed below.

4.1 Medicines and Surgical Equipment

- IPHS Guidelines for PHC on Health Service Provision include: "Basic Medicines to take care of common ailments […]"[65]

- IPHS Guidelines for PHC Annexure 4 on "Essential Drugs for PHC" gives an exhaustive list of all essential drugs which should be present at any PHC[66]

- IPHS Guidelines for PHC Annexure 3 on "List of Suggested Equipment and Furniture Including Reagents and Diagnostic Kits" gives an exhaustive list of all necessary surgical equipment which should be present at any PHC[67]

4.2 Antenatal care

The IPHS Guidelines for PHC Objectives on Maternal and Child Health Care Including Family Planning read:[68]

- Early registration of all pregnancies ideally in the first trimester (before 12th week of pregnancy). However, even if a woman comes late in her pregnancy for registration she should be registered and care given to her according to gestational age. Record tobacco use by all antenatal mothers.

- Minimum 4 antenatal checkups and provision of complete package of services.
  Suggested schedule for antenatal visits:
  1st visit: Within 12 weeks—preferably as soon as pregnancy is suspected—for registration of pregnancy and first antenatal check-up.

[65] Directorate General of Health Services, Ministry of Health & Family Welfare. *Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres (Revised 2012)* (p.7).

[66] *Ibid.* (p.29-44).

[67] *Ibid.* (p.23-26).

[68] *Ibid.* (p.4).

2nd visit: Between 14 and 26 weeks.

3rd visit: Between 28 and 34 weeks.

4th visit: Between 36 weeks and term.

Associated services like providing iron and folic acid tablets, injection Tetanus Toxoid etc (as per the "guidelines for Ante-Natal Care and Skilled Attendance at birth by ANMs and LHVs) Ensure, at-least 1 ANC preferably the 3rd visit, must be seen by a doctor.

Early registration of all pregnancies ideally in the first trimester (before 12th week of pregnancy

- Minimum laboratory investigations like Haemoglobin, Urine albumin and sugar, RPR test for syphilis and Blood Grouping and Rh typing. iv. Nutrition and health counseling. Brief advice on tobacco cessation if the antenatal mother is a smoker or tobacco user and also inform about dangers of second hand smoke.

- Identification and management of high risk and alarming signs during pregnancy and labour. Timely referral of such identified cases to FRUs/ other hospitals which are beyond the capacity of Medical Officer PHC to manage.

- Tracking of missed and left out ANC.

- Chemoprophylaxis for Malaria in high malaria endemic areas for pregnant women as per NVBDCP guidelines.

4.3 Postnatal Care

The IPHS Guidelines for PHC Objectives on Maternal and Child Health Care Including Family Planning read:[69]

- Ensure post- natal care for 0 & 3rd day at the health facility both for the mother and new-born and sending direction to the ANM of the concerned area for ensuring 7th & 42nd day post-natal home visits. 3 additional visits for a low birth weight baby (less than 2500 gm) on 14th day, 21st day and on 28th day.

- Initiation of early breast-feeding within one hour of birth.

- Counseling on nutrition, hygiene, contraception, essential new born care (As per Guidelines of GOI on Essential new-born care) and immunization.

[69] *Ibid.* (p.5).

- Others: Provision of facilities under Janani Suraksha Yojana (JSY).

- Tracking of missed and left out PNC.

5. National and International Legal Protections

In addition to the State Government's obligations under the IPHS Guidelines, there are numerous other legal and policy protections which protect the citizens' rights to access healthcare in an equal manner, independent of socio-economic status, geography, gender, and other factors. Four categories of legal protections can be distinguished: constitutional protections, case law, national healthcare schemes and policies, and international legal protections. This chapter will gives an overview of the most important national and international legal protections and State obligations in the domain of the right to health.

5.1 Constitutional Protections

The Constitution of India has provided various rights to its people, who can avail these rights without any discrimination.

- Under Article 21 of the Constitution of India are guaranteed the right to life and personal liberty, including the right to health and medical assistance, right to live with dignity, right to food, right to a clean environment, and right to adequate drugs, right to be free from torture and cruel, inhuman, or degrading treatment, and right to emergency health care. The Supreme Court held that preservation of human life is of paramount importance. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment is a violation of right to life guaranteed under Article 21of the Constitution.

- Article 14 guarantees equality before the law and equal protection by the law. The Supreme Court has described gender equality as one of the "most precious fundamental rights guaranteed by the Constitution of India."

- Article 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. It also empowers the state to make special provisions for women and children. While the burdens of pregnancy and childbirth are inequitably borne by women, the ability to reproduce should not increase women's chances of death, disability, or illness. There is no similar cause of death for young men in India. States should ensure and protect the life of a woman.

- Finally, Article 47 provides that the state should ensure the nutrition and the standard of living of its people and improve public health, which guarantees access to medical services, regardless of (socio-economic) status.

5.2 Case Law

The Supreme Court of India and various High Courts have issued orders and judgments to ensure women's reproductive rights, including the right to survive pregnancy, the state's duties and responsibilities to run and maintain health institutions, and to provide all medical services to which every person is legally entitled. The following case laws have set a strong precedent and legal

foundation for the improvement of public health in India, in general, and for the protection of maternal and child healthcare in India, in particular.

- In *Bandhua Mukti Morcha v. Union of India and Ors,* [AIR 1984 SC 802], the Supreme Court held that "right to live with human dignity' also includes right to "protection of health."

- In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal,* [1996 SCC (4) 37], the Supreme Court held that providing "adequate medical facilities for the people is an essential part" of the government's obligation to "safeguard the right to life of every person." It also held that it is the primary duty of a welfare state to ensure that medical facilities are adequate and available to provide treatment and if the state fails to do so, this constitutes a violation of right to life of the person who suffered from inadequate healthcare.

- In *Laxmi Mandal v. Deen Dayal Harinagar Hospital &Ors.,* [W.P. (C) 8853/2008], the Delhi High Court held that an inalienable component of the right to life is "the right to health, which would include the right to access government health facilities and receive a minimum standard of care. In particular, this would include the enforcement of the reproductive rights of the mother."

- In *Francis Coralie Mullin v. Union Territory of Delhi &Ors.*, [1981 (1) SCC 608], the Supreme Court held that the right to live with dignity and protection against torture and cruel, inhuman or degrading treatment are implicit in Article 21 of the Indian Constitution.

- In *Parmanand Katara v. Union of India &Ors.*,[1989 SCR (3) 997], the Supreme Court held that Article 21 of the Constitution casts the obligation on the state to preserve life. Every medical practitioner's duty is to treat emergency cases with expertise and never refuse to offer treatment for such cases.

- In *Consumer Education and Research Centre v. Union of India,* [1995 SCC (3) 43], the Supreme Court held that Article 21 of the Constitution of India includes a fundamental right to health, and that this right is a "most imperative constitutional goal".

- In *Sandesh Bansal vs. Union of India &Ors.*,[W.P. (C) 9061/2008] the Indore High Court concluded that timely health care is of the essence for pregnant women to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India. The Court held, "…[w]e observe from the material on record that there is shortage not only of the infrastructure but of the man power also which has adversely affected the effective implementation of the [National Rural Health Mission] which in turn is costing the life of

mothers in the course of mothering. It should be remembered that the inability of women to survive pregnancy and childbirth violates her fundamental rights as guaranteed under Article 21 of the Constitution of India. And it is primary duty of the government to ensure that every woman survives pregnancy and childbirth, for that, the State of Madhya Pradesh is under obligation to secure their life."

5.3 National Healthcare Schemes and Policies

- National Rural Health Mission (NRHM) was introduced in the year 2005 to provide effective health care facilities to states with weak health infrastructure. However, NRHM is now covered under the National Health Mission (NHM) in order to expand the health service facility to the entire nation with the objective *inter alia* to prevent and reduce maternal deaths in the country.

- Under the umbrella of NHM, the Government of India introduced Janani Suraksha Yojna (hereinafter "JSY") in 2005 with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women (Below Poverty Line ["BPL"] Women). It integrates cash assistance with antenatal care during the pregnancy period, institutional care during delivery, and postnatal care during the post-partum period. Under this scheme, cash assistance of Rs. 1400/- is for Rural Area and Rs. 1000/- for Urban Area has been provided to eligible pregnant women for giving birth in a government health facility. Moreover Rs. 500 are given to BPL women who give birth at home. Though JSY works as a safe motherhood intervention under the NHM, which focuses on reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women, until now safe motherhood remains a major challenge for the Government.

- Janani Shishu Suraksha Karyakarm (JSSK) was launched by the NRHM to improve the health care service by eliminating out-of-pocket expenses of pregnant woman and sick new-born children. Under this scheme, all pregnant women who come for delivery in a public health institution as well as their sick infants are entitled to free transport, free drugs, free diagnostic, free blood, and a free diet up to one year. It is the responsibility of the State Government to properly implement this scheme and to perform timely check-ups for better results.

- To develop the health care sector at the community level, Accredited Social Health Activists (ASHAs) have been introduced. They are the primary, accessible health workers, working for any health-related demands in deprived sections of the population, especially for women and children who find it difficult to access health services in rural areas. The ASHA Programme is expanding across States and has been particularly successful in bringing people back to the

public healthcare system. It has also increased the utilisation of outpatient services, diagnostic facilities, institutional deliveries and inpatient care.

5.4 International Legal Protections

In addition to legal protections in the Constitution, case law, and national health schemes and policies, India has signed and ratified various international treaties which provides international legal protections for the right to life, the right to health and other related human rights.. India as a party to these conventions has an obligation to fulfil their provisions. The relevant conventions which provide for the right to life and the right to health include the Universal Declaration of Human Rights (UDHR), Declaration of Alma-Ata, International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic Social and Cultural Rights (ICESCR), and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

- **Article 25(1) of the Universal Declaration of Human Rights (UDHR)**

  Art. 25(1) of UDHR stipulates that everyone has the right to an adequate standard of living including the right to health, which includes food, housing, and medical care with necessary social services and the right to security in the event of sickness, disability, old age etc.

- **Declaration of Alma-Ata**

  The International Conference on Primary Health Care was held in Alma Ata in 1978 and highlighted the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It urged governments, the WHO, UNlCEF, other international organisations, multilateral and bilateral agencies, nongovernmental organisations, funding agencies, and all health workers to support a national and international commitment to primary health care. It also garnered technical and financial support for health, particularly in developing countries. The conference called on all the aforementioned to collaborate in introducing, developing, and maintaining primary care in accordance with the spirit and content of this Declaration.

- **Article 12 of the International Covenant on Economic and Social and Cultural Rights (ICESCR)**

  The ICESCR was adopted by the United Nations General Assembly on December, 16, 1966 and entered into force on January 3, 1976. Article 12 of ICESCR establishes: “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” This Article lists some of the steps which are to be taken by State parties such as: the reduction of stillbirths and infant mortality; ensuring the healthy development of children; improving

environmental and industrial hygiene; the prevention, treatment and control of diseases; and access to medical care for all.

- **Article 10(h) and 12 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**

  CEDAW was adopted in 1979 and came into force in 1981. It deals with women's health, particularly reproductive rights. Article 10(h) states that women have the right to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." Article 12 of CEDAW relates to women's health. It obliges State parties: (1) to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and (2) to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." Article 14 mandates that State protect such rights for rural women: "[t]o have access to adequate health care facilities, including information, counselling and services in family planning."

India, as a State party of all conventions listed above, has an international legal obligation to implement these provisions to protect and provide its citizens with the right to life along with the right to healthcare and medical treatment.

6. Conclusion

The Raga Primary Health Centre of Lower Subansiri District has an obligation to provide for the minimal essential services, as stipulated in the IPHS Guidelines for Primary Health Centres. As analysed and argued in this report, the Raga PHC lacks in its fulfilment of the IPHS Guidelines, in relation to five elements of concern: ambulance and mobility, medicines and surgical equipment, antenatal care, institutional delivery, and postnatal care. These five elements of concern structurally contribute to one central problem: the underperforming maternal healthcare in Raga Sub-District, within Lower Subansiri District. All the major statistical sources invoked in this fact finding report are uniform in identifying Lower Subansiri District and specifically Raga Sub-District as a highly challenging region when it comes to the struggle for improving quality, availability, and accessibility of maternal healthcare facilities. More specifically, in terms of ANC, institutional delivery, PNC, and other maternal health-related services, the Ziro District Hospital does not satisfy multiple minimum standards set by the IPHS framework, which are legally enforced by a myriad of constitutional protections, case laws, national healthcare schemes and policies, as well as international declarations and conventions.

In this clear case of lacking IPHS performance, the State Government of Arunachal Pradesh has a duty to provide for an immediate and adequate response to improve the healthcare facilities at Raga Primary Health Centre, at least to a level at which all essential services under the IPHS Guidelines for Primary Health Centres are provided for. This response should ensure that the quality of and access to healthcare is offered in an equal manner to all people, independent of any person's socio-economic status, geography, or gender.

6.1 Recommendations

In order to improve the quality, accessibility, and availability of the essential services – in particular those relating to maternal health – offered by Raga Primary Health Centre, this fact finding report gives the following recommendations.

Ambulance and Mobility

- To have at least one fully operational ambulance, including all the necessary medical attributes and medical staff within Lower Subansiri District
- To contribute to an improvement of infrastructure between Raga Primary Health Centre and Ziro District Hospital
- To enhance the overall physical accessibility of Raga Primary Health Centre for the entire population of Raga Sub-District

Medicines and Surgical Equipment

- To ensure a constant and satisfactory supply of minimum essential medicines to Raga Primary Health Centre, particularly for those medicines essential for maternal and child healthcare

- To install new high-standard and hygienic surgical equipment which meets the standards set by IPHS Guidelines
- To ensure that all the premises of Raga Primary Health Centre are hygienic and fully operational at all times

Antenatal Care

- To raise awareness amongst women and men about the importance of ANC for maternal and child health
- To increase the rate of ANC registration during the first trimester
- To provide for all the medicines and equipment necessary to deliver for accessible, hygienic and high-standard ANC services

Institutional Delivery

- To raise awareness amongst women and men about the importance of institutional delivery for maternal and child health
- To increase the rate of institutional delivery
- To provide for all the medicines and surgical equipment necessary for women to deliver a child within an accessible, hygienic and high-standard institutional setting

Postnatal Care

- To raise awareness amongst women and men about the importance of PNC for maternal and child health
- To increase the rate of PNC within 48 hours of child delivery
- To provide constant and sufficient heating within Raga Primary Health Centre in order to create a better environment for women to stay in the health centre within the first 48 hours after child delivery
- To provide for all the medicines and equipment necessary for women to deliver a child within an accessible, hygienic and high-standard institutional setting

General Maternal Health

- To enhance the rates of ANC, institutional delivery, and PNC at Raga Primary Health Centre for women across Raga Sub-District
- To create comprehensive strategies for preventing maternal and child mortality and morbidity
- To further collaborate with other healthcare facilities (DHs, CHCs, and SCs) in Lower Subansiri District in order to ensure universal health coverage for all people, particularly pregnant women and mothers of new-born children

- To guarantee equal access to public healthcare, independent of a person's socio-economic status, geography, or gender

7. Bibliography

Arunachal Pradesh State Government. 2012. “Audit Report for the year ended 31 March 2012 (Social, General and Economic Sectors and PSUs): Chapter I Social Sector.”

Arunachal Pradesh State Government. 2011. “Audit Report on Lower Subansiri District for the year ended 31 March 2011: Chapter VII General Sector.”

Arunachal Pradesh State Government. 2013. *DC inspected district hospital at Ziro.* State Portal of Arunachal Pradesh.

Arunachal Pradesh State Government. n.d. “Map of Arunachal Pradesh.” *Official Website of the State of Arunachal Pradesh.* http://www.mdoner.gov.in/content/arunachal-pradesh-1# .

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Arunachal Pradesh Annexures Human Resources.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Arunachal Pradesh Annexures Human Resources.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Arunachal Pradesh Annexures Technical Strategies.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Arunachal Pradesh Drug Procurement Overview.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Blood Transfusion Service Narrative.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Blood Transfusion Service Narrative.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Copy of Annexure I Manpower Requirement: Requirement of Specialists Arunachal Pradesh.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Lower Subansiri Annexures Infrastructure.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Lower Subansiri Annexures Service Delivery.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Lower Subansiri Annexures Service Delivery.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “Maternal Health Document.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. *RMNCH+A Index: State Dashboard Arunachal Pradesh.* Statistics Wing, Ministry of Health & Family Welfare.

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “RRCNES Arunachal Pradesh District wise Health Score Card.”

Arunachal Pradesh State Programme Implementation Plan (PIP) 2015-16. 2015. “RRCNES State Profile: Arunachal Pradesh.”

Census of India 2011. 2011. *District Census Handbook: Lower Subansiri.* Series-13 Part XII-B, Directorate of Census Operations Arunachal Pradesh.

Census of India 2011. 2011. “List of states with Population, Sex Ratio and Literacy Census 2011.” *Census 2011.* http://www.census2011.co.in/states.php.

Department of Planning, Government of Arunachal Pradesh. n.d. *A Development Profile of Arunachal Pradesh.* Itanagar: Department of Planning, Government of Arunachal Pradesh.

Directorate General of Health Services, Ministry of Health & Family Welfare. n.d. “Indian Public Health Standards (IPHS): Guidelines for District Hospitals (101 to 500 Bedded).”

Directorate General of Health Services, Ministry of Health & Family Welfare. 2012. *Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres (Revised 2012).* Directorate General of Health Services, Ministry of Health & Family Welfare.

DNA India. n.d. *Arunachal Pradesh find difficult to run blood bank due to power shortage.* http://www.dnaindia.com/india/report-arunachal-pradesh-finds-difficult-to-run-blood-bank-due-to-power-shortage-2008097.

Health Management Information System (HMIS). 2015. *District Factsheet: Maternal and Child Health Indicator (2013-14 & 2014-15): Arunachal Pradesh, Lower Subansiri.* Health Management Information System.

Health Management Information System (HMIS). 2015. *HMIS State Factsheet Arunachal Pradesh: Year 2013-14 & 2014-15.* Health Management Information System.

Health Management Information System (HMIS). 2015. “Performance of Key HMIS Indicators for Arunachal Pradesh.”

Health Management Information System (HMIS). 2015. “Performance of Key HMIS Indicators for Lower Subansiri.”

Human Rights Council. 2010. *Annex to the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Paul Hunt: Mission to India (22 November to 3 December 2007).* United Nations General Assembly.

International Institute for Population Sciences (IIPS) and Macro International. 2009. *National Family Health Survey (NFHS-3), India, 2005-06: Arunachal Pradesh.* Mumbai: IIPS.

International Institute for Population Sciences. n.d. *District Level Household and Facility Survey (DLHS-4): State Fact Sheet Arunachal Pradesh (2012-2013).* Ministry of Health and Familiy Welfare.

Mehrota, Santosh, Neha Kumra, and Ankita Gandhi. 2014. *India's Fragmented Social Protection System: Three Rights Are in Place; Two Are Still Missing.* Working Paper 2014-18, United Nations Research Institute for Social Development.

Mehrota, Santosh, Neha Kumra, and Ankita Gandhi. 2014. *India's Fragmented Social Protection System: Three Rights Are in Place; Two Are Still Missing.* Working Paper 2014-18, United Nations Research Institute for Social Development (UNRISD).

Ministry of Development of North Eastern Region. 2011. "Literacy Rates 2001, 2011 - by gender." *Ministry of Development of North Eastern Region.* http://www.mdoner.gov.in/content/literacy-rates-2001-2011-%E2%80%93-gender.

Ministry of Development off North Eastern Region. 2011. "Literacy Rates 2001, 2011 - by gender." *Ministry of Development of North Eastern Region.* http://www.mdoner.gov.in/content/literacy-rates-2001-2011-%E2%80%93-gender.

Ministry of Health and Family Welfare. 2010. "Guidelines for Antenatal Care and Skilled Attendance at Brith by ANMs/LHVs/SNs."

Mukherjee, Sacchidananda, Debashis Chakraborty, and Satadru Sikdar. 2014. *Three Decades of Human Development across Indian States: Inclusive Growth or Perpetual Disparity?* Working Paper No. 2014-139, New Delhi: National Institute of Public Finance and Policy.

National Informatics Centre, Lower Subansiri Unit, Ziro. n.d. "Departments at a Glance." *Official Website of Lower Subansiri District.* http://lowersubansiri.nic.in/html/departments.htm.

National Informatics Centre, Lower Subansiri Unit, Ziro. n.d. "Physiography." *Official Website of Lower Subansiri District.* http://lowersubansiri.nic.in/html/physiography.htm.

National Rural Health Mission (NRHM). n.d. "National Rural Health Mission: Mission Document (2005-2012)."

Omeo Kumar Das Institute of Social Change and Development (OKDISCD): Guwahati. n.d. “Baseline Survey of Minority Concentrated Districts: District Report Lower Subansiri.”

State Programme Management Unit (NUHM) O/o MD (NHM), Government of Arunachal Pradesh. 2016. *National Urban Health Mission Programme Implementation Plan 2015-2016.* Naharlagun: Government of Arunachal Pradesh.

World Health Organization. 2015. *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.* Geneva: World Health Organization.