THE GUJARAT PUBLIC HEALTH ACT, 2009

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THE GUJARAT PUBLIC HEALTH ACT, 2009

STATEMENTS OF OBJECTS AND REASONS

To comply with the obligations imposed by the Constitution of India as well as relevant laws adopted by the national, state and local government, to ensure guaranteed public health conditions and rational and quality health services for all.

PREAMBLE

Recognizing:

1. The socio economic imbalances and inequities of health services especially affecting the vulnerable groups (those residing in rural and difficult-to-access areas, areas under environmental stress, tribals, urban poor, migrant population, unorganized labour, internally displaced people, people living with HIV/AIDS backward and scheduled castes and tribes, women, children and people living with disability);

2. The role of a clean living and work environment in maintaining and as a pre-requisite to public health;

3. The immediate and long-term health implications posed by industrial accidents and disasters;

4. The need to establish a society based on democratic values, social justice and fundamental human rights;

5. The need to improve the quality of life of all citizens and to free the potential of each person.

Bearing in mind that:

1. Article 47 of the Constitution of India's Directive Principles, recognizes the duty of the state to raise levels of nutrition and the standard of living and to improve public health as among its primary duties;

2. The Supreme Court of India has explicitly recognized the right to life under Article 21 of the Constitution, as including within its ambit the right to health and health care;

3. Public health and sanitation is a state subject according to the VII schedule of the Constitution, and it is the duty of the State Legislature to make laws with respect to it;

4. India has ratified various International Covenants (like the International Covenant for Economic, Social and Cultural Rights 1966) that recognize the right to health and health care as basic rights that all persons are entitled to, and that the State is thereby obliged to ensure these rights;

5. General Comment 14 (2000) on Article 12 of the International Covenant on Economic, Social and Cultural Rights lays specific obligations on the State Parties to take steps towards the full realization of

the right to health. The Indian government is obliged to comply with the General Comments of the respective monitoring bodies under International Covenants on the right to health and related matters;

6. India is a signatory to the International Health Regulations (2006) of WHO and is obliged to operationalise these regulations;

7. India has ratified various International Covenants (Convention for the Elimination of all Forms of Discrimination against Women, Convention for Child Rights and others mentioned above), that recognize the rights of certain groups, including women and girls, children, persons affected by HIV/AIDS, persons with mental health problems and persons with disability, to be provided with specific services that address their special health needs. There is thus an obligation on India, as a state party to ensure these rights;

8. India has been a signatory to the Programme for Action of the International Conference on Population and Development (1994) and the Platform of Action for the Fourth World Women's Conference (1995) that codify and legitimize reproductive and sexual rights of citizens of India

and is thus obliged to respect, fulfill and protect these rights;

9. India is a signatory to numerous treaties and international conventions, such as the Basel Convention on Transboundary Movement of Hazardous Wastes, the Stockholm Convention on Persistent Organic Pollutants, and the Rotterdam Convention on Prior Informed Consent aimed at protecting public health and environment;

10. Rapidly changing socio-economic cultural and political contexts in the era of Liberalization, Privatization and globalization is demanding the re-definition of public health to also include mental health needs;

11. Private Health Care Establishments have been providing services to people and have a potential of collaboration with the Public Health system, to ensure universal coverage with quality health care, and to establish a process of standardization and participatory regulation, in order to harness this resource.

In order to:

1. Operationalise the right to Health Care as recommended by the National Human Rights Commission through the enactment of a State

Public Health Act that recognizes and delineates the health rights of citizens, duties of the public health system and specifies broad legal and organizational mechanisms to operationalise these rights;

2. Identify and strengthen the public health infrastructure to improve and sustain the public's health through statutory reforms in a manner that ensures its accountability;

3. To set a broad mission for providing essential public health services and functions principally through the efforts of state and local public health agencies in collaboration with others in the public health system, including through the co-operation and formal collaborations between the Centre and State regarding public health planning, priority setting, information and data sharing, reporting, resource allocation, funding, service delivery in accordance with various National Health Policies and Programmes;

4. Identify scientifically and legally sound and effective powers and responsibilities of state or local public health agencies to provide essential and equitable public health services and functions, including powers to respond to public health emergencies, and to ensure that such agency while exercising its power to accomplish public health

services and functions, shall employ policies and practices that least infringes on the rights or interests of individuals. Employing the least restrictive alternative does not require the agency to adopt policies or programs that are less effective in protecting the public's health or safety;

5. Ensure respect for the dignity of each individual under the jurisdiction of the State or the Local Public Health Agency regardless of his/her residency status, especially of groups that may be in a vulnerable position;

6. Ensure that State and local public health agencies do not discriminate in an unlawful manner against individuals on the basis of their race, ethnicity, religious beliefs, sex, sexual orientation, or disability status;

7. Protect and promote ongoing public health education and outreach to ensure community participation in accomplishing public health goals. Ensure active involvement of Non-governmental Organizations, Community based organizations, Disabled Peoples Organizations, Organizations working on disability issues, Co-operatives, women's organizations, environment protection bodies, and traditional socio-cultural-religious organizations in promotion of public health;

8. Unite the various elements of the health system as well as elements of the health sector with other sectors affecting health, in a common goal to actively promote and improve the health system in the state (various elements of the health system like: private and public, rural and urban, promotive- preventive- curative and rehabilitative, Health and Family Welfare, national health programmes and HIV/AIDS);

9. Strive for the best/ optimal quality of health services while at the same time ensuring specified minimum standards in the short term;

10. Facilitate the implementation of the National Rural Health Mission (NRHM) that was launched by the Government of India. The NRHM aims to improve health care services by making provision for certain essential services to be provided as guaranteed services at various levels of the healthcare institution (PHCs, CHCs or SHCs) in accordance with the Indian Public Health Standards;

11. Establish a health system based on the comprehensive primary health care approach, decentralized management, principles of equity and efficiency and sound governance with active participation of civil society representatives;

12. Promote a spirit of shared responsibility and cooperation for public health among various stakeholders;

13. Involve the private medical sector in health service delivery, for promoting public health goals without weakening the public health system or diluting its responsibility;

14. Regulate the public and private health sectors, and their mutual relationships within a rights framework, for achieving the greatest public health good;

15. Provide opportunities for the exercise of community rights to determinants of health and health services by promoting awareness of health and human rights.

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THE GUJARAT PUBLIC HEALTH ACT, 2009

(……..of 2009)

[……., 2009]

An Act to make provision for different determinants of Public Health and for matters connected therewith or incidental thereto.

WHEREAS, it is expedient to make provision for promoting, advancing, improving health and also to ensure guaranteed public health services to all the people of State of Gujarat and other purposes connected thereof.

Be it enacted by Legislature, State of Gujarat in the ……year as follows:

PART - I

PRELIMINARY

1. Short title, extent, commencement and application

(1) This Act may be called the Gujarat Public Health Act, 2009.

(2) It extends to the whole of the State of Gujarat

(3) It shall come into force on such date as the State Government may, by notification, in the Official Gazette, appoint.

2. Definitions

(1) *"Aggrieved person"* means any person who can make an application for grievance under the Act or rules, and includes

(a) User of the service; or

(b) Person designated by the user; or

(c) An adult member of the family; or

(d) Guardian of the user, in case of user being a minor; or

(e) In event of the death of the user or his/her being incapacitated due to existing physical/mental/emotional state rendering him/her incapable to designate, a person willing to take up the responsibility for the user.

(f) Any person/persons whose collective community rights are violated.

(2) *"Community based services"* means preventive and promotive outreach services delivered at community level to specific individuals (such as immunization) or to the entire community at large (such as chlorination of wells, pollution prevention, epidemic control activities etc.)

(3) *"Communicable disease"* means a disease resulting from an infection due to pathogenic agents or toxins generated by the infection, following the direct or indirect transmission of the agents from the source to the host.

(4) *"Condition of public health importance"* means a disease, syndrome, symptom, injury, or other threat to health that is identifiable on an individual or community level and that can reasonably be expected to lead to adverse health effects in the community.

(5) *"Contagious disease"* means an infectious disease that can be transmitted from individual to individual.

(6) *"Contaminated material"* means wastes or other materials exposed to or tainted by chemical, radiological, or biological substances or agents.

(7) *"Council"* means a council or any such body recognized by the government for the registration of the various practitioners of any systems of medicine or providers of any health services;

(8) "Determinants of Health" means and includes, social and economic factors which have a direct bearing on health of the people. For instance,

the following may be construed as determinants of health:

(a) Nutrition

(b) Water Supply

(c) Environment

(d) Sanitation

(e) Education

and the like;

(9) *"Disaster"* means an actual or imminent event, whether natural or otherwise occurring in any part of the State which causes, or threatens to cause all or any of the following:

(a) widespread loss or damage to property, both immovable and movable; or

(b) widespread loss of human life or injury or illness to human beings; or

(c) damage or degradation of environment; and any of the effects specified in sub-clauses (i) to (iii) is such as to be beyond the capacity of the affected community to cope up with using its own resources and which disrupts the normal functioning of the community;

(10) *"Disaster Management"* means a continuous and integrated process of planning and implementation of measures with a view to:

(a) mitigating or reducing the risk of disasters;

(b) mitigating the severity or consequence of disasters;

(c) capacity-building;

(d) emergency preparedness;

(e) assessing the effects of disasters;

(f) providing emergency relief and rescue; and

(g) post-disaster rehabilitation and reconstruction;

(11) *"Disaster Management Committee"* shall mean the authority established under the Gujarat State Disaster Management Act, 2003.

(12) *"Essential drugs"* include all drugs, as enumerated by the State Government, on the basis of the National Essential Drug List, that shall be available free of cost to all users at all times in the respective public health care establishments.

(13) *"Essential public health services and functions"* mean those services and functions to:

(a) Monitor health status to identify and solve community health problems;

(b) Investigate and diagnose health problems and health hazards in the community;

(c) Inform, educate, and empower individuals and people about health issues;

(d) Mobilize public and private sector collaboration and action to identify and solve health problems;

(e) Develop policies, and plans, and programs that support individual and community health efforts;

(f) Enforce laws and regulations that protect health and ensure safety;

(g) Promote established linkage between various National Health Programmes;

(h) Ensure convenient and timely access by individuals to needed personal health services;

(i) Develop, maintain and assure a competent and efficient system for delivery of public health services prescribed in this Act , including management of trained cadres of public health personnel;

(j) Evaluate effectiveness, accessibility, and quality of personal and population-based health services;

(k) Promote interaction and joint action between health and other departments, such as environment and labour, the activities of which have a significant bearing on health.

(14) *"Health care establishment"* means the whole or part of a public or private institution, whether for profit or not; where inpatient or outpatient treatment; diagnostic or therapeutic interventions; nursing, rehabilitative, palliative, convalescent, preventive or other health care services or any of them are provided. Healthcare establishment includes clinical establishment meaning any premises used for persons suffering from any sickness, injury or infirmity and shall include hospital and maternity homes.

(15) *"Health Impact Assessment"* means a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential or effects on the health of a population, and the distribution of those effects within the population.

(16) *"Infectious disease"* means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, or virus.

Explanation: An infectious disease may be transmissible from individual to individual, animal/bird to individual, or insect to individual.

(17) *"Infectious waste"* means:

(a) Biological waste, including blood and blood products, excretions, exudates, secretions, suctioning and other body fluids, and waste materials saturated with blood or body fluids;

(b) Cultures and stocks, including etiologic agents and associated biological; specimen cultures and dishes and devices used to transfer, inoculate, and mix cultures; wastes from production of biological and serums; and discarded live and attenuated vaccines;

(c) Pathological waste, including biopsy materials and all human tissues; anatomical parts that emanate from surgery, obstetrical procedures, necropsy or autopsy and laboratory procedures; and animal carcasses exposed to pathogens in research and the bedding and other waste from such animals,

but does not include teeth or formaldehyde (or other preservative agents); and

(d) Sharps**,** including needles, I.V. tubing with needles attached, scalpel blades, lancets, breakable glass tubes, and syringes that have been removed from their original sterile containers.

(18) *"Informed consent"* means consent given to a proposed specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to the person giving consent adequate information including risks and benefits of, and alternatives to, the proposed intervention in a language and manner understood by such person with no binding to consent after being informed.

(19) *"Isolation"* means the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.

(20) *"License"* means, an authorization that conditionally allows the recipient to conduct, for a specified

period of time, activities that would be unlawful without the authorization.

(21) *"Local authority"* means:

(a) In urban areas, the Municipal Corporation/Mahanagar Palika and the Municipal Commissioner

(b) the Municipal Council/Nagar Palika and the Chief Officer,

(c) In any area in a district as defined in the Gujarat Panchayats Act, 1961, that is comprised within the jurisdiction of a Panchayat concerned, the District Collector/District Development Officer.

(22) *"Local Supervisory Authority"* means-

(a) in the areas falling within the jurisdiction of the Municipal Corporation – the Health Officer of the concerned Municipal Corporation;

(b) in the areas falling within the jurisdiction of the Municipal Council – the Civil Surgeon/ Chief District Medical Officer of the District in which such Council is situated

(c) in the areas not falling in sub-clauses (i), (ii) and (iii) above, the District Health

Officer/Civil Surgeon/ Chief District Medical Officer of the concerned Zilla Panchayat

(23) **"***Medical Treatment"* means systematic diagnosis and treatment for prevention or cure of any disease, or to improve the condition of health of any person through allopathic or any other recognized systems of medicine such as Ayurveda, Unani, Homeopathy, Yoga, Naturopathy and Siddha; and includes Acupuncture and Acupressure treatments.

(24) *"Municipal Health services"* includes:

(a) Water quality monitoring;

(b) Food control and safety;

(c) Waste management;

(d) Health surveillance of premises;

(e) Surveillance & prevention of communicable diseases, including immunization;

(f) Vector control;

(g) Environmental pollution control;

(h) Disposal of dead;

(i) Registration of births & deaths.

(25) **"***Notifiable Disease"* means a disease which a Registered Medical Practitioner is required to notify to the Medical and Health Officer of his area under the law for the time being in force, and includes those diseases specified in Schedule I.

(26) "Persons with limited paying capacity" means

(a) All persons who have received a ration card in the category of Below Poverty Line (BPL)

(b) All persons who have not been included in the above-mentioned sub-clause (i), but have been certified by a designated authority as having limited paying capacity.

Explanation 1: Designated Authority in a rural area for a specific village shall include the Sarpanch or the Government Headmaster; or the Gram Sabha or any other elected representative or the President/Secretary of the Mahila Mandal of the said village; or a Chief Functionary/Secretary of the registered NGO which is a member of the health monitoring committee at the Village Health Centre, Primary Health Centre (PHC) or Block level concerning the said village.

Explanation 2: Designated Authority in an urban area shall include a Government Headmaster; or the Corporator of the concerned area; or the President/ Secretary of the Mahila Mandal or Swasthya Juth; or the

President/ Secretary of the Community Development Society at the Falia Level, or the Neighborhood Group at Ward Level.

Explanation 3: The certificate shall be granted if the person in need of such a certificate falls in one or more of the following criteria:

(a) Member of a woman headed household;

(b) Member of SC/ST, unless he/she or his/her spouse is a government employee in Class I, II or III level, i.e. class III SC/ST employee level' after 'class I or II level';

(c) Member of a family with no landholdings or landholding less than two acres, not employed in the organized sector;

(d) A person who has been granted a Certificate of Disability under the Disabilities Act;

(e) People living with HIV/AIDS.

Explanation 4: All elderly persons shall be eligible for applying as a person with limited paying capacity.

(27) *"Physiotherapy Clinics/ Physical Therapy Clinics"* means an establishment where massaging, electrotherapy, hydrotherapy or similar work is usually carried on, for the purpose of treatment of diseases or of infirmity or for any other purpose

whatsoever, whether or not analogous to the purposes herein before mentioned in this clause**.**

(28) "*Precautionary Principle" means that* in order to protect the environment or public health, a precautionary approach should be widely applied, meaning that where there are threats of serious or irreversible damage to the environment or public health, lack of full scientific certainty should not be used as a reason for postponing cost-effective measures to prevent degradation. The precautionary principle permits a lower level of proof of harm to be used in policy-making whenever the consequences of waiting for higher levels of proof may be very costly and/or irreversible.

(29) *"Prescribed"* means prescribed by rules and regulations made under this Act.

(30) "Public health" means assuring the conditions in which the population can be healthy. This includes population-based or individual efforts primarily aimed at the prevention of injury, disease, disability or premature mortality, or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(31) *"Public health agency"* means an organization operated by the Public Health system of the Central, State, or Local government that principally acts to protect or preserve the public's health, with the participation of civil society.

(32) *"Public health agent"* means any official (including a public health official) or employee of a state or local public health agency who is authorized to carry out provisions of this Act.

(33) *"Public health authority"* is the authority envisaged under this Act.

(34) *"Public health emergency"* means an occurrence or imminent threat, including owing to degraded environmental conditions, of an illness or health condition that:

(a) Poses a high probability of any of the following harms:

(i) a large number of deaths or illness in the affected population;

(ii) a large number of serious or long-term disabilities in the affected population, including teratogenic effects, or ;

(iii) widespread exposure to an infectious or toxic agent that poses a significant risk

of substantial future harm to a large number of people in the affected population;

(b) And can be caused by any of the following:

(i) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, or;

(ii) any disaster, including major accidents.

Explanation: Public health emergency can be due to communicable infectious diseases, chronic non-infectious, non-communicable conditions affecting large population, notifiable diseases, conditions of public health importance or locally endemic diseases.

(35) "Public sector partner" means central, state or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a state or local public health agency.

(36) "*Qualified Medical Practitioner"* means a medical practitioner registered under the relevant medical laws in force. It shall mean a person who possesses any of the recognized medical qualifications and who has been enrolled in the register of the respective medical council, i.e. Allopathy, Dental, Homeopathic and Board of Indian Medicine or any

such council, Board or any other statutory body recognized by the Government.

It shall mean, with respect to Allopathy, persons registered under the Gujarat Medical Council Act, 1967, With respect to Ayurved, Unani and Siddha, persons registered under the Central Council of Indian Medicine Act 1970; with respect to Homeopathy, persons registered under the - Homeopathy Central Council Act 1973.

(37) **"***Qualified Nurse"* means any qualified nurse after three years of training and recognized by the Nursing Council.

(38) **"right to food"** means, at least, right of everyone to be free from hunger and malnutrition, and the right of every person to have regular and permanent access to food which is affordable, adequate, safe and nutritious, for a healthy and active life, and culturally acceptable to the population;

(39) **"right to health"** means right of everyone to a standard of physical and mental health conducive to living a life in dignity;

(40) **"right to housing"** means at least, right of everyone to an affordable place where a person can live in safety, privacy, dignity, and peace, under healthy conditions, with access to basic facilities,

and protection from forced eviction, harassment or other threats;

(41) **"right to sanitation"** means at least, right of everyone to access to affordable excreta disposal facilities which can effectively prevent human, animal and insect contact with excreta, and which ensure privacy and protect dignity of all persons, and shall also include provision of sewerage and drainage channels to remove wastewater and excreta and to ensure their safe disposal or treatment;

(42) **"right to water"** means at least, right of everyone to adequate, safe, acceptable, physically accessible and affordable water for personal and domestic uses, which would mean access at least to adequate amount of safe water that is necessary to prevent death from dehydration, to reduce the risk of water-related disease and to provide for consumption, cooking, personal and domestic hygienic requirements;

(43) *"State Public Health Board"* means the State Public Health Board established under this Act, to serve as an advisory and, in certain respects, as a decision-making body to the State Health Department and the Health Minister on all matters related to the public health system, including the development of the comprehensive State Public

Health Plan, and perform such other functions as provided for under this Act.

(44) *"underlying determinants of health"* shall mean conditions that are basically necessary for the realization by individuals of the highest attainable standard of health and shall include, without being limited to, adequate levels, in quality and quantity, of food/ nutrition, water, sanitation, and housing;

(45) *"Universal work precautions"* means infection control measures that prevent occupational and nosocomial exposure to or reduce the risk of transmission of pathogenic agents including Hepatitis B, Hepatitis C and HIV and includes the provision for education, training, personal protective equipment such as gloves, gown and masks, hand washing and employing safe work practices.

(46) *"Unsanitary condition"* means a condition or circumstance

(a) that is, or may be, or might become injurious to health; or

(b) that prevents or hinders the suppression of disease; or

(c) that contaminates or pollutes, or may contaminate or pollute food, air, or water; or

(d) that might render food, air, or water injurious to the health of any person;

And includes any hazardous and injurious substances and activities and any circumstance or condition declared to be an unsanitary condition by regulation, but does not include a serious health hazard;

(47) "Wholesome water" means water that is

(a) free from pathogenic agents;

(b) free from harmful chemical substances;

(c) pleasant to the taste, i.e. free from colour and odour and

(d) Usable for domestic purposes.

PART – II

PUBLIC HEALTH SYSTEM

CHAPTER I

DUTIES OF STATE GOVERNMENT

3. Role and Responsibility of State

The State Government shall take all measures to ensure that-

(a) In order to achieve the purposes of this Act, and to provide essential public health services and functions, the State Government shall establish an effective public health infrastructure, with assured necessary and adequate financial allocations and other resources

(b) The public health facilities shall be accessible and staffed with adequate trained human power as specified under the Indian Public Health Standards (IPHS) and other standards adopted by the State Health Department as also have sufficient infrastructure to meet its requirements.

(c) The State Government officers including the health care providers and the members of the

judicial services are given periodic awareness training on the issues addressed by this Act;

(d) Necessary budgetary provisions in terms of adequacy (in terms of how much is enough to offset inflation), priority (in terms of compared to other budget heads), progress (in terms of indicating an improvement in state's response), and equity (in terms of fair allocation of resources), are made for effective implementation of this Act.'

(e) The State government may, by notification, authorize any local authority to incur expenditure on any public health purpose specified in the notification.

(f) Effective co-ordination between the services provided by concerned Ministries and Departments is established and periodical review of the same is conducted;

(g) Protocols for the various Ministries concerned with the delivery of health services are prepared and put in place.

(h) The provisions of this Act are given wide publicity through public media including the television, radio and the print media at regular intervals;

4. Government Monitoring: In addition to the Health Information Systems, monitoring by Government agencies and the national and State boards shall include:

(1) Annual financial audits of the health systems at national, State and district levels by the Comptroller & Auditor General (CAG) as well as by a chartered accountants and any special audit that may be deemed fit by the Governments, by agencies like the Indian Public Auditors, with the help and under the supervision of one or more research and resource institutions in every State, that shall be contracted for this purpose;

(2) System of mandatory audits of medical records by every health care establishment and institution, public or private;

(3) System of mandatory audits into maternal and child deaths as well as any other unusual death, by every health establishment and institution, public or private;

(4) Mandatory requirement for all the health care institutions and establishments to prominently display information regarding the Indian Public Health Standards (IPHS) in various respects; the charter of users' rights; grants received by the institutions; medicines and vaccines in stock; services provided to the users, user charges to be paid (if any), as envisaged in the Right to

Information Act; and the monitoring of performance of the institutions and establishments on such parameters;

(5) Establishment of autonomous institutions with professional expertise and functional and administrative autonomy to conduct independent surveys to periodically assess the progress made on key health parameters; effectiveness of various health initiatives; status in health equity and access to quality health services including costs of health care and impact of health care costs on poverty; track public expenditure on health care; and the Governments, as advised by the respective health boards which shall lay down regulations for their functioning.

5. Authorities under the Act

The State shall establish the following authorities for the purposes of the Act:

(1) State Public Health Authority;

(2) State Public Health Board;

(3) Commissionerate of Health Services;

(4) Health Care Establishment (Registration and Regulation) Authority;

(5) Monitoring Committees, and;

(6) Public Health Redressal Mechanism.

CHAPTER II

PUBLIC HEALTH AUTHORITIES-ROLE AND RESPONSIBILITY

6. State Public Health Authority:

(1) The State government shall establish the State Public Health Authority.

(2) The composition of the Sate Public Health Authority shall be as follows:

(a) The Hon'ble Minister for Health and Family Welfare shall be the Chairperson;

(b) Hon'ble Minister for Education;

(c) Hon'ble Minister for Social Welfare;

(d) Hon'ble Minister for Food and Agriculture;

(e) Hon'ble Minister for Housing;

(f) Hon'ble Minister for Local Self Government;

(g) Hon'ble Minister for Public Works;

(h) Hon'ble Minister for Finance;

(i) Two members of the State Legislature belonging to opposition parties;

(j) Two representatives form recognized NGO's working in public health;

(k) Secretary of Health;

(l) Director of Health Services;

(m) Two Public Health experts and;

(n) One Public Health Law expert;

(3) The State Public Health Authority shall meet once in three months to discuss and implement various decisions taken with respect to the public health and health care services.

7. Powers of the State Public Health Authority:

(1) The authority shall formulate various policies with respect to public health and health care services.

(2) The authority shall allocate a certain portion of the annual budget for public health care services.

(3) The authority shall also direct the public health board to perform its functions, by notification.

(4) To promote the availability of and access to primary, secondary and tertiary health care including acute and episodic care, preventive health services, prenatal and postpartum care, child health, adolescent health, family planning, school

health, chronic disease prevention, child and adult immunization, testing and screening services, geriatric services, dental health nutrition and food safety and health education and other promotion services;

(5) To identify, assess, prevent and ameliorate conditions of public health importance including epidemics and outbreaks through surveillance; epidemiological tracking, programs; treatment; abatement of hazardous and injurious substances and activities; administrative inspections; or other methods;

(6) To create and empower health committees at various levels, so as to expand accessibility and quality of health services.

(7) to provide public health education and information through appropriate programs or messages to the public that promote healthy behaviors or lifestyles, and create awareness among citizens about health issues;

(8) To develop, adopt and implement public health plans through administrative regulations, formal policies, or collaborative recommendations that guide or support individual and community public health efforts.

(9) To establish formal relationships between public and private sector partners within public health system;

8. State Public Health Board

(1) A State Public Health Board shall be established by the State Government to serve as an advisory and, in certain respects, as a decision-making body to the State Health Department and the Health Minister on all matters related to the public health system, including the development of a comprehensive State Public Health Plan.

(2) The appointment of each member of the State Public Health Board shall be for a period of three years.

(3) The Board shall be represented by specific number of persons belonging to the State Health Department; local public health agencies; Public Health Experts; State or local governmental bodies, including those relating to environmental protection, women & child development, rural development, health care facilities, and representatives of Civil Society. Without prejudice to the generality of the composition above-

mentioned, the State Public Health Board shall consist of the following members:

(a) The Chief Secretary, State Government, who shall be the Chairperson;

(b) The Principal Secretary (Health & Family Welfare), who shall be the Co-Chairperson;

(c) The Commissioner of Health and Secretary of Family Welfare, State Government, who shall be the Convener;

(d) The Additional Director of Health Services, who shall be the Secretary;

(e) Secretaries or their nominees, in charge of Departments of Women and Child Development, Public Health Engineering, Water and Sanitation, Panchayat Raj, Rural Development, Social Welfare, Urban Development, Planning, Finance, Social Justice, Tribal Welfare, Information & Broadcasting, Disaster Mitigation/Preparedness;

(f) Nominated elected representatives such as Mayors and Commissioners of the largest Municipal Corporations, MPs, MLAs, Chairmen, Zila Parishad, representatives from the urban

local bodies (women should be adequately represented);

(g) Nominated non-official members (8-10 members) such as public health experts, representatives of medical associations, NGOs, etc.;

Provided that special invitees according to need may be included in the Composition of the Board.

(4) The Board may create sub-committees in order to address specific areas or needs concerning the public health system.

(5) The Board shall be adequately funded and staffed to conduct its operations and shall meet at least once in three months.

(6) Board members shall be compensated in accordance with the applicable State Laws.

9. Duties of State Public Health Board

(1) The State Public Health Board shall carry out the following functions:

(a) It shall prepare an annual Comprehensive Public Health Plan for the State, with focus on vulnerable sections of society and ill-served areas of the State.

(b) It shall propose amendments or repeal of any rules relating to the administration, implementation and observance of the provisions of the Act and may suggest amendments to the Act in the Reports laid before the State legislature;

(c) It shall develop norms and mechanisms to ensure equitable distribution of health resources. It shall review coverage norms every 5 years and suggest upward revisions;

(d) It shall monitor implementation of the Comprehensive Public Health Plan through quarterly/half-yearly meetings;

(e) It shall advise the State Health Department on public health plan and approve it for implementation;

(f) It shall consider the annual budget and the annual action plan, and pass it with modifications;

(g) It shall establish a sub-committee, which shall carry out clinical and medical audits for select conditions of public health importance, and receive relevant reports;

(h) It shall appoint committees and sub-committees for relevant purposes on such

terms as it may deem fit, and may dissolve or remove any of them;

(i) It shall develop and adopt rules and regulations for recruitment and appointment of technical experts and administrative and technical staff and set its compensation package for such experts and staff to be recruited from the open market and/or on deputation basis;

(j) It shall develop mechanisms for initiating public-private partnership in implementation of public health programmes;

(k) It shall develop mechanisms for empowering the decentralized monitoring committees at all levels, both rural and urban, as envisaged under this Act;

(l) It shall seek feedback and suggestions from members of the rural and urban Monitoring sub-committees in a structured manner, through sub-committees;

(m) It shall ensure preparedness for public health emergencies in coordination with other government departments, agencies;

(n) It shall take steps towards making equitable schemes for health insurance for persons of different income levels and special needs;

(o) It shall develop mechanisms for conducting health impact assessment for developmental activities/projects and ensure corrective action by concerned authorities;

(2) The State Public Health Board shall appoint an expert committee to develop Standard Treatment Protocols that are to be laid down and followed by public and private health care providers, including publicly funded treatment provided by private medical providers for:

(a) National Health Programmes

(b) Common diseases and conditions of public health importance, including major conditions affecting women and children.

(1) It shall establish standards for urban sanitation and hygiene and ensure that the Nagar Palikas adhere to these standards.

(2) It shall ensure that the prescribed structure for health care provision to the urban poor is set up within each city/town by obtaining an annual population estimate and health plan including a budget.

(3) Through periodic/annual reviews, it shall ensure that the urban health system provides affordable

quality care to the urban poor including the migrant population.

10. Commissionerate of Health Services:

(1) The Commissionerate of Health Services may consist of as many divisions as the Government may consider necessary for the administration of Health Care Services in the State.

(2) Subject to the control of the Government (a) the Director of Health Services shall be the Chief Administrative and Executive offer of the Directorate and (b) Chief Public Health Engineer shall be in charge of the public health engineering division of the Directorate.

(3) The DHS will be assisted by such members as deputy and assistant directors and the other officers at various levels of administration as the Government may, from time to time, deem fit to appoint.

(4) Powers of the Government and of the Commissionerate of Health Services:

(a) The Government shall have the power to inspect, control and supervise the operations of the local authorities under this Act.

(b) The Government may, from time to time, define the powers to be exercised, and duties to be performed by the Commissionerate of Health Services or any members.

(c) The Government may, by notification, direct that in respect of any function to be performed by a local authority under this Act and specified in the notification, the District Panchayat organization and not the Panchayat or the Panchayat Samithi shall be the local authority in all or any areas in the district which are comprised within the Jurisdiction of a Panchayat/Panchayat Samithi.

(d) The DHS shall have the power to supervise and control the medical and health establishments including training institutions and (public) health services within the State excepting those administered by the Central Government and will have the power to recover the cost from the local authorities for carrying out measures recommended by him in such in respect in respect of such institutions and services as fall those that fall within the purview of the local authorities.

(e) The DHS may, from time to time, as the occasion requires recommend for the

adoption by any Local Authority, such measures as may be necessary for improving the public health of the people therein. Provided that, if on any account of financial or other reasons, any local authority is unable to carry out such measures or if there is any difference of opinion between the local authority and the Director, then the matter may be referred to the Government, whose decision shall be final.

(f) The DHS shall have the power to cause to make the services of the Directorate available in the local authorities, non- profit making voluntary organizations, free of charge in respect of planning, execution and supervision of health measures including sanitary schemes.

(g) In case of emergency arising or threatening from outbreak of an epidemic due to communicable disease or from any other cause endangering the life or health of the public, the DHS shall have the power :

(i) To appoint additional personnel and organize public health care services for such periods as it may consider necessary, and

(ii) The approval of the government to assume all or any of the powers and functions of a local authority under this Act and in every case, the DHS shall forwith report the matter to the government.

11. Functions of Commissionerate of Health Services

(1) Bringing about co-ordination between the urban public health system and the private sector for public health goals. It shall ensure that the urban public health system co-ordinates with the ESI, Trust and other private hospitals and dispensaries, to ensure that the referral unit as well as the secondary hospital level respectively, are available and accessible to the poor, vulnerable and migrant populations.

(2) It shall ensure surveillance of notifiable diseases, conditions of public health importance and locally endemic diseases.

(3) It shall work out incentive systems and regulatory mechanisms, with respect to both Urban and Rural Health System for channeling the available resources for public health goals.

(4) It shall ensure that standards of safe drinking water, sanitation and garbage disposal are adhered to in entire jurisdiction of co-operations/councils including the habitations of the poor.

(5) It shall record vital statistics, including births and deaths of all persons, especially maternal and neo-natal.

(6) It shall encourage community participation and through a process of such participation, develop ward level public health plans, by incorporation of zonal public health plans.

12. Health Care Establishment (Registration and Regulation) Authority:

(1) As envisaged under Section 4 of the Act, the State shall establish the Health Care Establishment (Registration & Regulation) Authority at State level and in every District, viz., The State Health Care Establishment (Registration & Regulation) Authority and The District Health Care Establishment (Registration & Regulation) Authority.

(2) The Composition of the State Health Care Establishment (Registration & Regulation) Authority shall have the participation of various stakeholders. It shall be composed of not more than 15 members

nominated by the Government, with not more than 50% being Government representatives. The State Health Care Establishment (Registration & Regulation) Authority shall include:

(a) The Health Secretary shall be the Chairperson;

(b) The Commissioner of health and family welfare shall be the Convener of the Authority;

(d) Additional Director Medical Services, (Member Secretary);

(e) One representative from the State Indian Medical Association;

(f) Secretary or Commissioner in charge of Indian Systems of Medicines and Homeopathy;

(g) One representative from the Hospital Owners Association;

(h) One qualified practitioner running a Clinical establishment and registered under the Homeopathy Council;

(i) One qualified practitioner running a Clinical establishment and registered under the council of Indian System of Medicine;

(j) One representative from Nurses' Association;

(k) A Professor from Community Medicine Department, preferably from a Government medical college or one representative from a Government clinical establishment;

(l) One representative from a registered State level consumer organization;

(m) One representative from a State level NGO or coalition/ network of non-government organizations working in the area of health rights;

(n) One representative from a State level women's group;

(o) One representative from Jan Swasthya Abhiyan or the Dai Sangathan;

(3) The constitution of the authority shall be valid for a period of five years.

(4) The Functions of State Health Care Establishment (Registration and Regulation) Authority shall include the following:

(a) To lay down minimum requirements (standards) or upgrade existing requirements periodically (every 5 years) for all the Health Care Establishments;

(b) To suggest revision of fees charged periodically;

(c) To review and monitor the implementation of the Act and recommend changes in the said Act and Rules;

(d) To act as supervisory body for monitoring the Local Supervisory Authority. This shall involve receiving quarterly reports from the District Health Care Establishment Registration Authority and the Local Supervisory Authority, giving directives to the Local Supervisory Authority, acting as apex body at state level and supporting the District Health Care Establishment (Registration & Regulation) Authority.

(e) To act as a grievance redressal forum regarding provisions stipulated under this Act where it shall entertain complaints from patients, consumers, and the public. The State Private Health Care Establishment (Registration & Regulation) Authority shall only act on receipt of complaints to the board if the complainant is not satisfied with the decision of the District Private Health Care Establishment (Registration & Regulation) Authority;

(f) To conduct regular meetings of the board;

(g) To assess and review its own performance, in the prescribed manner at the end of each year;

(5) The meeting of the State Health Care Establishment (Registration & Regulation) Authority shall be called by the Chairperson or Convenor with a minimum notice of 15 days and shall need a minimum quorum of 50% of members. If on the day when the meeting is called, quorum is not present, the meeting shall be adjourned for 30 minutes and after that if the quorum is still not present the meeting shall proceed as if the quorum is present. The intervening period between two meetings shall not exceed 90 days;

(6) Emergency meetings may be called by the Chairperson or Convenor or Local Supervisory Authority or any of the members of the State Health Care Establishment (Registration & Regulation) Authority with the sanction of the Chairperson with a three clear days notice. Emergency meetings may be called on receipt of serious complaints made to the State Health Care Establishment (Registration & Regulation) Authority;

(7) All orders and decisions of the Board shall be authenticated by the signature of the chairperson or any member authorized by the Authority;

(8) The government and non- government members appointed to the State Health Care Establishment (Registration & Regulation) Authority shall be entitled to traveling allowance and daily allowance according to the traveling allowance rules of the state government, for attending the meeting;

(9) The Composition of the District Health Care Establishment (Registration and Regulation) Authority shall be set up at the district level composed of members nominated by the State Government, according to State Government directive out of which more than 50% shall be persons who are not government officers, and shall include the following:

(a) Collector of the District or Municipal Commissioner in case of Municipal Corporation who shall be the ex-officio Chairperson;

(b) Local Supervisory Authority who shall be the Member Secretary;

(c) A member of local chapter of Indian Medical Association;

(d) A professor or senior faculty, from Community Medicine Department, preferably from a government medical college;

(e) One representative from the hospital owner's association;

(f) One qualified practitioner running a private health care establishment and registered under the homeopathy council;

(g) One qualified practitioner running a private health care establishment and registered under the council of Indian System of Medicine;

(h) One representative from a government health care establishment;

(i) One local representative from the Nurses' Association;

(j) One representative from the local consumer organization;

(k) One representative from a non-governmental organization working in the area of health or coalition/ network of non-government organizations working in the area of health rights;

(l) One representative from a women's group active in the district;

(m) One representative from JSA or the Dai Sangathan;

Provided that any person, who is not a member of the District Health Care Establishment (Registration & Regulation) Authority, whose assistance or advice may be required for the functioning of the board, may be appointed to do so by the District Health Care Establishment (Registration & Regulation) Authority. Such person shall have the right to take part in the discussion relevant for the purpose but shall have no right to vote at a meeting of the Authority;

(10) The term of the members of the Authority shall be for a period of five years;

(11) The functions of the District Health Care Establishment (Registration & Regulation) Authority shall include the following:

(a) To review and monitor the implementation of the Act;

(b) To conduct regular meetings of the District Health Care Establishment (Registration & Regulation) Authority;

(c) To communicate to the State Public Health Authority any modifications required in the rules, especially with reference to minimum requirements (standards) and revision of fees charged;

(d) To act as an appellate body for any order passed by the Local Supervisory Authority;

(e) The authority shall have the power to appoint a committee or committees from its members for the performance of various tasks.

(12) The meeting of the District Health Care Establishment (Registration & Regulation) Authority shall be called by the Chairperson with a minimum notice of 15 days and shall need a minimum quorum of 50% of members. The intervening period between two meetings shall not exceed 90 days.

Provided that in event of the Chairperson not being available and looking at the urgency of the matter or in order to adhere to the time limit, the Local Supervisory Authority may call for the meeting with 7 clear days notice to all members.

(13) Emergency meetings may be called by the Chairperson or Local Supervisory Authority or any of the members of the District Health Care Establishment (Registration & Regulation) Authority

with the sanction of the Chairperson, with a three clear days notice. Emergency meetings may also be called on receipt of serious complaints made to the District Health Care Establishment (Registration & Regulation) Authority. The decisions of the District Health Care Establishment (Registration & Regulation) Authority shall be taken by consensus or by majority vote and in case of equal vote the Chairperson shall have the casting vote.

(14) All orders and decisions of the authority shall be authenticated by the signature of the Chairperson or any member authorized by the Authority.

(15) The Government and non-government members appointed to the District Health Care Establishment (Registration & Regulation) Authority shall be entitled to traveling allowance and daily allowance according to the traveling allowance rules of the State Government, for attending the meeting.

(16) Disqualification for appointment as members to District Health Care Establishment (Registration & Regulation) Authority- A person shall be disqualified as member of the board if he/she

(a) has been convicted by a court of law for offence of moral turpitude.

(b) Vacates or is dismissed from the position by virtue of which he/she was appointed.

(c) In case of medical practitioners, if they are found guilty by a court of law or the respective medical council of medical negligence and malpractice.

(17) The constitution of the authority shall be valid for a period of five years.

13. Powers of Health Care Establishment (Registration and Regulation) Authority

(1) The State and District Health Care Establishment (Registration and Regulation) Authority shall have the powers to register the existing and newly opened Healthcare Establishments.

(a) The Authority has powers to conduct periodic inspection of the Health Care Establishments;

(b) The Authority has the power to monitor the minimum standards implementation in the Health Care Establishments;

(c) The Authority has the power to receive complaints from the patient or any other stake holders and accordingly forward the same to the Tribunal;

(d) Issuance or grant of Certificate of need;

(e) The Authority shall file periodic reports before the Public Health Board.

14. Mechanism for Community-based Monitoring

An integrated system of community-based monitoring, planning and action shall be ensured by the State. The operationalization of this approach shall be based on interlinked committees at Village, PHC, Block, District level with respect to rural areas. There shall be a similar mechanism with Committees at basti, ward, zone and Municipal Council / Corporation for urban areas. These shall be linked with a State Health Monitoring and Planning Committee at the State level.

Section 14 dealing with Public Health Redressal Mechanism has been deleted

CHAPTER – III

PUBLIC HEALTH PLANNING

15. Comprehensive Public Health Plan

(1) State

(a) In order to promote the provision of essential public health services and functions, the State Public Health Board shall develop and monitor the implementation of a comprehensive, statewide Public Health Plan that assesses and sets priorities for the public health system. Each plan shall be operational for a period of five years, subject to annual revisions.

(b) The plan shall rely on existing or available surveillance data or other information acquired pursuant to this Act, as well as subject-specific public health plans or national guidelines or recommendations concerning public health outcomes/improvements.

(c) The purposes of the plan shall be to:

(i) Guide the public health system in targeting essential public health

services and functions through program development, implementation, and evaluation;

(ii) Strive to increase the efficiency and effectiveness of the public health system;

(iii) Identify specific geographical areas and social groups needing greater resources allocation to provide essential public health services and functions; and

(iv) Incorporate time-bound and monitorable commitments, obligations, goals and priorities, consistent with the United Nations' Millennium Development Goals and other national goals and priorities, in areas related to public health.

(d) The plan shall include the following aspects:

(i) Identify and quantify existing public health problems and disparities, both geographical and social, at the State and local levels;

(ii) Identify existing public health resources at the State and local levels, both in the public and private sectors, covering

allopathic and non-allopathic systems, including traditional providers of healthcare;

(iii) Declare goals of the plan which may be monitored at the State, district and local (town or Panchayat) levels, describing measurable indicators of effectiveness and successes;

(iv) Develop a plan for monitoring based of the above indicators

(v) Detailed description of the programs and activities that will be pursued to address existing public health problems, disparities,

(vi) Detailed description of how public and private sector health services will be integrated; and how public and private sector health resources will be shared to optimize efficiency and effectiveness of the public health system and describe strategy for coordinating service delivery within the public health system

(vii) Develop an information, education and communication (IEC) infrastructure that

shall support essential public health services and functions. This shall involve mass IEC campaigns and activities, with institutionalized involvement of educational institutions, Non-governmental Organizations, Community Based Organizations, Disabled People's Organizations and organizations working on disability, environmental and human rights organizations, religio-social organizations, association of medical practitioners, traditional healthcare practitioners, mass media (including privately owned mass media), and all other stakeholders in promotion of public health.

(viii) Formulate a human resource development plan to ensure capacity building commensurate with the public health needs

(ix) Develop and implement a capacity building plan for all the bodies and committees being set up at various levels under this Act.

(x) Estimate costs and time-lines for implementing the plan;

(e) It shall be the responsibility of the State Health Department to ensure that the coordination, planning and review bodies bring about coordination between District Health Services in the rural areas and Municipal Health Services in the urban areas.

(2) Local

(a) Local Authorities shall prepare public health plans for their area jurisdictions consistent with the comprehensive public health plan described under Section 15. Local public health plans shall:

(i) Examine data about health status and risk factors in the local community;

(ii) Assess the public and private sector resources, capacity and performance of the local public health system;

(iii) Identify goals and strategies for improving the health of the local community;

(b) The State Public Health Agency shall encourage and provide technical and financial

assistance to local public health agencies -and -work with local public health agencies to develop the plan.

(c) Effective implementation of the local public health plan shall be done through the establishment of a commensurate local public health establishment.

16. Training of Public Health Authorities

(1) The State Public Health Agency may directly, or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, including basic training and continuing education, or other tools for training public health agents and others within the public health system.

(2) Various individuals within the public health system shall be required by the state public health agency to meet minimal training requirements in order to provide essential public health services and functions, as they evolve.

(3) The State Government shall make adequate provisions for state level training institutes/district training centres for this purpose.

(4) The State Public Agency shall review periodically the curricula of medical and para-medical training institutions, so as to incorporate changing public health needs.

5) The State Public Health agency shall conduct training of private health care providers on surveillance criteria and Standard Treatment Protocols for diseases and conditions of public health importance, as decided by the state.

6) The State Public Health Agency shall ensure that the standard treatment protocols affectively integrate different systems of medicines like Allopathy and Ayush.

17. Earmarking of Revenue

(1) Every local authority shall earmark not less than 30 percent of its income from all sources other than Government grants for expenditure on the advancement of public health in its local area.

(2) The State Government may, by notification, authorize any local authority to incur expenditure on any public health purpose specified in the notification.

PART III

PUBLIC HEALTH DETERMINANTS

CHAPTER I

PUBLIC HEALTH CONDITIONS

18. Conditions of Public Health Importance

Conditions of public health importance are defined from the perspective of epidemiological significance, and include chronic and emerging conditions like diabetes, hyper-tension, cancers, Reproductive Tract Infection/Sexually Transmitted diseases, Cardio-vascular diseases, maternal and infant deaths, mental health, malnutrition, tobacco, alcohol and substance abuse and aging. Other conditions include environmental pollution – including noise, air, water and soil pollution – that can lead to widespread effects not restricted to any single or narrow set of symptoms. Other conditions of public health importance include, but are not limited to the diseases listed in Schedule I-B

19. Notifiable Diseases

(1) Without prejudice to anything provided for under the Factories Act, 1948, diseases may be characterized as notifiable where stern steps are needed to be taken to prevent them from taking

the form of an epidemic or spreading from one person to another, thereby increasing the levels of morbidity and mortality. Notifiable Diseases include, but are not limited to the diseases listed in Schedule I-A and occupational diseases (including pneumoconiosis, silicosis, byssinosis, bagganiosis, asbestiosis,)

(2) The State Government may from time to time by notification, declare a disease to be a notifiable disease for the purpose of this part either generally throughout the State or in such part or parts thereof as may be specified in the notification.

*Explanation***:** Occupational diseases shall also be notifiable diseases (including pneumoconiosis, silicosis, byssinosis, baggasosis, asbestosis,)

(3) In addition to Notifiable diseases mentioned above, certain diseases and health conditions shall be put under regular surveillance or the information shall be collated through sentinel surveillance or periodic surveys. The list of these diseases/conditions (schedule I-D) shall be based on disease burden in the community, potential to spread epidemic and availability of public health response. The said list shall be reviewed and modified at least once in 2 years.

20. Locally Endemic Diseases

Locally endemic diseases are defined from the perspective of local epidemiological significance and include chronic and emerging conditions like sickle cell anemia, flurosis, thalassemia, goitre, filariasis, leptospirosis. Locally endemic diseases include, but are not limited to the diseases listed in Schedule I-B

21. Obligations of State Government

(1) The State Government has the following general obligations at all times, within the maximum limits of their available resources, towards the progressive realization of health and well being of every person in the country.

(a) Undertake appropriate and adequate budgetary measures, as per the globally accepted norms, to satisfy, the obligations and rights set out herein, throughout ensuring transparency and equity in the allocation, planning and rational allocation and distribution of resources for health and health related issues and concerns;

(b) Take all measures and steps, for addressing bio-medical determinants as well as the underlying socio-economic, cultural and

environmental determinants of health and wellbeing to ensure the enjoyment of right to health and well-being of every person, equally and without any discrimination;

(c) Provide free and universal access to health care services and ensure that there shall not be any denial of health care directly or indirectly, to anyone, by any health care service provider, public or private, including for profit and not for profit service providers, by laying down minimum standards and appropriate regulatory mechanism;

Provided that notwithstanding the above the Governments have an immediate duty to prioritize the most vulnerable and marginalized persons and groups,-who are unable themselves to access means for adequate and appropriate health care services, and ensuring them at least the minimum conditions of health care;

(d) Ensure comprehensive involvement of civil society, especially vulnerable or marginalized individuals/ groups, including by enabling them to effectively articulate their health needs and to participate in all health related decision-making processes, including in setting health priorities and goals; and in devising, planning, implementing and

evaluating the policies and strategies for health and well-being at every level; also integrally incorporating their roles and participation in the contents of such policies, strategies and plans; and ensuring demonstrably serious consideration to diverse expert views, in the planning of health care;

(e) Where imposition of limitations on right to health of individuals becomes necessary in compelling public health or interest, ensure proportionality of such limitations by adopting the least restrictive alternative, and in any case ensure that they be of limited duration and subject to review against the reference to the rights provided for herein;

(f) Ensure that all their policies, especially the economic, agricultural, industrial, technology related, intellectual properties related, be subject to health and equity impact assessments;

(g) Ensure *inter se* convergence among programmes of all the sectors related to health and also *inter se* integration among all health care related programmes, vertically as well at every level of health care, horizontally; and

(h) Take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other countries, international organizations and other entities, such as development partners, donor organizations and multinational corporations.

(2) Within the framework of general obligations mentioned above, the core obligations of Governments towards right to health and well-being shall include the minimum essential levels of the following obligations towards the underlying determinants of health:

(a) Ensure equitable distribution of and access to essential health facilities, goods, drugs, services and conditions to all, and especially for vulnerable or marginalized groups;

(b) Ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger and malnutrition to everyone;

(c) Ensure adequate supply of safe water;

(d) Ensure sanitation through appropriate and effective sewerage and drainage systems, waste disposal and management systems,

pollution control systems, control of ecological degradation, control of insects and rodents and other carriers of infections, addressing practices resulting in unhygienic disposal of human excreta and refuse, consumption of unhygienic water or food and through other measures;

(e) Ensure access to basic housing with dignity, access to basic facilities, and protection from forced eviction, harassment or other threats; and

(f) To devise, adopt, implement, and periodically review, health policies, strategies and plans of action, on the basis of epidemiological, sociological and environmental evidence, addressing the health concerns of the whole population, which shall include methods such as right to health indicators and benchmarks, by which progress can be closely monitored, and evaluate them on the basis of outputs.

Provided that until the policies and plans are notified by the State Government under this Act, the National Health Plan, (NHP) 2002, National Population Policy (NPP) 2000, National AIDS Control Programme-III (NACP-III), National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM), or any other existing plans,

policies or programmes relating to health shall be deemed to be the plans, policies and programmes under this Act. However, within 6 months of this Act coming into force they would be assessed and where necessary, strengthened and modified, with reference to this Act, especially the rights and obligations provided for herein and its basic framework.

Provided further that within 1 year of this Act coming into force, the State Government shall adopt and implement national strategies and plans of action for ensuring access to underlying determinants of health: food, water, sanitation and housing, and in the light of the framework laid down in this Act, review, and if necessary, redraft, the currently existing schemes and programmes on them, and within 6 months thereafter, the State Governments shall accordingly adopt and implement compatible State level strategies and plans of action through their respective local bodies.

Explanation: The above obligations shall be 'core' obligations of the Governments in the sense that they shall be non-derogable and the Governments cannot, under any circumstance, justify their non-compliance with these obligations.

22. Functions of the Local Authority with respect to Notifiable Diseases, Conditions of Public Health Importance and Locally Endemic Diseases

(1) The Local Authority shall perform the following functions:

(a) Assess the community health status, identify the notifiable diseases, conditions of public health importance and locally endemic diseases, their risk factors, and establish a system for surveillance of these diseases through regular data collection and analysis, in the manner prescribed.

(b) Prepare a district and local health plan for control of notifiable diseases, conditions of public health importance and locally endemic Diseases on the basis of data collected and its analysis, with the involvement of community members in the making of the plan and in its implementation.

(c) Enumerate a list of notifiable diseases, locally endemic Diseases and conditions of public health importance and review it regularly. Such a list shall include diseases or conditions of humans or animals caused by exposure to toxic substances, microorganisms, or any other pathogens. The list may include

notifiable diseases under Occupational health acts (factories act, mines act etc).

(d) Ensure the implementation of ongoing National Infectious Disease (TB, Leprosy, Vector-borne, Polio, STD, AIDS etc) control programmes.

(e) Establish Public Health laboratories in each District and Municipal Corporation, whose functions shall include the following:

(i) Testing of water samples for hardness, total dissolved solids (TDS), harmful chemicals and presence of pathogens, for newly established water source in routine activities.

(ii) Testing of samples of milk for pathogens, harmful chemicals, adulteration and adequacy of pasteurization.

(iii) Testing of samples of foods for adulteration, harmful chemicals, and pathogens in case of occurrence of cases of food poisoning.

(iv) Analysis of samples of air for harmful substances, toxic gases and their amounts, suspended particles etc.

(v) Analysis of blood samples for screening of infectious diseases, confirmation of diagnosis in cases of outbreaks of diseases/conditions of public health importance.

(vi) Analysis of human and animal tissue to detect environmental toxins, including chemicals, heavy metals etc.

Provided that where there is no Municipal Corporation for a particular district, the laboratory shall be set up at the District Headquarters. .

23. Powers of the Local Authority with Respect to Burial and Burning Grounds

(1) The Local Authority shall have the following powers with respect to burial and burning grounds:

(a) Provide suitable place with care-takers for burial and burning or otherwise disposal of the dead bodies according to different religious customs at reasonable distance from inhabited areas. The clothing and bedding in which the dead body has been carried to the burial or burning ground shall be buried or burn according to religious tenets.

Provided that the care-taker shall not permit the burial or burning of dead bodies except on production of a certificate showing the probable cause and time of death and signed by a registered medical practitioner or a member of the local authority for the locality in which the deceased was resident.

(b) Grant license for all burial and burning grounds, in the prescribed manner.

(c) Arrange for proper registration of all dead bodies buried or burnt or other wise disposed.

(d) Arrange for thorough disinfection of the vehicles and bulky articles not disposed off, at the prescribed charges.

24. Function of health care providers in reporting

(1) All health care providers, medical examiners, pharmacists, laboratories, whether in public or private sphere, shall, subject to the right of confidentiality of a user, report all cases of persons who harbor any illness or health condition, including any notifiable diseases, condition of public health importance and locally endemic diseases, that may be potential causes of a public health emergency in the prescribed manner to the following persons:

(a) In municipal areas, to the executive authority, the Health Officer or a Sanitary Inspector

(b) In non municipal areas, to the Chief District Health Officer, a Health or Sanitary Inspector or the Village Headman.

Explanation: Reportable illnesses and health conditions shall mean infectious diseases and condition of public health importance required by the state public health agency to be reported and diseases listed in the notifiable diseases list mentioned under Schedule I-A and any other illnesses or health conditions identified by the public health authority.

Explanation: In this section, 'medical practitioner' includes a Vaidya or Hakim, whether registered or not.

(2) A veterinarian, livestock owner, veterinary diagnostic laboratory director, or any other person having the care of animals shall report animals having or suspected of having any diseases or conditions that may be potential causes or indicators of a public health emergency.

(3) Any other person who knows or suspects a case of a reportable disease or condition may provide available information concerning the case to the concerned persons mentioned in sub-section (1).

(4) Without prejudice to anything provided under the Registration of Births and Deaths Act, 1969 it shall be the duty of the health care provider to ensure effective implementation of the recording of all birth, death and cause of death to the appropriate authority, which occurs in their presence. In all other cases, it shall be the duty of the family members to record birth and death. All provisions relating to penalty shall be as provided under the Registration of Births and Deaths Act.

CHAPTER II

PUBLIC HEALTH MANAGEMENT IN SITUATIONS OF DISASTERS

25. Planning for public health emergencies caused due to disasters

(1) The State Public Health Board shall set up State Disaster Management committee under the Gujarat State Disaster Management Authority established under the Gujarat State Disaster Management Act, 2003, which shall:

(a) prepare a disaster management plan setting out –

(i) the manner in which the concept and principles of disaster management shall be applied for saving lives and preventing outbreaks of diseases;

(ii) roles and responsibilities of the Public Health department in respect of emergency medical relief and post disaster recovery and rehabilitation;

(iii) capacity to fulfill roles and responsibilities of the department;

(iv) strategies and procedures in the event of a disaster, including measures to finance the strategies; This should include chronological action plan to be followed after initial alert of the disaster, activating hospital disaster plan for medical relief, triage, declaration of public health emergency, management of life supporting services

(b) co-ordinate preparation and the implementation of plan with other departments, local authorities , communities and stakeholders;

(c) regularly review and update the plan at the state & local authority level

(2) The State Disaster Management committee shall make suitable provisions in the plan after considering the following, namely:-

(a) the types of disaster that may occur and their possible effects;

(b) the communities and property at risk;

(c) provision for appropriate prevention and mitigation strategies;

(d) inability to deal with disasters and promote capacity building;

(e) the integration of strategies for prevention of disaster and mitigation of its effects with development plans, programmes and such other activities in the State;

(f) provision for assessment of the nature and magnitude of the effects of a disaster;

(g) contingency plans including plans for relief, rehabilitation and reconstruction in the event of a disaster, providing for –

(i) procurement of essential goods and providing essential services;

(ii) establishment of strategic communication links;

(iii) dissemination of information.

26. Services in Case of Epidemics, Disasters and Conflict Situations

(1) In case of epidemics, conflict situations and disasters, natural as well as man made, all required health services shall be made available to all affected persons with no discrimination on the grounds of age, sex, economic status, place of residence, religion, caste, physical or mental ability, nationality, mental health status or HIV/AIDS status, or type of epidemic on the following principles:

(a) Prompt and comprehensive responses;

(b) Immediate response- outreach of services to all including setting up of health camps and mobile clinics within 48 hours;

(c) Multifaceted response- Physical, social and psychological;

(d) Comprehensive response taking into account public health services that may be disrupted;

(e) Ensuring provision of services other than health care, like food and water supply;

(f) Uniform compensation.

CHAPTER III

PUBLIC HEALTH EMERGENCIES

27. Detecting and Tracking Public Health Emergencies

(1) Tracking for public health emergencies shall be based on the data generated through the Integrated Disease Surveillance Plan (IDSP) operative in the State.

(2) The local public health authority shall ascertain the existence of cases of an illness or health condition that may be a potential cause of a public health emergency, investigate all such cases for sources of infection, ensure that they are subject to proper control measures and define the magnitude of the problem by assessing the distribution of the disease or health condition.

Deleted:

(3) The local public health authority shall routinely monitor industry-level information on environmental pollution generated by the pollution control board, and assess other information pertaining to public water bodies to ascertain areas that are routinely receiving environmental toxins in excess of prescribed standards. High pollution areas shall be defined as such, and steps shall be taken to mitigate pollution. Such steps shall include

monitoring of health with a view to assessing outcomes resulting from exposure to environmental pollution, coordinating with Pollution Control Board to mitigate pollution, extending specialized training to health providers in diagnosing and treating potentially environmentally-affected persons, and specially equipping local health care centers with the ability to detect and respond to environmental diseases and epidemics.

(4) To fulfill the above duties the public health authority shall follow the prescribed chronological action plan as prepared by State Disaster Management committee

(5) If an outbreak of disease is suspected, the medical officer of the concerned health facility will verify the outbreak, send the requisite sample to the public health laboratory for confirmation of diagnosis, provide standard case management for diagnosed cases and contacts through active search in the community, initiate proper control measures to prevent further spread of outbreak including vaccination, submit a report to the local authority, district health authority in consultation with BHO/CDHO.

28. Declaration of a state of Public Health Emergency

(1) A state of Public Health Emergency may be declared by the State Government/Local Authority upon the occurrence of a "public health emergency" as defined in Section 2(62)

In the event of the prevalence or threatened outbreak of a notifiable disease, or other illness or condition that could adversely effect public health in any area, the State Government /Local Authority may declare that such an area is affected by, or threatened with, an outbreak of such disease, and such declaration shall also amount to a declaration of public health emergency.

(2) Prior to such a declaration, the State Government shall consult with the State Public Health Board and National Institute of Communicable Diseases

Provided that the State Government /Local Authority may declare a public health emergency without consulting with the public health authority or other experts when the situation requires immediate and timely action.

(3) A state of Public Health Emergency shall be declared by an executive order that specifies the:

(a) Nature of the public health emergency,

(i) Administrative divisions or geographic areas subject to the declaration,

(ii) conditions that have brought about the public health emergency,

(iii) duration of the state of the public health emergency, if less than 30 days, and

(iv) primary public health authority responding to the emergency

(4) The primary public health authority specified under sub section 3(e) shall be :

(a) if emergency is due to any disaster as per the State Health Emergency and Mitigation Plan,

(b) If emergency is due to any other reasons, person so designated from the State public health board.

(5) Where a declaration of a state of Public Health Emergency is published in the Government Gazette, it shall activate the response mechanisms of the State, local and inter-jurisdictional emergency plans in the affected political sub-division(s) or geographic area(s). Such declaration shall authorize the deployment and use of any agencies and official cadres in the areas to which the plans apply and the use or distribution of any supplies, equipment, and

materials and facilities assembled, stockpiled, or available pursuant to this Act.

29. Termination of Public Health Emergency

(1) The State Government or the Public Health Authority at the local level shall terminate the declaration of a state of Public Health Emergency by an executive order upon finding that the occurrence of an illness or health condition that caused the emergency no longer poses a high probability of a large number of deaths in the affected population, a large number of incidents of serious permanent or long-term disability in the affected population, or a significant risk of substantial future harm to a large number of people in the affected population. In the case of Public Health Emergencies declared owing to environmental pollution, the State Government or the Public Health Authority at the local level shall terminate the declaration by an executive order upon termination or regulation of the source of environmental pollution, and clean-up of environmental contamination caused by the same.

(2) All orders terminating the declaration of a state of Public Health Emergency shall indicate the nature of the emergency, the area(s) that was threatened,

and the conditions that make possible the termination of the declaration.

(3) Notwithstanding any other provision of this Act, the declaration of a state of public health emergency shall be terminated automatically after 30 days after the last case detected, unless renewed by the State Government under the same standards and procedures set forth in this Chapter.

30. Emergency Powers of the State Government

(1) The State Government shall, for such period as a state of Public Health Emergency exists, exercise the following powers:

(a) Suspend the provisions of any regulatory statute prescribing procedures for conducting State business, or the orders, rules and regulations of any State agency, to the extent that strict compliance with the same would prevent, hinder, or delay necessary action (including emergency purchases) by the public health authority to respond to the public health emergency, or increase the health threat to the population.

(b) Utilize all available resources of the State government and its Administrative divisions,

as reasonably necessary to respond to the public health emergency.

(c) Temporarily transfer the personnel of State departments and agencies in order to perform or facilitate response and recovery programs regarding the public health emergency.

(2) The State Government may, for such period as the state of Public Health Emergency exists, exercise the following powers:

(a) Mobilize all or any part of the organized armed and security forces into service of the State. An order directing the armed and security forces to report for active duty shall state the purpose for which it is mobilized and the objectives to be accomplished.

(b) Respond immediately to international humanitarian aid.

(c) Provide aid to and seek aid from other states in accordance with any inter-state emergency pact made with this State.

(d) Seek aid from the Central Government in accordance with national disaster plans

(e) Appoint temporarily, by order, for such period as may be specified therein, one or more

additional Health Officers, for the treatment of such infectious disease and to prevent it from spreading, or for investigating the cause of and preventing, such mortality, as the case may be.

CHAPTER – IV

PUBLIC HEALTH IMPACT ASSESSMENT

31. Powers of the Local Authority with Respect to Burial and Burning Grounds

(1) The Local Authority shall have the following powers with respect to burial and burning grounds:

(e) Provide suitable place with care-takers for burial and burning or otherwise disposal of the dead bodies according to different religious customs at reasonable distance from inhabited areas. The clothing and bedding in which the dead body has been carried to the burial or burning ground shall be buried or burn according to religious tenets.

Provided that the care-taker shall not permit the burial or burning of dead bodies except on production of a certificate showing the probable cause and time of death and signed by a registered medical practitioner or a

member of the local authority for the locality in which the deceased was resident.

(f) Grant license for all burial and burning grounds, in the prescribed manner.

(g) Arrange for proper registration of all dead bodies buried or burnt or other wise disposed.

(h) Arrange for thorough disinfection of the vehicles and bulky articles not disposed off, at the prescribed charges.

32. Clearance of development projects based on health impact assessment

(1) All projects that fall under Category A and B1 of EIA Notification, 2006, shall under this Act require a Health Impact Assessment which will be commissioned by the Public Health Authority at the District level, and paid for by the project proponent.

(2) In addition there needs to be a supporting resolution of the Gram Sabha of all the relevant villages in support of the project, if there are any concerns, these need to be explicitly included in the EIA / HIA. The project cannot go to the public hearing stage without the express consent of the

respective Gram Sabhas. Any case of undue influence on these villagers should be dealt with very severely.

(3) The village health committee will be appraised of the situation, and will have the power to make specific queries, objections etc, that need to compulsorily be addressed in the HIA report.

(4) The District-level Public Health Authority shall conduct a public hearing at a venue as close as possible to the project site, after giving due notice of 30 days in at least two newspapers, one of which shall be in the local language prevalent in the project area, and by the printing of pamphlets to be distributed in interior villages, and making available copies of the Health Impact Assessment report at the below-mentioned offices:

(a) District Industries Centre

(b) Office of the District Collector

(c) Block Development Office or Municipal Corporation or Council

(d) Office of the Chief District Health Officer, or Health officer in the case of Municipal Corporation/Council

(e) Primary Health Centre

(f) Panchayat offices of every concerned village – this report should also contain a translation into local language and a complete and accurate executive summary.

(5) The terms of reference (TOR) and scope of the Health Impact Assessment shall be intimated to the project proponent within 30 days of receipt of application consisting of project report. The TOR shall be finalized by a Health Impact Assessment Committee consisting of the Chief District Health Officer, or Health Officer in the case of Municipal Corporation/Council, at least two independent medical experts, members of NGOs working in the health sector.

(6) The Public Hearing shall be conducted by a panel comprising of the members of the Health Impact Assessment Committee, in addition to the District Collector and a representative of the local body.

(7) Minutes of the hearing will be finalized and read out at the end of the public hearing, and forwarded to the Secretary, Department of Health, for evaluation by a State Level Health Impact Appraisal Committee comprising relevant members The Committee shall forward its recommendations to the Secretary, Department of Health, for final project approval which shall be granted with conditions or denied for

reasons stated no later than the date of grant of environmental clearance from Centre or State Government as the case may be.

33. Need for additional health impact assessment

The Public Health Authority shall monitor the project for compliance with conditions stipulated in the approval granted and submit half-yearly compliance report, along with recommendations for additional assessment and mitigation of health impacts to the Department of Health, with copies to the local body and the Pollution Control Board.

34. Register of Approval

The Public Health Authority shall maintain a register of approval granted along with conditions, raw materials used, products manufactured, and details of emissions (to air, water and land) by the project activity, the hazards to health and environment therein, and such details shall be open to inspection by interested members of public and the same shall be published via internet. Interested members of public shall be allowed to take copies of relevant documents from the Register upon payment of fees as shall be decided by the Authority. Persons under

BPL category shall be provided the information free of cost.

CHAPTER – V

Public Health Rights

35. Right to Health

Every person has the right to a standard of Physical and Mental Health conducive to living a life in dignity.

36. Right to access, use and enjoy

Every person has the right to access, use and enjoy all the facilities, goods, services, programmes and conditions necessary for ensuring the right to health, including but not limited to at least the following:

(a) Right to food;

(b) Right to water;

(c) Right to sanitation;

(d) Right to housing;

(e) Right to appropriate health care, and health care related functional equipment and other infrastructure, trained medical and professional personnel, and essential drugs;

Appropriate health-related IEC, including on sexual and reproductive health, to be able to make more informed health related choices;

Explanation: The information hereunder, where needed for the purposes of fulfillment of this Act, shall not be limited to, and shall be in addition to, the information receivable under the Right to Information Act, 2005.

(f) Protection from and mitigation during environmental disasters like famines, floods, and earthquakes, disease outbreaks/ epidemics, and other public health emergencies;

(g) Protection from and abatement of hazardous and injurious substances and activities; road and transport safety; industrial hygiene and occupational safety; hygiene and safety in places and situations of large collection of people occasioning mass food production or disposal of biological wastes including at fairs, festivals, cinema, theatres, circuses, markets, shopping places, malls, lodging houses, burial and burning grounds, slaughter houses; and

(h) Health Impact Assessment (HIA) of all new development projects.

Explanation: Right to access, use and enjoy all the facilities, goods, services, programmes and conditions

necessary for the realization of the a standard of health conducive to living a life in dignity shall mean that facilities, goods, services, programmes and conditions providing all the above shall be:

(a) *available* in sufficient quantity;

(b) *accessible* to everyone, such that 'accessibility' shall mean and entail:

  (i) access without discrimination on any of the prohibited grounds;

  (ii) physical access; in case of persons with disabilities further ensuring adequate access to buildings, and infrastructure through reasonable accommodation measures;

  (iii) economic access or affordability; and

  (iv) access to information and ideas concerning health issues; in case of persons with disabilities, further ensuring access to information through reasonable accommodation measures.

(c) *acceptable* such that the facilities, goods, services, programmes and conditions must be respectful of medical ethics and socio-culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities; sensitive to gender and lifecycle requirements, as well as designed to

respect confidentiality and improve the health status of those concerned; and

(d) scientifically and medically *appropriate and of good quality,* requiring, *inter alia*, trained and skilled medical and para medical personnel, scientifically approved and unexpired drugs and hospital equipment and other infrastructure satisfying the relevant safety standards.

37. Right against discrimination:

(1) No person shall be subject to any discrimination in any form or manner, by the Government or any other person or body of persons, whether public or private, in access to facilities, goods, services, programmes, conditions, or rights for health care and for underlying determinants of health, as well as to means and entitlements for their access, use and enjoyment, on one or more of the grounds of sex, class, monetary or other economic status, place of birth, age, marital status, actual or perceived health status, sexual orientation, physical or mental disability, occupation, religion, sect, region, language, political or other opinion, caste, civil, political, social or other status or affiliation, race, or any other arbitrary ground (herein called 'prohibited grounds'), which has the intention or effect of nullifying or impairing the equal

enjoyment or exercise of the right to health, and the right to dignity, of that person.

Explanation: "Discrimination" in the above provisions and also wherever else it is mentioned in this Act shall include any act of omission or commission including any policy, law, rule, regulation, any other executive decision; practice, custom, tradition, usage; condition or situation which, in law or in fact, directly or indirectly, expressly or by effect, immediately or over a period of time, distinguishes, excludes or prefers any person or group of persons, to:

(i) impose burdens, obligations, liabilities, disabilities or disadvantages on; or

(ii) deny or withhold benefits, opportunities or advantages, from; or

(iii) compel or force the adoption of a particular course of action, by, such person or group of persons, based on one or more of the prohibited grounds of discrimination.

(2) Notwithstanding the above, with a view to ensuring full equality in practice, Governments shall proactively adopt specific measures by way of affirmative action for the protection, benefit or advancement of vulnerable and marginalised individuals and groups, to eliminate the existing discrimination and promote equality of opportunities with regard to any aspect of health

rights mentioned herein, and such affirmative action shall not be construed as discrimination.

38. Right to dignity

Every person has a right to privacy, the right to be treated with dignity and to be free from any inhuman, cruel or degrading treatment, at the hands of Government or any other person or body of persons, whether public or private, in the matter of health rights; especially in the matter of health care this shall mean that every person seeking any health care is entitled to be treated by health care providers with patience, empathy, respect, tolerance for that person's culture and values, and humanness; further, this shall mean that no one shall be subjected to any coercive health measures or subjected to indiscriminate denials.

39. Right of participation, information

Every person has a right to participate in all health-related decision-making and actions at all levels, including at the community level, which shall include right to information about all the health related measures being initiated by the Governments, including information on Health Impact Assessments (HIAs), resource allocation and all health information collected by the Governments,

and information that can enhance health seeking and healthy lifestyles.

40. Right to justice

Every person whose right to health is actually or perceived to be violated in any manner, at the hands of anyone, has a right to seek redressal of his/ her grievance through a choice of appropriate dispute resolution and grievance redressal mechanisms, including those especially set up under this Act, against such violation, and for claiming his rights, and/or reparation.

PART – IV

PUBLIC HEALTH CARE SERVICES

CHAPTER – I

Health Care System

41. Structure of Healthcare System

(1) The envisaged Health Care Services under this Act, Rules shall be rendered by every Health Care establishment.

(2) The State Government shall notify form time to time the Jurisdiction and the nature and the extent of Health Care Services to be offered by every Public Health Care establishment located in rural

and urban areas. While doing so, the State Government shall consider the inputs rendered by State and District Public Health Authority and the concerned Local Authority.

42. Certificate of Need

(1) The State Public Health Board shall formulate operational norms and standards for numerical requirement of public and private health care establishments for each population unit. The population unit for general health care services shall be the block in rural areas and a cluster of 50,000 population in urban areas. There shall be separately designated norms for rural and urban population units. These norms and standards shall specify for a population unit at least the following regarding general health care services:

(a) Optimal and maximum number of general medical, surgical and maternity beds;

(b) Optimal and maximum number of general laboratories;

(c) Optimal and maximum number of general imaging units (ultrasound, X-ray).

(2) The State Public Health Board shall formulate requirement norms for specialist health care services. The population unit for specialist health care services shall be the District. Concerning larger cities with a population of more than 5 lakhs, separate norms shall be specified for population clusters of 5 lakh population each or fraction thereof. These norms and standards shall specify for a population unit, at least the following regarding specialist health care services:

(a) Optimal and maximum number of specialist health care institutions of major types;

(b) Optimal and maximum number of specialist laboratories;

(c) Optimal and maximum number of specialist imaging units (CT scan, MRI scan).

(3) A certificate of need for the health institution shall certify that the health care facility is in accordance with the required norms and standards.

(4) A person shall not:

(a) Establish, construct, modify or acquire a health establishment;

(b) Increase the number of beds in, or acquire prescribed health technology at, a health establishment;

(c) Provide prescribed health services; or

(d) Continue to operate a health establishment or after the expiration of 6 months from the date this Act took effect, without being in possession of a certificate of need.

Provided that these provisions shall not be applicable to health care establishments that are in existence at the time of the coming into force of the Act.

(5) A person who wishes to obtain or renew a certificate of need shall apply to the concerned Health Care Establishment (Registration & Regulation) Authority in the prescribed manner and shall pay the prescribed application fee, at the time of first registration or certification as the case may be and there-in-after at the prescribed intervals.

(6) Before the Health Care Establishment (Registration & Regulation) Authority issues or renews a certificate of need, he or she shall take into account:

(a) The need to ensure consistency of health services development in terms of national, provincial and municipal planning;

(b) The need to promote an equitable distribution and rationalization of health services and health care resources, and the need to correct inequities based on racial, gender, economic and geographical factors;

(c) The need to promote an appropriate mix of public and private health services;

(d) The demographics and epidemiological characteristics of the population to be served;

(e) The potential advantages and disadvantages for existing public and private health services and for any affected communities;

(f) The need to protect or advance persons or categories of persons within the emerging small, medium and micro-enterprise sector;

(g) The potential benefits of research and development with respect to the improvement of health service delivery;

(h) The need to ensure that ownership of facilities does not create perverse incentives for health service providers and health workers;

(i) If applicable, the quality of health services rendered by the applicant in the past;

(j) The probability of the financial sustainability of the health establishment;

(k) The need to ensure the availability and appropriate utilization of human resources and health technology;

(l) Whether the private health establishment is for profit or not;

The concerned Health Care Establishment (Registration & Regulation) Authority shall, for the purpose of issuing of certificates of need act under advice from the District public health board.

(7) The concerned Health Care Establishment (Registration & Regulation) Authority may investigate any issue relating to an application for the issue or renewal of a certificate of need and may call for such further information as may be necessary in order to make a decision upon a particular application.

(8) The concerned Health Care Establishment (Registration & Regulation) Authority shall issue or renew a certificate of need subject to—

(a) Compliance by the holder with specified norms and standards for health establishments and health agencies, as the case may be; and

(b) Any condition regarding—

(i) The nature, type or quantum of services to be provided by the health establishment;

(ii) Human resources and diagnostic and therapeutic equipment and the deployment of human resources or the use of such equipment;

(iii) Public private partnerships;

(iv) Types of training to be provided by the health establishment; and

(v) Any criterion contemplated in subsection (1) (of this clause).

(9) The concerned Health Care Establishment (Registration & Regulation) Authority shall withdraw a certificate of need

(a) On the recommendation of the State Public Health Board

(b) if the continued operation of the health establishment, as the case may be, or the

activities of a health care provider or health worker working within the health establishment, constitute a serious risk to public health;

(c) if the health establishment, as the case may be, or a health care provider or health worker working within the health care establishment, is unable or unwilling to comply with minimum operational norms and standards necessary for the health and safety of users; or

(d) if the health care establishment, as the case may be, or a health care provider or health worker working within the health establishment, persistently violates the constitutional rights of users or obstructs the State in fulfilling its obligations to progressively realize the constitutional right of access to health services.

(10) If the concerned Health Care Establishment (Registration & Regulation) Authority refuses an application for a certificate of need or withdraws a certificate of need the Local Supervisory Authority shall within a reasonable time give the applicant or holder, as the case may be, written reasons for such refusal or withdrawal.

(11) A certificate of need is valid for a prescribed period, but such prescribed period shall not exceed 20 years.

(12) Any person aggrieved by an order refusing an application or withdrawing a certificate of need may, within 30 days after the date on which the copy of the order was sent to him/her, appeal to the (State/ District) Public Health Board.

Provided that no such order of refusal of application or withdrawal of certificate of need shall come into force until after the expiration of 30 days from the date on which it was made or, where notice of appeal is given against it, until the appeal has been decided or withdrawn.

43. Public – Private Partnership

(1) The Public Health system may enter into partnerships with non-governmental health care providers, including private health care establishments, subject to the provisions of this Act. Any such public private partnership entered into shall not be for more than a five-year term, and shall be subject to annual evaluations.

(2) The State Public Health Board shall develop norms for regulating public-private partnership with the overall objective of strengthening the Public health

system and harnessing private medical resources for public health goals.

(3) All such partnerships shall be accompanied by effective quality regulation based on the standards laid down under Section 133 of this Act. All non-governmental agencies participating in partnerships shall be required to operationalise the Internal Redressal mechanisms and submit reports to the Monitoring committee as envisaged in the Rules and shall be subject to the monitoring mechanisms as prescribed.

(4) In any such partnerships, there shall be no payment made by any persons with limited paying capacity at the point of service. Any payment charged from any other user or any charge recovered at a later stage, shall be made below or at a prescribed maximum cost. Any health care providers found to be charging beyond the norms for such services shall be debarred from further partnership and shall be deemed to have committed a punishable offence under the Act.

(5) Preferably, there shall be no contracting out of the management of Public health facilities at any level. Any contracting out shall be based on permission from the State Public Health Board, based on provision of satisfactory reasons for such an

exceptional measure, by the relevant Public health authority under whose jurisdiction such a partnership is proposed. This contracting out would be for a maximum period of five years with annual revisions, based on strict conditions of partnership. A violation of any term of the contract shall result in the termination of such partnership. Contracting in of medical staff by public health facilities shall be permitted where requisite staff is not available, with the intention of strengthening the public health facility.

Explanation: Contracting in shall mean when the public health system either uses the facilities or avails the services of the staff belonging to private system on payment.

Contracting out shall mean the handing over or outsourcing full or part of services, management to private parties. Contracting in implies greater control with public system. Contracting out means reduction of such control.

(6) In all blocks / wards where such partnerships are entered into, the utilization of PHCs / CHCs providing similar services shall be reviewed by the concerned Monitoring committee on an annual basis. In a case where the utilization of defined services from the public health facility has declined

by more than 10 % in any year, an official enquiry shall be conducted into the causes of the same and depending on the results of the enquiry; no further partnerships shall be approved in such a block / ward in the subsequent year.

(7) Transfer of any assets from public to private ownership may be done only after being authorized by the State Public Health Board, which may be given only after scrutiny based on the norms laid down under sub-section(6).

(8) There shall be an annual review of every public-private partnership, on the basis of which it shall be allowed to continue.

(9) During selection of providers for partnership, preference shall be given to not-for profit / voluntary sector providers over for-profit providers.

(10) All private providers involved in such partnerships shall provide relevant minimum wages and social security to their employees. In case any complaint of inadequate payment of wages or social security is received, an enquiry shall be conducted into such complaint by the local supervisory authority. If such a complaint is proved during the enquiry, such provider would be debarred from further partnership.

(11) No Government doctors and staff shall be engaged in any form including as consultants, in non-governmental for profit health care facilities involved in a Public Private Partnership. All non-Governmental for profit health care facilities where government doctors or staff are engaged in any form including as consultants shall be debarred from partnership with the public health system.

44. Participation in National and State Health Programmes

(1) Every private health care establishment registered under this Act shall participate in the National Health Programmes, follow national guidelines for national health programmes, notify diseases and perform statutory functions for detection and prevention of communicable diseases and occupational health problems.

(2) All medical personnel in private health care establishment shall be aware of the various notifiable diseases mentioned under this Act, including infectious and communicable diseases, and the national programmes for control of diseases. They shall integrate their efforts with the official programmes/ activities for the same. During outbreaks, epidemics and disasters they shall

extend full cooperation and work in partnership with the government machinery.

(3) Every private health care establishment shall maintain records of all cases of notifiable diseases and concerned authorities shall be intimated in accordance to current law or specifications given by the government from time to time.

(4) Every private health care establishment shall perform statutory duties in respect of communicable diseases to prevent the spread of the disease to other persons, and report the same to the concerned public health authorities immediately.

CHAPTER – II

APPLICABILITY

45. Applicability of Part IV

This part shall be applicable to all types of Health Care Services provided by any Health Care establishment.

CHAPTER – III

REGISTRATION AND COMPLIANCE CONDITIONS OF HEALTHCARE ESTABLISHMENTS

46. Registration

(1) No Healthcare Establishment shall commence any activity relating to any kind of Healthcare Services either for promotive, preventive, curative or rehabilitative purposes after the commencement of this Act, unless such Healthcare Establishment is duly registered under this Act.

Provided that every Healthcare Establishment engaged either partly or exclusively in any activity relating to the rendering of the aforementioned healthcare services immediately before the commencement of this Act, shall apply for registration within 60 days from the date of such commencement.

Provided further that every Healthcare Establishment engaged in any activity aforementioned shall seize to be engaged in any such activity on the expiry of 3 months from the date of commencement of this Act unless such Healthcare Establishment has applied for registration and is so registered or such application is disposed of, whichever is earlier.

(2) Every application for registration under sub-section (1) shall be made to the Healthcare Establishment Registration Authority in such form and in such manner and shall accompany by such fees as may be prescribed in the Regulation.

(3) No Healthcare Establishment shall be registered under this Act unless the concerned Healthcare Establishment (Registration & Regulation) Authority has specified that such Healthcare Establishment is in a position to render the envisaged Healthcare services and facilities possessed such as skilled manpower and equipments and maintain such standards as may be prescribed.

(4) For the purposes of this part, Healthcare Establishment means the whole or part of a public or private institution, whether for profit or not; where inpatient or outpatient treatment; diagnostic or therapeutic interventions; nursing, rehabilitative, palliative, convalescent, preventive or other health care services or any of them are provided. Healthcare establishment includes clinical establishment meaning any premises used for person suffering from any sickness, injury or infirmity and shall include hospital and maternity homes.

47. Standards and quality of Care

(1) Every Healthcare Establishment shall adhere to the following minimum standards:

a. Functional Programme for the establishment that shall consist of a prescribed set of services that are to be made available through the functional programmes of the health care establishment in accordance to the nature, specialty and size of the establishment, and shall include a prescribed set of emergency and lifesaving drugs. The list of services and the respective charges shall be displayed in local language in a prominent place in the health care establishment or made readily available in the form of a booklet in local language.

b. Minimum physical and process standards that shall be in accordance to nature, size and specialty of the establishment. Physical standards shall include prescribed minimum floor space per bed in the health care establishment, space for operation theatre, sterilization, space for out patient care, emergency care/ casualty room, treatment and dressing room, minimum size and number of toilets, space for medical records and storage facilities, entrance zone, diagnostic zone, service zone and infrastructure for adequate safety of patients. Process standards shall include prescribed clinical

standards, managerial standards and such other standards as are deemed essential to running the health establishment.

c. Maintenance and preservation of Medical Records as prescribed by the rules and shall include preservation of medical records such as out-patient case paper, in-patient case records, investigation records, discharge papers and follow up records. Such records shall contain relevant personal details, medical history, history of the illness (es), diagnosis and status of health, investigation findings, treatment prescribed and follow up, and specifications for duration of storage of records. All records shall be made in duplicate and a copy of all such records shall be given to the patient.

d. Recording and preserving vital records, as prescribed by the rules and shall include the records of births, deaths, miscarriages, abortions, still births, ultrasonography conducted, record of children born and removed to the custody or care of a guardian or relative or orphanage or alternative arrangement, record of people with disability, any notifiable diseases encountered to be reported.

e. Minimum essential equipments, as prescribed by the rules that are required to run the establishment, and shall include equipment for adequate safety and quality of care for patients.

f. Human Resources, that shall include a prescribed number and qualifications of medical, nursing, para-medical and administrative staff required in the private health care establishment, in proportion to the number of beds available in the facility. With regard to the employment of nurses, two categories of nurses shall be recognized, Qualified Nurses and Trained Nurses, as defined by the Act.

g. Special provisions prescribed for certain categories of health care establishments including Radiotherapy, Nuclear Medicine Centre and Ultrasound Clinics.

h. Safety, protection and healthy working conditions of hospital staff, as prescribed by the Rules and shall include provision of adequate vaccination and other equipment to hospital by management, for protection of self from infections and other health hazards.

i. Adhere to National Guidelines on Hospital Waste Management based on the Bio-Medical Waste (Management & Handling) Rules, 1998 rules

Provided that separate standards may be prescribed for rural and urban areas, for different bed-wise sizes of hospitals and according to different specialties of care available therein. Towards this purpose, the standards may be classified into Core and Critical. Critical standards in any given circumstances, warrant 100% compliance. However, the Core standards warrant a minimum of 80% compliance.

48. Right to Healthcare Services

(1) Every person shall have the right of equal access to all guaranteed Healthcare Services and Essential drugs as envisaged in Schedule II and III respectively, free of cost.

Provided that registration fees not more than Rs. five (which may be reviewed by the State Health Department from time to time) may be charged at only one point for services referred to under sub-section (1), for persons other than persons with limited paying capacity.

(2) In addition to guaranteed services all other services shall be available free of cost to persons with limited paying capacity.

(3) In the case of the user being referred to a higher level of health care establishment, by any public health care establishment, the person in charge of the referring health facility shall provide the user with a referral slip stating the reasons for not admitting or treating the user, and the health care establishment to which such reference has been made.

(4) In the case of emergency and critical patients, transport shall be arranged for by the referring Health Care Establishment.

(5) All referrals shall be treated with priority, and all establishments to which cases have been referred shall send a report on the patient referred to the referring Health Care Establishment.

CHAPTER – IV

RIGHTS AND DUTIES OF HEALTHCARE CONSUMERS

49. Choice of System of Medicine

(1) All users shall have the right to be administered treatment or facilities according to the system of

medicine chosen by them, subject to the availability of such treatment in a particular health care establishment. In case of the chosen system of medicine not being available in the establishment that is approached, the user shall be referred to the nearest available establishment that provides such services.

(2) Systems of medicine as contemplated in sub-section (1) includes Allopathy, Ayurveda, Homeopathy, Unani and any other recognized Indian System of Medicine and proven local health traditions being provided in Gujarat.

50. Rights and duties of Patients

(1) **Survival, integrity and security:** Every person has the right to survival, physical and mental integrity and security of his or her person, such that he/ she shall be entitled to safe and sensitive health care, in accordance with the standards/ protocols prescribed hereunder; and shall be entitled to not be subjected to any service, testing, treatment, procedure or medical intervention or research which endangers or violates such survival, integrity and security in any manner; the right to be free from harm caused by the poor functioning of health services, medical malpractices or negligence; and

the right to a clean and healthy environment in the hospital, with least risk of hospitalrelated infections.

(2) **Right to seek:** Every person has the right to approach and seek health care facilities, goods, services, programmes and conditions, equitably, without discrimination;

(3) **Right to receive:** Every user has the right to receive, use and enjoy, and right not to be denied, health care appropriate to that person's health needs;

(4) **Right to emergency treatment and care:** No person shall be denied, under any circumstance, including inability to pay the requisite fee or charges, prompt and necessary emergency medical treatment and critical care, including emergency obstetric treatment and care, by any health care provider, establishment or facility, including private provider, establishment or facility, that is qualified/ certified to provide such care or treatment;

Further, in a case of medico-legal nature (MLC), no health care provider or health care establishment shall delay treatment merely on the grounds of receiving police clearance or a police report.

Explanation: A medico-legal case means any medical case which has legal implications, either of a civil or criminal nature, and includes but is not limited to cases relating to accidents, assault, sexual assault, suicide, attempt to murder, poisoning, injuries on account of domestic violence, injuries on workers during course of employment, in some of which the service provider may be required to prepare documents in compliance with demands by authorized police-officer or magistrate.

(5) **Right to reproductive and sexual health care:**

(a) With regard to reproductive health services, every adolescent girl and adult woman has the following rights:

(i) right to comprehensive obstetric health care & services with continuum of care, including ante natal care and post natal care;

(ii) right to safe abortion/ termination of pregnancy;

(iii) right to equality of opportunities in all health matters; and

(iv) right against discrimination in all health matters including less favourable treatment of women for reasons of pregnancy and maternity;

(b) In addition to the above, all adolescents and adults, both male and female, shall have the following rights:

(i) right to reproductive and sexual self-determination and autonomy and right against all coercive measures in population and family planning; this right would include choice of safe and effective methods of contraception, including emergency contraception and safe, voluntary sterilization; and the right to safe and effective methods of assisted reproductive technologies (ARTs);

(ii) right to appropriate counseling and treatment for all sexual and reproductive health related morbidities, including management of sexually transmitted infections (STIs)/ reproductive tract infections (RTIs).

(6) **Right to quality of care:** Every user has the right to a quality of care in compliance with standards and protocols prescribed under this Act;

(7) **Right to rational health care:** Every user has the right to receive rational health care and to not be subjected to irrational health care or over-medicalisation;

(8) **Right to choice:** Every user has the right to choose and change his/her health care provider and health

care establishment, and/ or any recognized system of medicine, including Allopathy, Ayurveda, Homeopathy, Unani, Siddha and any other recognized Indian System of Medicine (ISM) and local health traditions, provided that it is available in and compatible with the functioning and competence of the particular health care establishment; and this right shall include the right to refuse to be subjected to any system of medicine or particular medical procedures or medication prescribed thereunder by the health care provider.

(9) **Right to be treated by a named health care provider:** Every user has the right to know the name of the person who is providing health care to him/ her and therefore must be attended to by clearly identified health care provider/s.

(10) **Referral rights:** Users who must be referred to another health care establishment or facility, for medical reasons, are entitled to a full explanation by referring establishment or facility before they can be transferred to another health care establishment or facility, and in any case transfer of that user can only take place after another health care establishment has been requested by the referring establishment or facility and has agreed to accept that user; and further, only if and when

there is available and accessible referral transport service;

(11) **Right to continuity of care:** Every user has the right to continuity of care, through close and continuous cooperation between all the health care providers and/or establishments that might be involved in his/ her diagnosis, treatment and care;

(12) **Right to fair selection:** In circumstances where a choice must be made by health care providers between potential users for a particular treatment which is in limited supply, all such users are entitled to a fair selection procedure for that treatment, based on medical criteria and made without discrimination;

(13) **Right to benefits of scientific progress and technology assessment:** Every user is entitled to benefits of scientific and technological progress and advancement in relation to health care.

Provided that any new health technology with potential to be used towards health care shall not be brought into use before being subjected to a due Health Impact Assessment (HIA) for its stated benefits and its possible ill effects, and the results of such HIA shall be made available and accessible to public;

(14) **Right to terminal care:** Every user has the right to humane terminal care and to die in dignity.

(15) Right to information:

a) Every user has the right to information about health care facilities, goods, services, programmes, conditions and technologies, how best to access, use and enjoy them, and such information must be made available to the public by the Government in the most effective manner, in order to benefit all those concerned;

b) Every user has the right to be fully informed about his/ her health status, including the medical facts about his/ her health condition; proposed health care, together with the potential risks and benefits, costs and consequences generally associated with each option of health care; alternatives to the proposed health care, including the implications, risks and effects of refusal of health care; and the diagnosis, prognosis and progress of health care; and any other information that may be pertinent to the user in taking a decision, providing consent or to understand his/ her current and possible future health status.

Provided that any of such information may be withheld from the user but only exceptionally when there is good reason to believe that this information would without any expectation of obvious positive effects cause him/ her serious harm;

c) Every user has the right that the information be communicated to him/ her in a way appropriate to the latter's capacity for understanding, with minimum use of unfamiliar or complicated technical terminology, and where the user does not speak the common language, some effective method of language interpreting should be available;

d) Every user has the right to choose who, if anyone else, should be informed on their behalf.

e) Every user has a right to obtain a second opinion from another health service provider.

f) When admitted to a health care establishment, users have a right to be informed of the identity and professional status of the health care providers providing them services and of any rules and routines of the establishment which would bear on their stay and care.

(16) **Right to medical records and data:**

(a) Every user has a right that complete medical records pertaining to his/ her case, containing the health status, diagnosis, prognosis, all the details of the health care provided including the line of treatment, be maintained by the service provider and be kept in protected conditions till 2 years of the last date of service/s provided, and any disclosure of the records or information contained in them to anyone else shall be subject to his/ her rights to confidentiality, privacy and disclosure as elaborated herein under sub-section (18);

(b) Every user has the right of access to his/ her medical files and technical records and to any other files and records pertaining to his/ her diagnosis, treatment and care (including X-ray, laboratory reports and other investigation reports) and to receive a copy of his/ her own files and records or parts thereof; and

(c) Every user has a right to request for and to be given a written summary of his/ her diagnosis, treatment and care and in case of an inpatient, the complete discharge report at the time of discharge, which must also

include the advised follow-up actions to be taken by the user.

(17) **Right to autonomy/ self determination and prior voluntary informed consent:**

(a) Every user has a right to consent as a prerequisite for any health care proposed for him/ her, such consent being a prior and fully informed consent formed without the exercise of any influence, duress, coercion or persuasion by the service provider proposing it;

(b) Every user has a right that the service provider empowers and facilitates the exercise of his/ her right to consent in the above manner;

(c) Every user has the right to refuse or to halt a medical intervention and on his/ her exercising such right, the implications of refusing or halting such an intervention must be carefully explained by the service provider to the user, provided that the refusal or halting comes to the knowledge of the provider;

(d) When a user is unable to express his or her consent due to medical reasons and a medical

intervention is urgently needed in the user's interest, the consent of the user may be presumed, unless it is clear from a previous declared expression of will within the knowledge of the provider that consent would be refused in the situation;

(e) Every user who lacks the full capacity to give consent, due to his/ her being a minor or due to any mental disability, temporary or permanent, shall, to the extent of incapacity, have the right to supported (or substituted, only where absolutely necessary) decision-making on his/ her behalf, through a *de jure* or *de facto* guardian, next friend or personal representative, whose bonafides and credentials are clear to the service provider;

Provided that the service provider shall personally assess in each case if a user lacks the full capacity to consent, by assessing his/ her evolving capacity and intellectual maturity in the case of a minor; and his/ her state of mind at the relevant time of decision-making in the case of person with mental disability, such that there is no *per se* loss or denial of right to self-determination and voluntary informed consent in all cases of minors and persons with mental disabilities;

Provided further that when a person lacks full legal capacity to consent, and it is not possible to get substituted/ supported consent in time, or the person who can give such consent on behalf of the user unreasonably withholds such support or consent, but the proposed intervention is urgently needed, the service provider may proceed without any consent, to the best of his professional competence and judgment, if he/ she is of the opinion that the intervention is in the interest of the user; alternatively, in cases where there is no urgency, the service provider shall refer the matter to the head of the institution who shall take the decision in consultation with the service provider or through another mechanism that may be duly established at the institutional level for such purposes;

Provided further that even where he/ she lacks full capacity to consent, the user (whether minor or adult) has a right to be involved by the service provider in the decision-making process to the fullest extent and in proportion to which their capacity allows;

(f) Every user also has similar right to consent for the preservation and use of all substances of his/ her body (though consent may be presumed when the substances are to be used in the current course of diagnosis, treatment and care of that user); and for participation

in clinical or scientific teaching and/ or research;

Provided that as an exception to the requirement of involvement being in the interest of the user, an incapacitated person may be involved in observational research which is not of direct benefit to his or her health, provided that person offers no objection, that the risk for burden is minimal, that the research is of significant value and that no alternative methods and other research subjects are available; and

(g) In any case, no user shall be provided any health care for experimental or bio-medical or clinical research purposes, except according to guidelines laid down by the Indian Council for Medical Research (ICMR) and unless:

(i) It is in association with a health establishment that has been registered with the State Health Board as required therein;

(ii) The Institutional Ethics Committee as laid down by the prescribed guidelines, has given prior written authorization for the commencement and continuation of such health care; and

(iii) The user has been given prior information in the prescribed manner that the health care is for experimental or research purposes or part of an experimental or research project, and he/ she has given informed consent as per the requirements of relevant earlier provisions herein.

18) **Right to confidentiality, information disclosure, privacy:**

a) Every user has the right that all information about his/ her health status, medical condition, diagnosis, prognosis and health care and all other information of a personal kind (identified or identifiable to him/ her), must be kept confidential, even after his/ her death, and such confidential information can only be disclosed if the user gives explicit consent or any law expressly provides for this; it may be used for study, teaching or research only with the authorization of the user, the head of the health care establishment concerned and the Institutional Ethics Committee of the establishment.

Provided that consent may be presumed where disclosure is to other health care providers involved in that user's treatment;

b) Every user has the right that all the identifiable user data must be totally protected, and appropriately stored for protection of the user's confidentiality, including the human substances from which identifiable data can be derived;

c) Every user has a right to privacy such that there can be no information disclosure resulting in or amounting to violation of or intrusion into the user's private or family life, unless and only if it can be justified as necessary to the user's health care, when the user's consent must be taken as per the earlier relevant provisions for consent herein;

d) Every user has a right that he/ she may be subjected to any health care in a manner that proper respect is shown for his/ her privacy and dignity, and that a particular health care intervention may be carried out only in the presence of those persons who are necessary for the intervention, unless the user consents or requests otherwise; and for women users they may be carried out only if a female service provider is also present, unless the user herself waives this right or unless it is not feasible at all in given circumstances;

e) Users admitted to health care establishments have the right to expect physical facilities which ensure privacy and dignity, particularly when health care providers are offering them health care or carrying out examinations of personal nature.

19) Rights towards the application of users' rights:

a) In the exercise of all the above rights, users shall be subjected, where necessary, only to limitations and least restrictive alternatives that are compatible with human rights instruments and in accordance with procedures prescribed by law;

b) The users shall also be protected by adequate due process in all other respects as required by this Act or other applicable State laws;

c) Users must have access to such notice of rights, information and advice as will enable them to exercise the rights set forth in this document;

d) Appropriate, adequate and comprehensive information on the available health care services, written in a manner understandable by a non-technical person and in local language, shall be displayed in a prominent

place in the health care establishment or facility, which shall in any case include all the information required to be disseminated under this Act;

e) Users have a collective right to representation and participation within health care institutions at each level of health care in matters pertaining to the planning and evaluation of health care services, including the range, quality and functioning of the services;

f) Where users feel that their rights have not been respected they should be enabled to lodge a complaint and have it investigated, mediated or adjudicated upon, which must entail, in addition to recourse to courts or any quasi judicial mechanism that is available, independent mechanisms at institutional level within the health care establishment where he/ she sought or received health care.

Explanation 1: An application for grievance against a private healthcare establishment may be made for a grievance regarding the violation of any rights specified in Pat IV of the Act.

Explanation 2: An application for grievance against a public health care establishment may be made for a grievance regarding:

(a) Non-provision of guaranteed services

(b) Defective or sub-standard quality of guaranteed services

(c) Costs and financial loss incurred due to non-provision of service from Public health care establishment, leading to availing of private medical services under compulsion

(d) Costs and financial loss incurred due to medicines or supplies being prescribed by the public health care provider, to be purchased from outside the public health care establishment

(e) Grievances regarding inadequate personnel, infrastructure or supplies experienced related to provision of care

(f) Grievances regarding any malpractice, including extortion of money in excess of standard charges

(g) Grievances regarding any sexual harassment of the user by health care providers and staff of heath care establishment

(h) Violation of any rights specified this Act

(i) Negligence, with relation to provision of services

(l) Access to Health Records

(i) The user shall have complete access to all of his health records, and shall have the right to be provided with a report of the diagnosis, the medical treatment, and state of his/her medical condition and investigation reports (including X-ray and lab reports).

(ii) A health care provider may examine a user's health records for the purposes of-

a. treatment with the authorization of the user; and

b. study, teaching or research with the authorization of the user, the head of the health care establishment concerned and the Institutional Ethics Committee established under Section 64

20) Duties of users: Every user has the following duties:

(i) To provide health care providers with the relevant and accurate information for health care, subject to the user's right to confidentiality and privacy;

(ii) To comply with the prescribed health care, subject to the same having been administered after duly observing the user's rights as enumerated above;

(iii) To take care of health records in his or her possession;

(iv) To respect the rights of health care providers by treating them with respect, courtesy, and dignity and refrain from any abuse or violent or otherwise abusive behaviour towards them or the rights provided to them; to similarly respect rights of other users;

(v) To utilize the health care system properly by following all the rules of the relevant establishment or facility, that are brought to the user's knowledge, in all other respects and not indulge in any other abuse or obstructionist action;

(vi) To not lure any care provider or staff in the health care establishment or facility with favours in terms of cash or kind for any personal gains or illegal purpose;

(vii) To sign a discharge certificate or release of liability if he or she refuses to accept recommended treatment; and

(viii) To recognize his/her role not merely as an end-user but as a proactive stakeholder and facilitator of the health care services provided to him/ her.

CHAPTER - V

RIGHTS AND DUTIES OF HEALTHCARE PROVIDERS AND ESTABLISHMENTS

51. Rights and duties of healthcare providers

(1) Every Healthcare Provider in any Healthcare Establishment shall be ensured with the following rights pertaining to –

(a) No health care establishment shall discriminate against a health care provider in matters concerning employment and conditions of employment on age, sex, economic status, place of residence, religion, caste, physical or mental ability, mental health status or HIV/AIDS status.

Provided that, subject to any applicable law, the head of the concerned health facility may in accordance with any determined guidelines, impose conditions on the service that may be rendered by a health care provider on the basis of his or her health status

(2) Every health care establishment shall provide measures to–

(a) Prevent injury or damage to the person or property of health care providers during the course of his employment; and

(b) Prevent disease transmission including protection from HIV-AIDS, Hepatitis-B and other communicable diseases

(c) Ensure the personal safety of health care providers.

(3) A health care provider shall not be forced by the State or any private party to reveal private confidential information or perform any act that is against medical ethics. All information on the health of a user shall be deemed to be confidential, unless required to

be disclosed in public interest or public health.

(4) A health care provider, in consultation with the head of the health care establishment, may refuse to treat a user who is physically or verbally, abusive, who sexually harasses him/her, or who acts contrary to 64 of this Act.

(5) Every Healthcare Service Provider shall respect and adequately respond to the patients or Healthcare Consumers' rights as detailed above.

(6) Responsibility of specific health care providers shall be defined based on health department manuals, government resolutions/orders, guidelines, policy papers, directives and other official documents.

(Annexures specifying the responsibility of specific health care providers may be placed)

52. Duties of Healthcare Establishments

Display of Information in the Health Care Centre:

(1) Appropriate, adequate and comprehensive information written in a manner and language

understood by a non technical person of the concerned area on the health care services shall be displayed in a prominent place in the health care centre.

(2) Information mentioned in subsection (1) shall include information on —

(a) Types and availability of health care services, and

(b) Schedules and timetables of visits of specialist staff, if any, and

(c) Schedule of rates for major categories of services, including

(i) outpatient consultation charges,

(ii) inpatient bed charges (which includes all charges, except charges for consultants and specialist medical procedures)

(d) Details of the drugs available free of cost/at subsidized rates in the health center

(e) Preparations and details of all formulations available in the inventory of the hospital.

(f) Charter of users rights and responsibilities,

(g) Full contact details of the vigilance committee, internal redressal mechanism, hospital user welfare committee, hospital administration with clear mention of the time of availability of the same.

(h) Procedures for making an application for a grievance, and

(i) Any other aspects of health care services, which may be of use to the public.

(3) Appropriate, adequate and comprehensive information about the available health care services shall be displayed in a comprehensive manner in Gujarati at a prominent place

(a) In the health care centre, and

(b) In the Village Gram Panchayat, Anganwadi and the Village School

(4) Information mentioned in subsection (1) shall include information on —

(a) The types of health care services available including guaranteed health care services;

(b) Schedules and timetables of visits of specialist staff, if any;

(c) Charter of users rights and responsibilities;

(d) Procedures for making an application for a grievance, within the institution, to the monitoring committee as well as the district tribunal level;

b. Any other aspects of health care services which may be of use to the public;

(5) As part of community based activities, it shall be the function of the concerned field based functionary to provide to the community on a regular basis, information on healthy living conditions, health care services available and community health requirements.

(6) The person in charge of a health care establishment shall ensure that a health record containing such information as may be prescribed is created and maintained at that health care establishment for every user of health care services.

(7) Such information shall include information on

(a) Services provided by the health care center,

(b) Complaints received under this Act- state of complaint, and orders given

(c) The number of patients reimbursed from the private sector

53. Universal Safety Precaution

(1) Every health care establishment shall provide free of cost, universal precautions to all persons working or present in such institution who may be occupationally exposed to HIV, including employees, interns, attendants and contract workers, and appropriate training for the use of such universal precautions.

(2) Every healthcare provider and every other person who may be occupationally exposed to or may occupationally transmit HIV shall use Universal Precautions as prescribed in the course of their work.

Explanation: Universal precautions shall mean infection control measures that prevent exposure to or reduce the risk of transmission of pathogenic agents including HIV and includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices

54. Internal redressal mechanism

(1) All Public Health Care establishments and all private health care establishments with more than 10 beds, both in the rural and urban areas shall have an internal redressal mechanism as provided below.

(2) A specific member of the staff at each level of health care establishment shall be appointed as person in charge of internal redressal for the purpose of receiving applications for grievances from any aggrieved person.

(3) On the receipt of an application for grievance, the persons in charge of internal redressal shall

(a) Provide the aggrieved person with a written response for his / her application, along with the action taken/proposed to be taken, and an application number which may be used as reference by the applicant.

(b) Contact the concerned health service provider and remedy the situation, when possible; and

(c) Provide to the aggrieved person, printed information in Gujarati and Hindi on all the remedies available to him / her, including the right to file an application for a grievance at the district tribunal.

(4) The person in charge of internal redressal shall submit extracts from the register of grievance on grievances made, action taken or not taken, to the respective monitoring committee at the end of each month.

(5) The Ward /Health Officer shall obtain report of grievances and submit them to the Monitoring Committee at the appropriate level.

CHAPTER – VI

SPECIAL HEALTHCARE NEEDS OF THE IDENTIFIED GROUPS

55. SPECIAL PROVISIONS RELATING TO HEALTHCARE NEEDS

(1) The State Government shall ensure special provisions in the case of the following groups:

(a) Reproductive and Sexual Health of Women and Girls

(b) Aggrieved persons in cases of Domestic Violence

(c) Compliance of sexual assault

(d) People living with HIV/AIDS

(e) Mentally ill persons

(f) Persons from Tribal Region

(g) Internally displaced persons

(h) Elderly persons

(i) Persons living with disability

(j) Migrants

(k) Workers

(l) Sex workers

In this specific regard, the State Government may by a notification in the official Gazette, make relevant rules and regulations.

PART V

56. Disputes Resolution through Public Dialogues and Public Hearings *(Swasthya Jan Sunwais)***:** The State shall facilitate forums for amicable and non-adversarial disputes resolution at community level by establishing

mechanism of public dialogues and public hearings on health *(Swasthya Jan Sunwais)* in the following manner:

a) The *Swasthya Jan Sunwais* shall be conducted at primary health centre (PHC), block and district levels twice in a year, and once a year at State and national level as events open to all citizens, which would enable the general public and various groups and organizations to give free and independent feedback about health care services;

b) The *Jan Sunwais* shall be announced with at least one month's public notice, with PRIs and community based organizations being entrusted with the task of publicizing them, preferably preceded by group interviews in some of the concerned villages / PHCs, where both positive incidents and possible negative events should be documented.

c) The panel for these *Jan Sunwais* shall include, appropriate level PRIs and nominated civil society representatives (from community organizations, people's organizations, or NGOs involved in monitoring of health services) while the Respondents would be the appropriate level Government health officials whose presence would be mandated as essential and representatives of private health care establishments and providers

who volunteer to present themselves to the people's scrutiny and verdict.

57. Issues before *Swasthya Jan Sunwais***:** The *Swasthya Jan Sunwais* would be the appropriate forums to raise the following, amongst other, kinds of issues through voluntary testimonies presented by individuals or groups:

(i) People's perceptions, both positive and negative, about existing health care services and providers;

(ii) Specific experiences of denial of health services or violations of rights enumerated herein;

(iii) Status of access, availability, acceptability and quality of health care infrastructure and staff and services;

(iv) Specific problems faced by vulnerable and marginalized individuals and groups in accessing health services;

(v) Suggestions for improving service delivery, which will make services more accessible;

(vi) Involvement of community in their health care;

(vii) People's perceptions about behavior/attitude of health care providers and their availability in the health centers; and

(viii) Other concerns and health needs of the community.

Provided that advance copies of the testimonies would preferably but not essentially be served on the concerned

respondents to enable and facilitate prompt response by the *Jan Sunwai* Panel.

58. Outcome and follow-up of *Swasthya Jan Sunwais***:** After hearing both sides, the *Swasthya Jan Sunwais* panels would record the issues and where possible immediately recommend actions regarding cases of denial of health care or violation of rights enumerated herein or suggest follow-up actions by the parties; similarly it would recognize service providers acknowledged for providing exemplary good services. All recommendations of the panels would be followed up for appropriate actions, including by entry in the formal service records and annual evaluation reports of the concerned service providers in Government health care establishments. The Government shall throughout ensure that the *Swasthya Jan Sunwais* are conducted peacefully and with the objective of amicably resolving issues in non-adversarial manner, without any intimidation of those presenting their testimonies and where needed providing them necessary protection; for this the Governments shall appropriately educate and sensitise people and service providers.

59. Grievance redressal through In-house Complaints Forums at the institutional level:

(1) Without prejudice to the above rights, and in addition to the above, every user who had accessed the services of health establishment/ institution with more than 10 employees (including contractual and part-time employees) shall in any case have the right to have his/ her complaints examined within such health establishment/ institution internally and to have it dealt with in a thorough, just, effective and prompt way by the establishment/ institution, and to be informed about their outcome.

(2) In case of Government owned or controlled health establishment, the authority under which the establishment functions, and in the case of private health establishment, the head of that establishment, shall:

(a) Set up an "In-House Complaints Forum" for this purpose within the health establishment, but with equal number of independent, outside members from civil society organizations, preferably users' rights groups or consumer groups, or eminent citizens, media persons, respected lawyers, of the area, and shall appoint a person of senior rank with full administrative powers, working full time in the institution, as the Complaints Officer;

Provided that where an institution carries on its activity in one or more places with 10 or more employees in any of such additional places, a separate Complaints Officer shall be appointed for each of such places.

(b) Establish a procedure for the lodging of complaints with the Forum and for its investigation, arbitration or adjudication, including a contact mechanism for emergencies;

(c) Include provisions for the acceptance and acknowledgment of every complaint directed to a health establishment, whether or not it falls within the jurisdiction or authority of that establishment;

(d) Display the names and contact details of Complaints Officer and members of the Forum and the procedure for a complaint resolution in a manner that is visible to any person entering the establishment and such information must be communicated to users on a regular basis;

(e) Where necessary, provide assistance, advice and advocacy on behalf of the user through a panel of independent persons established by the establishment, for consultation regarding the most appropriate course of action for the user to take;

(f) Allow for referral of any complaint that is not within the jurisdiction or authority of the health establishment, to the appropriate body or authority;

(g) The Complaints Officer may order *suo moto* inquiry into violations of the provisions of this Act by the institution or any person in the institution;

(h) The Forum shall act in an objective and independent manner when inquiring into complaints made under this Chapter;

(i) The Forum shall inquire into and decide a complaint promptly and in any case within seven working days.

Provided that in cases of emergency the Complaints Officer shall decide the complaint within one day.

(3) The Forum, if satisfied, that a violation of the Act has taken place as alleged in the complaint, shall:

a) direct the institution to take measures to rectify the breach or violation complained of; to take specific steps or special measures or both towards compliance with health rights; or to refrain from or discontinue certain action/s amounting to violation of health rights;

b) counsel the person alleged to have committed the act and require such person to undergo training and social service; and

c) upon subsequent violations, recommend to the institution to, and the institution shall, initiate disciplinary action against such person/s responsible for the violation.

(4) The Complaints Officer shall inform the complainant of the action taken in relation to the complaint and shall be responsible for ensuring that the complaints, their nature and number and the action taken are published on the institution's web site or web page where such a web site or web page exists and are reported to the concerned Government on a six-monthly basis.

Provided that the Complaints Officer and the other members of the Forum shall ensure the maintenance of confidentiality of complainants and parties to a complaint.

60. Cause of action for complaints related to health, before designated district courts:

A complaint may be made by any user (or in case of the user's death, by user's representative, or in case of systemic complaints or complaints of violation of any of the health rights of group or class of individuals by any

concerned organization with proven bona fide credentials, or the concerned monitoring committee of the district), as enumerated hereinabove, before a district court designated (hereafter referred to as court or designated court) by State Government to hear health related complaints for the district within whose jurisdiction the health care establishment/ provider is situated, or the cause of action, wholly or in part, arises, including:

(a) Denial or non-provision of guaranteed services by a public health care establishment;

(b) Denial of emergency treatment and/ or critical care by any health care establishment or provider, public or private, for or not for profit;

(c) Defective or sub-standard quality of care or guaranteed services by a public health care establishment;

(d) Inadequate personnel, infrastructure or supplies related to provision of care by a public health care establishment;

(e) Absenteeism of the health care related staff in any public health care establishment;

(f) Any medical malpractice, including extortion of money in excess of standard charges, for any health care service, or denial of service in contravention of regulatory mechanism for

ensuring access to health care, by any health care establishment or provider, public or private, for or not for profit;

(g) Costs and financial loss incurred due to non-provision or denial of any guaranteed service by public health care establishment, leading to availing of private medical services under compulsion;

(h) Costs and financial loss incurred due to medicines or supplies being prescribed by the public health care provider, to be purchased from outside the public health care establishment, where the drug is covered under service guarantee;

(i) Negligence, with relation to provision of services by any health care establishment or provider, public or private;

(j) Sexual harassment or any other kind of abuse of the user by health care providers and staff of heath care establishment, public or private;

(k) Non-compliance with or mis-performance of the obligations of the Governments or any of the authorities as enumerated under this Act;

(l) Any violation of any other rights of users on part of the Government/s, authorities or private sector health service providers.

Provided that except for (f), (g), (h) & (i) above, there shall be no requirement for proof of actual prejudice, damage or loss suffered by the complainant and notwithstanding the absence of such proof. There shall be strict liability on part of the alleged offender/s even if only the allegation/s of the act of commission or omission is/are proved in such cases, which shall be sufficient. However, in case actual prejudice, damage or loss is also proved, that shall be taken into account for the purposes of the reliefs granted or the quantum of relief.

61. Remedies:

(1) **Orders of designated district courts:** On being satisfied of the correctness of the complaint, the designated court shall issue any of the following orders to the State or the concerned health care establishment or provider:

a) To pay such amount as may be awarded by the court as compensation and damages to the user (or user's legal representatives in case of death of the user), for the violation of his/ her rights, including mental torture and emotional distress;

b) To pay such amount as may be awarded by the court as reimbursement to the user of a public health care establishment for having to use private services or for having to purchase medicine or supplies prescribed by the public health care provider, from outside the public health care facility or establishment;

Provided that in both the above, the alleged offenders may be held jointly and severally liable for any compensatory damages or other costs awarded;

Provided further that a portion of the compensation so awarded may be ordered to be recovered personally from the concerned health care personnel who was/ were responsible for the violation;

c) Order an inquiry to be carried out in respect of the concerned health care personnel or establishment or Government department or office, and/ or issue notice to the concerned statutory council with which they are registered for appropriate action under the respective statutes, and/or direct criminal action to be initiated by the police, which may be in addition to and notwithstanding initiation of any internal departmental inquiry;

d) Recommend appropriate disciplinary action to be taken against concerned head of

establishment or institution in cases where it is clearly proved that the denial of care was due to non-performance or mis-performance of duties on part of the establishment or institution;

e) Where complications or adverse consequences have been caused to a user due to mismanagement of a health condition, or medical negligence, direct the responsible establishment and/ or provider to take prompt and appropriate steps for its restoration/ correction, at no further cost to the user, including by referral where necessary;

f) Pass order/s directing the person who has committed the violation to undergo a fixed period of counselling related to the violation committed and a fixed period of social service;

g) Direct the Government or the health care establishment or provider to take specific steps or special measures or both to protect or fulfil any of the health rights; or to refrain from or discontinue any law/ policy/ action that may amount to violation of health rights;

h) Direct the Government or the health care establishment or provider to take steps to

ensure that the alleged or similar health right violation is not repeated in future;

i) Pass appropriate directions to the concerned health care establishment, with respect to grievances that are systemic and regular in nature;

j) Direct the concerned Government or establishment or institution to make regular reports to the designated court regarding implementation of the court's orders, especially those passed under (h), (i) & (j) above.

k) Pass any interim order or recommendation in nature similar to the above to protect the rights of the complainant during the pendency of the complaint and such that the complaint does not become infructuous;

l) Make such other recommendations as may be necessary for the better implementation of this Act in respect of the concerned health care establishment;

Provided that the designated court may, in cases of emergency, be available and accessible 24 hours and in the interest of justice, pass urgent orders without considering the representations of the parties to the complaints or without hearing them as the case may be, including directing admissions, operations, treatment or

any specific medical intervention, and the provision of universal precautions.

Provided that the designated court shall, as soon as may be, after the passing of such urgent orders in emergency, consider the representations of the parties or give them an opportunity to be heard as the case may be, and pass further appropriate orders.

(2) **Reasoned order:** The designated court shall pass orders that contain brief reasons for the passing of such orders.

(3) **Costs:** The designated court may, subject to any Rules made in this behalf, make such orders as to costs of complaint as are considered reasonable.

(4) **Binding effect:** An order of the designated court shall be binding on the parties to the complaint. Further, all authorities including civil authorities functioning within the jurisdiction of the court shall be bound by the orders of the court and shall assist in their execution.

(5) **Consequences of Breach of designated court's Temporary Orders:** All temporary injunctions and interlocutory orders passed by courts shall be deemed to be orders under Order XXXIX Rule 1 of the Code of Civil Procedure, 1908 and the breach of such an order shall be dealt with by applications to the court which application shall be treated as an

application under Order XXXIX Rule 2A of the Code of Civil Procedure, 1908.]

(6) **Appeals:** For purposes of appeal the orders or judgment passed by the designated courts shall be treated as orders or judgment of ordinary district court of that level.

(7) **Timeframe for designation of courts:** The State Governments shall within 60 days of the commencement of this Act designate a particular court in each district to hear the complaints related to death for the district and train and sensitise the judge of that court on people's health and laws related to health, who shall commence hearing all health related cases in the district.

(8) **Dispensing of lawyer's appearance and waiver of court fee:** There shall be no requirement of the complainants to engage lawyers to appear on their behalf in these courts and there shall be minimum technical requirements of filing and hearing of complaints and a complete waiver of court fee except a nominal amount of processing fee for the filing of complaints, and the State Governments shall lay down the rules for ensuring these.

(9) **Information on website:** The State Governments shall within 30 days of commencement of exercise of functions of the designated courts, establish a website or web page on the internet which shall

provide inter alia information relating to the functioning of the said courts, the procedure for filing and sending complaints, the number, nature and of complaints received, and decisions and directions given by the courts.

Provided that the provision of the information on the website shall ensure the maintenance of the confidentiality of complainants and other parties to the complaints, unless waived by the parties themselves.

62. Enforcement of monetary orders of the courts:

(1) **Recovery as arrears of land revenue:** Where any amount is due from any person under an order made by the court under this Act, the person entitled to the amount may make an application to such court, and such court may issue a certificate for the said amount to the Collector of the District (by whatever name called), and the Collector shall proceed to recover the amount in the same manner as arrears of land revenue.

(2) **Maintenance of insurance cover by private health establishments:** Every private health establishment shall maintain insurance cover sufficient to indemnify a person for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees.

(3) **Health Reparation Funds:** The Central and State Governments shall, within 1 year of the notification of this Act, set up funds, to be known as National Health Reparation Fund and State Health Reparation Fund, at national and respective State levels, to disburse the amounts awarded as compensation to be paid by the Government or Government body.

PART VI

MISCELLANEOUS

63. Reports to the State Legislative Assembly

(1) It shall be mandatory for the Ministry of Health and Family Welfare, Gujarat, to place its reports, including reports from the State Public Health Board before the State Legislative Assembly with description of actions taken, not taken and future plans for improvements on a yearly basis.

The State Public Health Board shall submit a report to the Department of Family and Welfare.

(2) An independent report from the State Health Monitoring and Planning Committee outlining key issues requiring improvement and recommended

actions shall also be tabled in the Assembly on an annual basis.

64. Power to make Rules and Regulations:

(1) The State Government may, by notification in the Official Gazette, make Rules, Regulations and Orders to carry out the provisions of the Act.

(2) Every such Rule, Regulation or Order made thereunder, not inconsistent thereto and in accordance with the Authority granted shall have the force of Law.

(3) In particular, and without any prejudice to the generality of the foregoing power, such Rules, Regulations, or orders may provide for all or any of the following matters namely;

(a) Prescribing powers of the State Public Health Authority.

(b) Prescribing duties of the State Public Health Board.

(c) Prescribing duties of Local Authorities.

(d) Prescribing duties of Commissionerate of Health Services.

(e) Prescribing powers and procedural formalities to be complied by the Health Care Establishment (Registration and Regulation) Authority.

(f) Prescribing powers, Role and Responsibility of Monitoring Committees.

(g) Prescribing Powers, Jurisdiction Composition, and procedural formalities to be complied by the Public Health Redressal Mechanism.

65. Power of Local Authorities to Make By-laws:

The concerned local authority may make by-laws, not inconsistent with this Act or the rules there under or with any other law, for carrying out all or any of the purposes of this Act.

66. Rules to be laid before the State Legislature:

Every rule, every regulation and every order made under this Act shall be laid, as soon as it is made, before the State Legislature, while it is session,for it's approval and if the Legislature decides to make any modification in the rule or decides that the rule should not be made, then the rule shall thereafter come into effect only in such modified form or be of no effect, as the case may be, so

that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

67. Offence and Penalties:

(1) Whoever contravenes any of the provisions of this Act or of any rule, regulation or order made under it shall, if no other penalty is elsewhere provided in this Act or the rules for such contravention, on conviction, be punished with fine which may extend to 5000 rupees and in the case of a continuing offence to a further fine of 50 rupees in respect of each day on which the offence continues after such conviction.

(2) Notwithstanding anything contained in sub-section (1), whosoever contravenes the provisions of section 93 (non-registration) of this Act, shall ,on conviction, for a first offence ,be punishable with a fine of fifty thousand rupees, or in the case of a second or subsequent offence (continued non-registration or failure to register again after expiry of registration) with imprisonment for a term which may extend to four years or with fine which may extend to one lakh rupees ,or with both and shall in addition be liable to a fine which may extend to

five hundred rupees for everyday for which the offence continues after conviction.

(3) Offences by Corporations- Where a person committing an offence under this Act is a company or other body corporate, the Government or an association of persons (whether incorporated or not), every person, who, at the time of the commission of the offence, was a director, manager, secretary, agent or other officer or person specified in the registration form and concerned with the management thereof shall, unless he proves that the offence was committed without his knowledge or consent, be deemed to be guilty of such offence.

68. Jurisdiction:

No court other than that of a Presidency Magistrate or a Magistrate of the first class shall take cognizance of or try any offence under this Act.

69. Cognizance of Offences under the Act:

No person shall be tried for any offence under the provisions of this Act or of any rule, or by law made under it, unless a complaint is made within three months of the

commission of the offence by the police, or the executive authority or the health officer or by a person expressly authorized in this behalf by the local authority, the executive authority or the health officer.

Provided that nothing contained in this section shall affect the provisions of the *Code of Criminal Procedure, 1973, in regard to the power of certain Magistrates to take cognizance of offences upon information received or upon their own knowledge or suspicion.

70. Powers of Police Officers to Arrest Offenders under the Act:

Any police officer who finds a person committing an offence against any of the provisions of this Act or of any rule or by law made there under, may arrest such person, if his name and address are unknown to the officer and such person on demand declines to give his name and address or gives a name and address which the officer has reason to believe to be false.

71. Powers of Executive Officer and Public Health Staff to Arrest Offenders under the Act:

(1) The executive officer of a local authority or any member of the public health establishment of a

local authority, not below the rank of a health or sanitary inspector, who finds a person committing any of the offences specified in sub section (2) in the area over which the local authority has jurisdiction, may arrest such person, if his name and address are unknown to the executive officer or member aforesaid and such person on demand declines to give his name and address or gives a name and address which such officer or member has reason to believe to be false. Any person so arrested shall be handed over to the officer in charge of the nearest police station as expeditiously as possible.

(2) The offences referred to in sub-section (1) are –

(a) Offences against any of the provision of this Act or of any rule or by law made there under and

(b) Offences falling under any of the provisions that are in force in the area over which the local authority has jurisdiction.

72. Bar of Suits and Prosecutions in Certain Cases

No suit, prosecution or other proceeding shall lie against any local authority or any executive authority of a local authority, or against the Government or any officer or

servant of a local authority, or of the Government, for any act done or purporting to be done under this Act, without the previous sanction of the Government, or if the act was done in good faith in the course of the execution of duties or the discharge of functions imposed by or under this Act.

73. Punishment for Malicious Abuse of Powers:

Any executive authority or a local authority or any officer or servant of a local authority or of the Government, or any person appointed under of this Act, who maliciously abuses any powers conferred on him by or under this Act, shall be punished with imprisonment which may extend to one year or with fine which may extend to one thousand rupees or with both.

Provided that no prosecution shall be instituted under this section without the previous sanction of the Government.

74. Method of Serving Notices:

(1) When any notice is required to be given under this act or under any rule, by law, regulation or order made under it, such notice shall be given.

(a) By giving or tendering the notice to such person; or

(b) If such person is not found, by leaving such notice at his last known place of abode or business or by giving or tendering the same to some adult member or servant of his family; or

(c) If such person does not reside in the local area and his address elsewhere is known to the executive authority, by sending same to him by post, registered; or

(d) If none of the means aforesaid be available, by affixing the same in some conspicuous part of such place of abode or business.

(2) When the person is an owner or occupier of any building or land, it shall not be necessary to name the owner or occupier in the notice and in the case of joint owners and occupiers, it shall be sufficient to service it on or send it to one of such owners or occupiers.

75. Delegation of Powers by the Government:

The State Government may, by notification and subject to any restrictions, limitations and conditions specified therein, authorize any person to exercise any one or more of the powers vested in them by this act and may, in like manner, withdraw such authority.

76. Act to Override Other Enactments:

If any provisions relating to public health contained in any other enactment in force in the state of Gujarat are repugnant to any provision contained in this Act, the latter provision shall prevail and the former provision shall, to the extent of the repugnancy be void

77. Power to Remove Difficulties

(1) If any difficulty arises in giving effect to the provisions of the Act, the State Government may, by order in the Official Gazette, make such provisions not inconsistent with the provisions of this Act as it appears to be necessary or expedient for removing the difficulty.

Provided that no such order shall be made after the expiry of a period of two years from the commencement of this Act

(2) Every order made under this sub-section (1) shall, as soon as or after it is made, be laid before each House of Parliament.

78. Indemnity to persons acting under this Act:

No suit, prosecution or other legal proceeding shall be instituted against any person for anything which is done in good faith or intended to be done under this Act, rules or By-Law's.

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सत्यमेव जयते

JAY NARAYAN VYAS

No. MIN/HFW/T/NGO/NRG/
Minister,
Health & Family Welfare, Tourism,
Holy Places, Pilgrimage Development,
NGOs, NRG
Government of Gujarat,
1/8, Sardar Patel Bhavan,
Gandhinagar-382 010.
Phone : (079) 23238109, 23243502 (O)
Fax : 23250135

17th April 2009

Dear Dr. Kanani,

Apropos to the discussions we had with the delegation of Indian Medical Association led by you on 16th April 2009, I am happy to confirm the following –

(i) It is a proposed draft with no intention to implement in the present format.
(ii) State Government shall have wider consultation with all stakeholders including IMA GSB.
(iii) Consensus emerging out of this discussion shall prevail in the process of making a law.

I hope this satisfies you and your members and would look forward to your active involvement and cooperation in working out the modifications.

I am advising the Principal Secretary (Health) to place a copy of this letter also on the website.

Best Wishes,

Sincerely,

Jay Narayan Vyas

To :
Dr. Mansukhbhai R Kanani
President
Indian Medical Association, Gujarat State Branch
Amar Hospital
Shri Veer Bhadrasinhji Shopping Centre
Nilambaugh
Bhavnagar 364 001

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH

OFFICE : A.M.A. HOUSE, 2nd FLOOR, OPP. H. K. COLLEGE, ASHRAM ROAD, AHMEDABAD-380 009.
Fax/Phone : (079) 2658 73 70 • E-mail : imagsb@youtele.com

HON. STATE SECRETARY :
DR. ASHOK D. KANODIA ; Ahmedabad
Mobile : 94284 05746
Phone : (R) 079-25454263 (C) 079-25453267

Date : 17/4/2009

To,
Honorable Shri Jaynarayan Vyas
Minister of Health & Family Welfare
Govt. of Gujarat

Sub: Your letter dated 17 April 2009

Respected Sir,

Indian Medical Association, Gujarat State Branch (IMA GSB) appreciates your prompt response to our request regarding the draft on "Gujarat Public Health Act-2009"

We are pleased to note that the Health Ministry does not intend to implement the said draft in the present format.

We are also happy to note that I.M.A. G.S.B. is recognized by the State Government as an important stakeholder.

With a growing sense of mutual trust we are sure that this process will evolve satisfactory consensus in this issue.

We request you to ensure that the copy of your letter is displayed on the website clubbed with the draft.

Assuring you of our cooperation.

Your Sincerely

Dr. Mansukh R Kanani
President
Gujarat State Branch IMA

Dr. Ashok D Kanodia
Hon Secretary
Gujarat State Branch IMA

GUJPHACT-09