WORKING PAPER

June 2023

IMPLEMENTATION OF THE RIGHT TO HEALTH THROUGH LAWS AND POLICIES IN INDIA

Implications for UHC

RTH-UHC Working Paper 3

C-HELP | CENTRE FOR HEALTH EQUITY, LAW & POLICY

RTH-UHC Working Paper 3
Implementation of the Right to Health through Laws & Policies in India: Implications for UHC
June 2023

The Centre for Health Equity, Law & Policy of the Indian Law Society, Pune, is a research, knowledge production and advocacy forum, which works on law & policy issues related to health, embedding its work in the right to health as envisaged within India's constitutional framework and her international commitments.

Authorship and acknowledgement

In 2022, C-HELP was commissioned by the Governance Workstream of the Lancet Citizens' Commission on Reimagining India's Health System to conduct research into the critical intersections of rights, health and law. This research is being updated, edited and published by C-HELP in a series of working papers on the Right to Health and Universal Health Coverage in India.

This Paper is built on the shared knowledge and experience of C-HELP. It was written by Shefali Malhotra (Sections 2, 4 and 6), Gargi Misra (Sections 3, 4 and 6), Disha Verma (Sections 2, 4 and 6), Shivangi Rai (Sections 3 and 5), Suraj Sanap (Section 3 and 5) and Vivek Divan (Section 3) with contributions from Kajal Bhardwaj. It was edited by Vivek Divan. The content emerged from extensive research mapping on health-related laws and policies in India conducted by Kajal Bhardwaj, Vivek Divan, Shefali Malhotra, Gargi Misra, Harshit Pande, Shivangi Rai, Suraj Sanap and Disha Verma.

Copyright © Indian Law Society 2023
All rights reserved

Contact Information
contact@c-help.org

Centre for Health Equity, Law & Policy
Indian Law Society
Law College Road
Pune 411004
Maharashtra, India

CONTENTS

BACKGROUND **4**

1. INTRODUCTION & METHODOLOGY **5**

1.1 Introduction 5
1.2 Methodology and Structure 5

2. IMPLEMENTATION OF RIGHTS-BASED HEALTH LAWS **9**

2.1 HIV & AIDS (Prevention & Control) Act, 2017 9
2.1.1 History and Context 9
2.1.2 Recognition of Rights 11
2.1.3 Administrative Machinery 14
2.1.4 Grievance Redress Systems 15
2.1.5 Comment 20
2.2 Mental Healthcare Act, 2017 21
2.2.1 History and Context 21
2.2.2 Recognition of Rights 23
2.2.3 Administrative Machinery 24
2.2.4 Grievance Redress Systems 26
2.2.5 Comment 26

3. PUBLIC HEALTH LAWS AND THE RIGHT TO HEALTH IN INDIA: A STUDY IN CONTRASTS **29**

3.1 Background 29
3.2 Epidemic Diseases Act, 1897 31
3.2.1 Scheme of the Act 31
3.2.2 Role of Union and state government in implementation 32
3.2.3 Lack of a rights-based approach 32
3.2.4 Relevance of the Disaster Management Act 2005 34
3.2.5 Comment 34
3.3 Assam Public Health Act, 2010 35
3.3.1 Rights-based foundation for public health 35
3.3.2 Health related obligations 36
3.3.3 Implementation and Monitoring 37
3.3.4 Comment 38
3.4 Implications for UHC 40

4. IMPLEMENTATION OF HEALTH-RELATED GRIEVANCE REDRESS SYSTEMS **43**

4.1 Overview of grievance redress systems in Indian healthcare 43
4.2 Assessing the functioning of grievance redress systems 45
4.2.1 Have the grievance redress bodies been set up? 46
4.2.2 Are the grievance redress bodies functioning? 47
4.2.3 If yes, what kind of complaints are grievance redress bodies receiving? 47
4.3 Other jurisdictions 48
4.3.1 Australia 48
4.3.2 Canada 50
4.3.3 United Kingdom 51
4.3.4 South Africa 52
4.3.5 Thailand 53
4.4 Implications for UHC 54

5. IMPLEMENTATION OF COMMUNITY PARTICIPATION IN HEALTH PROGRAMMES 57

5.1 Overview of community participation in health policies 58
5.2 Assessing the functioning of community participation mechanisms 58
5.2.1 Rogi Kalyan Samiti 58
5.2.2 Village Health, Sanitation, Nutrition Committees (VHSNCs) 61
5.2.3 Jan Arogya Samiti 64
5.2.4 Community-based Monitoring 65
5.3 Other Jurisdictions 67
5.3.1 Health Assemblies – Thailand 67
5.3.2 Health Councils – Brazil 68
5.3.3 Lessons and challenges 69
5.4 Implications for UHC 70

6. IMPLEMENTATION OF SOCIAL SECTORS LEGISLATIONS: LESSONS FOR UHC 72

6.1 Mahatma Gandhi National Rural Employment Guarantee Act 2005 (MGNREGA) 73
6.1.1 Overview 73
6.1.2 Availability of Resources 75
6.1.3 Administrative Machinery 77
6.1.4 Accountability and Transparency 78
6.1.5 Use of Technology 81
6.1.6 Key Issue: Social audit 85
6.2 Right of Children to Free and Compulsory Education Act 2009 (RTE Act) 87
6.2.1 Overview 87
6.2.2 Availability of Resources 88
6.2.3 Administrative machinery 91
6.2.4 Accountability and Transparency 92
6.2.5 Use of technology 93
6.2.6 Key Issue: Regulation of the private sector 94
6.3 National Food Security Act 2013 (NFSA) 96
6.3.1 Overview 96
6.3.2 Availability of Resources 98
6.3.3 Administrative machinery 100
6.3.4 Accountability and Transparency 100
6.3.5 Use of Technology 102
6.3.6 Key Issue: Identification of eligible households 104
6.3.7 Key Issue: Quality of food 107
6.4 Implications for UHC 112

7. CONCLUSION AND KEY MESSAGES 114

Annexure: List of Experts Interviewed 117

BACKGROUND

In December 2020, the Lancet Citizens' Commission on Reimagining India's Health System was set up and tasked to develop a roadmap for achieving Universal Health Coverage (UHC) in India in the next 10 years. A commentary published by the co-chairs of the Commission noted that, "*underpinning the Commission's work is a normative commitment to strengthening India's public health system in all its dimensions, including promotive, preventive, and curative care.*"[i] Some of the key questions identified for the Commission's work include, "*negotiating the intersections and complementarities between public and private health provision and the design of a regulatory structure that holds each component of the health system accountable; addressing the role of traditional systems of medicine; negotiating the federal dimensions and associated heterogeneity of health systems' capacity across India's states to articulate the distinctive roles and responsibilities of the central, state, and local governments in delivering and regulating health care; and building health system capacity for enabling and regulating the use of technology in a way that supports and strengthens health delivery while protecting citizens' rights.*"[i]

The Commission recognises that its work requires consultative and participatory engagement. Its many workstreams represent this attempt at multisectoral collaboration, with its Governance workstream seeking to "*articulate pathways for building a robust and accountable governance framework…to achieve a vision of universal health coverage which is equitable, affordable, and accessible to all*."[ii] In particular, this workstream focuses on health sector regulation, accountability, and governance systems linked with federalism that impact health delivery. All the workstreams mention the key issues of accessibility, availability, affordability, equity and citizen's engagement.

Critical to the key questions identified by the Commission is a well-rounded understanding of how legal frameworks and policy impact health – positively and negatively. Indeed, inherent to the features of equity, affordability and accessibility that the different workstreams seek to address, is the issue of rights. Experience has shown that rights-based approaches to health challenges, reflected in law, policy and practice play a vital role in positive health outcomes. The World Health Organisation (WHO) has categorically stated that, "*UHC is firmly based on the 1948 WHO Constitution, which declares health a fundamental human right and commits to ensuring the highest attainable level of health for all.*"[iii] While the co-chairs' commentary suggests that theCommission's work may, "*serve as the foundation for propelling a citizens' movement to demand the practical realisation of the aspiration of health as a fundamental right*"[i] it may be noted that the right to health is already well-recognised and articulated in Indian jurisprudence and law. The commentary also notes that the Commissionwould focus only on the "*architecture of India's Health System*."[i] However, the links between the right to health and UHC may require the Commission to also take into account the social determinants of health.

In this background, an examination of health-related law/ policy frameworks and developments in the context of rights becomes essential to informing the Commission's findings and recommendations on UHC. C-HELP was commissioned by the Governance workstream of the Lancet Commission to conduct research in this regard. The outcomes of that research are being updated, edited and published by C-HELP in four working papers on the Right to Health and UHC in India:

- **Working Paper 1** provides a framework of analysis to apply the right to health to UHC, articulating linkages between the two and accounting for contemporary debates and critiques of UHC.
- **Working Paper 2** presents an overview of judicial pronouncements on health, the roles of central and state governments in health and regulation of the private health sector.
- **Working Paper 3** examines the implementation of the right to health through laws and policies in India while also exploring lessons from the implementation of rights-based social sector laws.
- **Working Paper 4** explores legal-ethical issues that arise in the use of digital technologies in health.

i. Patel, V., Mazumdar-Shaw, K., Kang, G., Das, P., & Khanna, T. (2021). Reimagining India's health system: A Lancet citizens' commission. The Lancet, 397(10283), 1427–1430. Available at: https://doi.org/10.1016/s0140-6736(20)32174-7.
ii. Workstreams - Reimagining India's Health System – Citizens health. Available at: https://www.citizenshealth.in/workstreams/
iii. World Health Organisation. (2022, December 12). Universal Health Coverage. Factsheet. Available at: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

1. INTRODUCTION & METHODOLOGY

1.1 Introduction

Since its early days, the aspiration for Universal Health Coverage (UHC) has been articulated in rights-based language. In 2015, the United Nations (UN) resolution on Sustainable Development Goals (SDGs) set out its commitment towards the realisation of UHC.[1] Emphasising the importance of the Universal Declaration of Human Rights (UDHR), the resolution enjoins member states "*to respect, protect and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status.*"[2] The 2019 Political Declaration of the High-level Meeting on UHC reiterates the right of every human being to the enjoyment of the highest attainable standard of physical and mental health, and that investment in health contributes to the promotion and protection of human rights and dignity.[3]

The right to health is well recognized and established in national and international law. As described in Working Paper 1 in this series, internationally the right to health is embodied in Article 12 of the International Covenant on Economic, Social and Cultural Rights[4] (ICESCR), which states, "*State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*."[5] The basis for understanding and implementing the normative content of the right lies in General Comment No. 14 ("General Comment 14" or "Comment") issued by the Committee on Economic, Social and Cultural Rights.[6]

The Comment acknowledges that implementation at the national level will differ from one State to another and calls for the discretion of the State to adopt the most effective measures. The obligations on States in terms of the right to health are to be realised progressively and there is a recognition of resource constraints. The State is required to take deliberate, concrete and targeted steps towards the full realisation of the right to health. Apart from general legal obligations, there are three specific legal obligations on States i.e. to respect, protect and fulfil the right to health. In particular, the duty to fulfil requires States to adopt appropriate **legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health**.[7] The implementation and enforcement of the right to health in India through the judiciary has been discussed in detail in Working Paper 2 in this series.

This paper examines the implementation of key elements of the right to health through select laws and policies and the implications for UHC in India.

1.2 Methodology and Structure

The health sector in India is populated with multiple laws and policies at the Central, State and local levels. In Working Paper 1 in this series, several examples of these laws and policies were highlighted

---

[1] SDG 3.8 states: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." See, General Assembly resolution 70/1, *Transforming our world: the 2030 Agenda for Sustainable Development*, A/RES/70/1 (25 September 2015).

[2] See, preamble paras 10 and 19. General Assembly resolution 70/1, *Transforming our world: the 2030 Agenda for Sustainable Development*, A/RES/70/1 (25 September 2015)

[3] See, paras 1 and 8. General Assembly resolution 74/2, *Political declaration of the High-level Meeting on Universal Health Coverage*, A/RES/74/2 (10 October 2019)

[4] International Covenant on Economic, Social and Cultural Rights, 1966, ("ICESCR")

[5] ibid. Art. 12.1

[6] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000). Available at: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En ("General Comment 14")

[7] Office of the High Commissioner of Human Rights, World Health Organization, United Nations, Factsheet no. 31, The Right to Health. Available at: https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf

to demonstrate the manner in which the right to health is embedded in India's law and policy framework, and therefore intrinsic to any conception of UHC. There is considerable literature and analysis on the gaps in the implementation of health-related laws and policies and as noted in Working Paper 2 in this series, the judiciary has often stepped in where these gaps violate the right to life and the right to health. *Given extant literature, this paper does not present a comprehensive report or overview of the implementation of laws and policies in the health sector. Instead, discreet areas of inquiry where additional research was required relating to issues of implementation that have implications on UHC, the right to health, and law and policy were identified in discussion with the Governance workstream of the Lancet Citizen's Commission on Reimagining India's Health System, and are focused on here.*

In recent years, three rights-based health laws have been passed by Parliament – the *HIV/AIDS (Prevention & Control) Act*, *2017* (HIV Act), the *Mental Healthcare Act, 2017* (MHCA) and the *Persons with Disabilities Act, 2016* (PWDA). India's international obligations which fall under the Central list of Schedule VII of the Constitution provide the basis for the power of the central government to have passed these health laws. Another relatively recent central legislation is the *Clinical Establishments Act, 2010* (CEA). A separate research project within the Governance workstream is examining implementation of the CEA. Given time constraints, two of the three Central laws, the *HIV Act* and the *MHCA* were identified for a closer look at implementation. However, it may be noted that the implementation of the *PWDA* also has critical implications for UHC in India and a separate review of its implementation should also be considered in future discussions on UHC in India. Section 2 reviews the implementation of these two rights-based health laws with an important caveat; although both laws have been in force for over five years now, their implementation has been impacted by the COVID-19 pandemic.

Several states in India are currently considering state level right to health laws, with Rajasthan just having passed a Right to Health Act.[8] In terms of rights-based state level health laws that have already been adopted, however, there is only one example which is the *Assam Public Health Act, 2010*. As many provisions in this law also feature in the current drafts, a review of this law was included. However, instead of just a simple review, Section 3 juxtaposes the analysis of the Assam law with that of the *Epidemic Diseases Act, 1897* as laws that provide starkly opposing conceptions of public health governance.

Perhaps the most critical aspect in the implementation of UHC within a rights framework would be the issues of remedies and participation. In terms of remedies, General Comment 14 states that any person or group whose right to health is violated should be able to approach the court or have access to other remedies and identifies a range of institutional mechanisms apart from court such as ombudspersons, human rights commissions, consumer forums and patients' rights associations that should be involved in addressing these violations. If UHC in India relies largely on private hospitals and private insurance companies, then the issue of grievance redress and accountability will require particular attention from policy makers. While there is significant literature on the judicial systems of grievance redress, little is known about alternative mechanisms that seek to address complaints outside the system of courts and tribunals. Accordingly, Section 4 explores the functioning of alternate grievance redress mechanisms under two laws (the *HIV Act* and the *MHCA*) and two programmes (National Health Mission – NHM – and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana – AB-PMJAY).

People's participation is considered a key principle of the right to health. According to General Comment 14, "*promoting health must involve effective community action in setting priorities, making*

[8] Rajasthan Becomes First Indian State to Enact a Right to Health Act. What's the Next Step? (2023, March 23). *The Wire.* Available at: https://thewire.in/health/rajasthan-becomes-first-indian-state-to-enact-a-right-to-health-act-whats-the-next-step.

decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States." In Working Paper 1 in this series, the historic role of people living with HIV (PLHIV) in working with the government programme and in holding it accountable has been highlighted. In other sections of this paper, well documented peoples' participation in the drafting and implementation of health and social sector laws are also highlighted. Less well known or documented have been mechanisms of participation that have been introduced through health policies and programmes. Section 5 examines the implementation of key mechanisms of participation that have been included in the NHM and AB-PMJAY.

Sections 4 and 5 also highlight grievance redress and participation mechanisms from other jurisdictions.

The rights-based approach in legislation has not been limited to health. Several widespread and long-standing social movements in India have culminated in rights-based policies and programmes with some resulting eventually in the enactment of national legislations guaranteeing socio-economic rights. Many of these laws pre-date the rights-based health laws and there is considerably more literature and experience with these laws that could provide important lessons for the effective rollout of UHC in India. Section 6 reviews the implementation and impact of three social justice legislations: *Mahatma Gandhi National Rural Employment Guarantee Act 2005* (MGNREGA), *Right of Children to Free and Compulsory Education Act 2009* (RTE Act) and the *National Food Security Act 2013* (NFSA) with a view to identify implications for UHC.

The methodology adopted for this paper includes literature review of academic papers, community writing, reports, media articles and court judgments, as well as interviews with subject matter experts. The Centre for Health Equity, Law & Policy interviewed 28 experts for this paper. C-HELP is deeply grateful to those who took the time and effort to share their expertise and insights. Quotations or statements are not attributed to any particular individual in the paper, referring to them only as 'respondent interviewees.' While some experts spoke on the condition of anonymity, those who consented to being acknowledged are listed in the Annexure. In addition, to assess the functioning of grievance redress mechanisms, Right to Information (RTI) applications were also filed.

Section 2: IMPLEMENTATION OF RIGHTS-BASED HEALTH LAWS

In recent years, three rights-based health laws have been passed by Parliament – the *HIV and AIDS (Prevention and Control) Act*, *2017* (HIV Act), the *Mental Healthcare Act, 2017* (MHCA) and the *Persons with Disabilities Act, 2016* (PWDA). Although health is a state subject, India's international obligations which fall under the Central list of Schedule VII of the Constitution provide the basis for the power of the central government to have passed these health laws. Another relatively recent central health legislation is the *Clinical Establishments Act, 2010* (CEA). A separate research project within the Governance workstream is already examining implementation of the CEA. Given time constraints, two of the three Central laws, the *HIV Act* and the *MHCA* were identified for a closer look at implementation. However, it may be noted that the implementation of the *PWDA* also has critical implications for UHC in India and a separate review of its implementation should also be considered in future discussions on UHC in India. This section reviews the implementation of these two rights-based health laws with an important caveat; although both laws have been in force for over five years now, their implementation has been impacted by the COVID-19 pandemic.

2. IMPLEMENTATION OF RIGHTS-BASED HEALTH LAWS

2.1 HIV & AIDS (Prevention & Control) Act, 2017

2.1.1 History and Context

The history of the *Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017* (HIV Act) can trace its roots to a massive global campaign that placed human rights at the centre of the response to the HIV epidemic. Around the late 1990s, health experts and activists began pushing back against over a decade of punitive, coercive and fear-driven policy responses[9] like forced testing, public identification and isolation[10] and advocated for evidence-based counselling, support and education in relation to HIV.[11] In 2001, the United Nations General Assembly unanimously adopted the Declaration of Commitment on HIV/AIDS, a global commitment to cooperate and strengthen national, regional and international efforts to combat the epidemic in a comprehensive manner.[12] The Declaration called upon countries to respond to HIV/AIDS through progressive prevention efforts, care, support and treatment, realisation of human rights and fundamental freedoms, attention to vulnerable groups including women and children, and community engagement. By the early 2000s – in rapid response to the Declaration and global campaigns – counselling, community support and education had become essential features of a comprehensive HIV/AIDS response in almost every signatory country.[13]

India's tryst with the virus followed a similar path – from an isolationist to a rights-based response driven by community activism – and has been described in some detail in Working Paper 1 in this series. Much of the change in the policy response emerged from legal challenges filed by people living with HIV (PLHIV) and key affected and vulnerable populations like sex workers, men who have sex with men (MSM), transgender people, and people who use drugs. The earliest legal challenge was in the case of Dominic D'Souza who was diagnosed and incarcerated under the *Goa, Daman & Diu Public Health Act, 1985*, which was amended in 1987 to permit forced testing of anyone suspected of having HIV and for their immediate isolation.[14] D'Souza challenged the amendment insofar as it mandated complete isolation of an HIV-positive person, and subsequently led many campaigns against HIV-status-based discrimination in India.[15] Though the Bombay High Court upheld the provision,[16] it was never used thereafter and was eventually repealed in 1995.[17]

---

[9] Fairchild, A.L., et al. (2018). *The Two Faces of Fear: A History of Hard-Hitting Public Health Campaigns Against Tobacco and AIDS*. American Journal of Public Health, 1*08(9),* pp. 1183-1184, 1180-1186. doi:10.2105/AJPH.2018.304516; Geiling, N. (2013). The Confusing and At-Times Counterproductive 1980s Response to the AIDS Epidemic. *The Smithsonian Magazine.* Available at: https://www.smithsonianmag.com/history/the-confusing-and-at-times-counterproductive-1980s-response-to-the-aids-epidemic-180948611/

[10] Divan, V., and Rai, S. (2023). Confidentiality & HIV/AIDS: the need for humaneness and precision in the law. In Parsheera, S. (ed.). *Private and Controversial: When Public Health and Privacy Meet in India.* (2023 ed.). New Delhi: HarperCollins India.

[11] Kamb, M.L., et al. (1998). Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial. *JAMA,* p. 1161–1167. doi:10.1001/jama.280.13.1161.

[12] United Nations General Assembly. (2001). Declaration of Commitment on HIV/AIDS. G.A. Res. S-26/2, U.N. Doc. A/RES/S-26/2.

[13] United Nations General Assembly. (2019). Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Progress report of the Secretary-General, A/HRC/10/47.

[14] Section 53, *Goa Public Health (Amendment) Act, 1987.*

[15] Patient zero: legacy of an AIDS warrior (2017, May 20). *Livemint.* Available at: https://www.livemint.com/Leisure/WzgebcWZh2qUIaT1wwhfrL/Patient-zero-legacy-of-an-AIDS-warrior.html

[16] *Lucy R. D'Souza v State of Goa & Ors.* AIR 1990 Bom 355.

[17] See, *Goa Public Health (Amendment) Act, 1987*. The impugned provision (Section 53(1)(vii)), which authorized isolation of PLHIV, stands legislatively repealed as of 1995. Clause (vi), which provides for mandatory testing, is still on the books. However, it is implicitly repealed by the nationally applicable HIV Act, 2017 now.

By the late 1990s, the Indian courts were increasingly approached by PLHIV, their networks and legal aid groups who successfully challenged a range of anti-discriminatory laws, policies and actions. Rights of PLHIV in the context of employment were first recognised in 1997 by the Bombay High Court in *Mx v Zy*[18] when the petitioner's employment was terminated based on their HIV-positive status. The court held that no person can be deprived of their right to livelihood simply because of their HIV status, if they are otherwise capable of performing their regular duties and do not pose a threat or health hazard to other persons or property at the workplace. Other High Courts have since taken a similar stance in subsequent cases.[19] In 2001, the Andhra Pradesh High Court issued directions on HIV testing and treatment to antiretroviral therapy (ART) centres and hospitals, which included staff training, education and sensitization to reduce stigma associated with the virus.[20] In 2008, the Bombay High Court directed NACO to provide HIV counselling and testing facilities in prisons across Maharashtra.[21] In 2010, the Supreme Court ruled to universalise second-line ART treatment and urged NACO and the State AIDS Control Societies (SACS) to continue moving towards universalisation of available HIV treatments.[22]

Although a considerable body of progressive jurisprudence related to HIV developed in India, conflicting decisions did still emerge from the courts from time to time. For instance, in *Mr. X v Hospital Z*,[23] the Supreme Court suspended the right of PLHIV to marry (only to overturn its decision subsequently). And, while the rights-based response was embedded in the national programme and was largely adhered to in the public sector, the private sector remained unregulated. Responding to increasing demands for a rights-based law on HIV, NACO tasked a legal aid organisation, the Lawyers Collective HIV/AIDS Unit (LCHAU) with drafting an HIV/AIDS law – which took an evidence-, rights- and research-based, and participatory approach to public health.[24] The drafting process involved numerous consultations, as a respondent interviewee recalled – with PLHIV networks, marginalised groups such as MSM and transgender communities, sex workers, drug users, healthcare workers, non-governmental organisations (NGO)s, SACS, government representatives, women's groups, children and child welfare groups, workplace-related organisations and lawyers. Feedback from these consultations and experience from HIV litigation led LCHAU to draft an HIV/AIDS Bill in 2005, a comprehensive charter of rights and entitlements rooted in the bottom-up approach, which would then undergo a long series of negotiations.

This Bill was revised in 2007, 2011 and again in 2014 through inputs from NACO, other union ministries and the Solicitor General's office; the inputs to the 2014 draft in particular diluted considerably the expansive and comprehensive scheme of the original Bill.[25] In 2015, the report of the Standing Committee gave recommendations that intended to restore some provisions of the 2014 draft, such as including marginalised groups in the scope of "*protected persons*" (section 2d), and deletion of the phrase "*as far as possible*" from section 14. However, these recommendations were not reflected in the 2017 Act in force today. There remain several differences between the draft presented by civil society and the one that was passed into law.[26] However, several respondent interviewees believe

[18] *Mx of Bombay Indian Inhabitant v M/S. Zy & Anr* AIR 1997 Bom 406.
[19] *Age 32 Years v State Bank of India*, W.P. (C) 576 of 2008, BomHC; *G v New India Assurance Co. Ltd.*; *X v The Chairman, State Level Police Recruitment Board & Ors*, 2006 ALT 82.
[20] *M. Vijaya v Chairman and Managing Director, Singareni Collieries Co. Ltd.* 2001 (5) ALT 154.
[21] *Ramdas R. Ubale v State of Maharashtra*, Crim. AP 371 of 2008.
[22] *Sankalp Rehabilitation Trust v UOI*, W.P. (C) 512 of 1999; *Sahara House v UOI*, W.P. (C) 535 of 1998.
[23] *Mr. X v Hospital Z*, Civil Appeal 4641 of 1998, Supreme Court.
[24] Lawyers Collective (2003). *Legislating an epidemic: HIV/AIDS in India*. New Delhi: Universal Law Publishing.
[25] Department-Related Parliamentary Standing Committee on Health and Family Welfare, Parliament of India. (2015). *85th Report on The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Bill, 2014.* Available at: https://prsindia.org/files/bills_acts/bills_parliament/2014/Standing%20Committee%20Report_0.pdf
[26] According to one respondent during the drafting process, a chapter that would have provided statutory recognition of key fundamental rights, including the constitutional rights to equality and privacy, was dropped early on. Provisions on access to free and accessible treatment, which extended obligations of the government to intellectual property rights regulation and removal of trade barriers, were diluted. Treatment obligations that remain in the law

that the Act still retained some powerful provisions, and the very fact that there now existed a law that protected key rights of PLHIV and marginalised populations in public and private settings was a significant milestone. Although the *HIV Act* was passed in Parliament in 2017, it came into effect on 10 September 2018 with a notification by the Central Government's Ministry of Health and Family Welfare (MoHFW)[27] followed by the notification of the *Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention And Control) Rules, 2018* (HIV Rules 2018).[28]

2.1.2 Recognition of Rights

The *HIV Act* recognises a number of substantive rights of "*protected persons*", which under section 2(d) includes PLHIV, children affected due to the death or illness of a guardian with HIV, and any person ordinarily residing with a PLHIV. The scheme of rights enshrined in the Act can be broadly divided into issues of a) discrimination, b) consent and confidentiality, c) access to treatment, and c) protection of vulnerable groups.

The Act prohibits discrimination/unfair treatment/denial or discontinuation based on HIV. The right extends to public and private employment, access to healthcare, insurance and education, enjoyment of public infrastructure and services, and freedom of movement and residence (section 3). Isolation or segregation of a protected person and mandatory HIV testing as a prerequisite to access employment, education, healthcare and other services expressly constitute discrimination as well. The right of protected persons to reside in and not be excluded from a shared household is also recognised (section 29). The Act also prohibits hate speech against protected persons (section 4).

The *HIV Act* recognises the right of persons to informed consent before being subjected to any testing, treatment, or research (section 5) and to confidentiality, which includes privacy of data and non-disclosure of HIV status, except under special circumstances (sections 8, 9). The Act obligates central and state governments to ensure access to treatment for HIV and related infections, along with infrastructure for treatment and testing "*as far as possible*" (sections 13, 14) and to ensure access to welfare schemes for PLHIV (section 15).

The Act insulates any person carrying out or accessing HIV risk reduction strategies or programmes from criminal charges under other laws (section 22). This includes, 'targeted interventions'[29] such as the distribution of condoms and lubricants to sex workers or their clients and to MSM or drug substitution programmes for drug users which were often disrupted by law enforcement agencies on the pretext of violation of criminal laws like the *Immoral Traffic (Prevention) Act, 1956*, (erstwhile) section 377 of the *Indian Penal Code, 1860* (IPC) or the *Narcotic Drugs and Psychotropic Substances Act, 1985* respectively. This provision of the *HIV Act* has an overriding effect on these laws and protects the provision of information and services to key populations and the work of peer educators from being criminalised.

---

have an in-built limitation reflected in the phrase "as far as possible" for the central and state government, which is a drastic dilution from the earlier drafts that contained a clear obligation on the government. Protections for marginalised groups such as sex workers, people who use drugs, women and children were diminished to a few narrow provisions in the current Act. Obligations of establishments to create and maintain safe working environments, which were a prominent pressure-point in the community consultations, were cut back significantly. Obligations for social security, information dissemination, education and empowerment were distilled into general welfare measures under the Act. The Act includes punitive and adversarial provisions that community consultations had recommended against and that have proven to be an archaic and ineffective approach in other countries and in other sectors (domestic violence, sexual harassment and other GBV).

[27] Ministry of Health and Family Welfare. (2018, September 10). Notification. Available at: https://egazette.nic.in/WriteReadData/2018/189234.pdf

[28] *Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Rules, 2018.* Available at http://naco.gov.in/sites/default/files/Centre%20Rules.pdf

[29] National AIDS Control Organisation. *Prevention Strategies: Targeted Intervention for High Risk Group*. Available at: http://naco.gov.in/prevention-strategies

Recognising age and gender as key vulnerabilities in relation to HIV, the Act enshrines special provisions for women and children. This includes a prohibition on forced sterilisation and abortions (section 18), the provision of HIV-related information, education and communication (IEC) before marriage (section 30), protection of the property of children affected by HIV (section 16), appointment of an older sibling as guardian of a younger sibling in a family affected by HIV for certain purposes such as school admissions, operation of bank accounts, etc. (section 32) and the recognition of living wills by PLHIV for the appointment of guardians for the protection of their children and their property in case of death or incapacity (section 33). The Act also recognises the right of persons in the care or custody of the State, for instance in prisons or juvenile homes or even shelters, to HIV-related services (section 31).

Some analysis in the recent past reveals a picture that speaks to the need for increased awareness of and redress actions based on the Act. A survey in two districts of Bihar conducted shortly after the passing of the Act revealed that medical staff displayed fear and neglect towards PLHIV[30] citing risk of occupational exposure to HIV, absence of a cure and stigma. The survey also found that doctors refer PLHIV to tertiary centres rather than treating them at primary health centres (PHC) or local clinics, regardless of the severity of their condition.[31] Respondent interviewees also revealed the ongoing discrimination faced by PLHIV and marginalised populations. Four years since the notification of the Act, respondent interviewees noted that PLHIV continue to be de-prioritised and stigmatised in healthcare settings, public or private; it is common for PLHIV to be operated on only at the very end of the day or after other surgeries have been performed. One respondent interviewee noted that, often, insurers are in the dark about their obligations under the Act with PLHIV facing undue delays and evasive behaviour while seeking insurance policies; this despite the fact that Insurance Regulatory and Development Authority of India has summarised the *HIV Act*'s anti-discrimination provision in a notification directed to Indian insurers.[32] In employment settings, respondent interviewees noted that there are a fair number of discrimination cases currently being litigated or conciliated under the Act. Common cases pertain to covert demotion of employees based on HIV-positive status, or mandatory HIV testing as a hiring prerequisite. In two separate employment discrimination cases taken up by C-HELP recently, reputed hotel chains were found denying employment or demoting employees on learning of their HIV-positive status.

Partner notification in the context of HIV has been the subject of much controversy. The Act balances the right of confidentiality of PLHIV with the right of a partner at significant risk of HIV transmission by specifying a clear protocol for partner notification (section 9). Studies indicate high levels of voluntary partner notification in India; but where a partner has been notified of a spouse's HIV-positive status without their consent, it has been predominantly by medical staff.[33] This underscores the need for the detailed protocol specified in the Act. Respondent interviewees noted instances of indirect disclosure of a person's HIV status; one recounted recently visiting a notable hospital in Mumbai and seeing PLHIV's beds tagged with their HIV-positive status. The government provides for a free travel pass to PLHIV to approach ART centres and collect their medicines, but the pass and the vial of drugs clearly mention "HIV & AIDS" which may disclose one's seropositive status in public settings. Consequently, respondent interviewees noted that some PLHIV have been reluctant to avail of the pass.

---

[30] Nair, M., et al. (2019). Refused and referred-persistent stigma and discrimination against people living with HIV/AIDS in Bihar: a qualitative study from India. *BMJ Open* 9(11). doi: 10.1136/bmjopen-2019-033790.
[31] Ibid.
[32] Insurance Regulatory and Development Authority of India. (2008). Circular on HIV and AIDS (Prevention and Control) Act, 2017 (Reference no. IRDA/HLT/MISC/CIR/169/10/2018). Available at: https://www.irdai.gov.in/admincms/cms/whatsNew_Layout.aspx?page=PageNo3620&flag=1
[33] Lathwal, S., et al. (2020). Disclosure of HIV status by people living with HIV/AIDS in tertiary care hospitals in Western Maharashtra. *International Journal of Community Medicine and Public Health, 7(7)* doi:10.18203/2394-6040.ijcmph20202999.

Access to ART is critical for PLHIV to live long, healthy lives. The expansion of the government's HIV treatment programme took place under the watchful eyes of the Supreme Court over the course of a decade in the case of *Sankalp Rehabilitation Trust v Union of India*.[34] Today 14.05 lakh PLHIV are on first, second or third line ART provided free of cost by the government.[35] As was the case before the passing of the Act, the role of PLHIV networks remains integral to the success of the government treatment programme. During the COVID-19 pandemic, PLHIV networks stepped in to deliver ART as their members were unable to access their medication during the lockdowns. Through most of 2022, stock-outs of the critical first line ART, dolutegravir were reported by PLHIV networks across the country due to an unsuccessful bidding and procurement process at NACO and states were instructed to make arrangements for themselves.[36] Eventually, ART supply resumed and a 42-day long protest at NACO offices concluded on 31 August 2022 with a joint monitoring committee of NACO and PLHIV networks being established to ensure that such a situation did not arise again. For people who use drugs in particular, a respondent interviewee highlighted instances of denial of medication at some ART centres, and the inhumane treatment of drug users at these venues where they are seldom offered care, counselling or support.

Apart from treatment, prevention programmes are another critical arm of the government's HIV response, achieved mostly through targeted interventions implemented by NGOs and PLHIV networks. This includes IEC, condom and lubricant distribution, outreach services, counselling, HIV testing, sexually transmitted infection (STI) management, needle/syringe programmes, and Opioid Substitution Therapy (OST) with key populations under the guidance of NACO's Technical Resource Groups, each of which include civil society and community representation.[37] Respondent interviewees expressed concern over the decrease in awareness campaigns related to HIV for key populations and reports note uncertainty over the functioning and resumption of targeted intervention programmes for sex workers particularly after the COVID-19 lockdowns.[38] In the case of OST, a respondent interviewee noted that NACO has been attempting to decentralise the programme by asking state governments to procure their own substitution drugs, needles, and syringes. However, a shortage of funds at the state level leads to frequent shortage of harm reduction components and with SACS unable to maintain buffer stocks, people end up on waiting lists for weeks for the most basic of amenities like fresh needles.

A key concern raised by respondent interviewees in relation to the government's Prevention of Parent to Child Transmission (PPTCT) programme, which is a decade-long effort to prevent vertical transmission of HIV during pregnancy and breastfeeding,[39] is the exclusion of sex workers from the programme. As indicated by a respondent interviewee, sex workers often become single mothers and have to go through the health system on their own. Not only are they not provided the benefits of the PPTCT, but are additionally subjected to mistreatment and dehumanisation.

---

[34] The orders issued by the SC in the course of this case covered issues related to ensuring availability of healthcare facility-level grievance redress systems, personal protective equipment (PPE) for medical staff, training and sensitization of healthcare workers in line with NACO protocols, rationalisation of treatment in private sector and progressively scaling-up the availability of HIV-related healthcare goods, services and facilities in India. See *Sankalp Rehabilitation Trust v Union of India*, W.P. (C) 512 of 1999 (orders dt. 01.10.2008, 11.12.2012 and 02.12.2013); *Sahara House v UOI*, W.P. (C) 535 of 1998.

[35] National AIDS Control Organisation. (2022). Status of National AIDS Response. Available at: http://naco.gov.in/sites/default/files/Sankalak_Report_1.pdf

[36] Barnagarwala, T. (2022, June 28). 'This is hell,' say HIV patients as government body stops supply of life-saving drug. *The Scroll*. Available at: https://scroll.in/article/1026878/this-is-hell-say-hiv-patients-as-government-body-stops-supply-of-life-saving-drug

[37] National AIDS Control Organisation. Technical Resource Groups. Available at: https://naco.gov.in/technical-resource-group

[38] Bhattacharya, A. (2021, September 17), 'Sex workers in Asansol sitting on a ticking time bomb of HIV/AIDS.' *GaonConnection.* Available at: https://en.gaonconnection.com/sex-workers-asansol-west-bengal-hiv-aids-covid19-rural-bihar-health/

[39] National AIDS Control Organisation. (2013). *Updated Guidelines for Prevention of Parent to Child Transmission (PPTCT) of HIV using Multi Drug Anti-retroviral Regimen in India.* Available at: http://naco.gov.in/sites/default/files/National_Guidelines_for_PPTCT.pdf

2.1.3 Administrative Machinery

The *HIV Act* does not establish any specific mechanisms or authorities for the implementation of the Act. The various governance and administrative functions are largely distributed between the central government (section 46), state governments (section 47) and ombudsmen. Courts and child welfare committees also have a few ancillary duties (sections 16 and 34 respectively). Grievance redress systems covering both the public and private sector are established through the appointment of state-wise Ombudsmen (sections 23-25) and Complaints Officers for establishments (section 21).

Although there were proposals made at the drafting stage for the institutionalisation of NACO and SACS through the law, a respondent interviewee recalls that these provisions were removed in light of the growing push to integrate the HIV response within the broader health programme. Instead, central and state governments are tasked with both legislative powers (to make rules, regulations, policies) and executive roles (to implement the law). The Act lists legislative functions of the centre and states (sections 46 and 49, read with sections 12 and 14). At the central level, the government is required to notify guidelines and policies on specified areas under the Act, which include preparing a) *procedural guidelines* for obtaining informed consent, pre or post-test counselling, ensuring data protection, and giving care and treatment to persons in custody; b) *strategy documents* for risk reduction in HIV transmission, implementing ART and IOM infrastructures, and raising awareness; and c) *policies* for care, support and treatment of protected persons generally. Additionally, the centre is tasked with publishing model HIV policies for private establishments (section 12). Most of these documents existed prior to the Act and are gradually being updated even as new guidance is being issued such as the Operational Guidelines on HIV and TB interventions in Prisons and Other Closed Settings issued in 2019.[40] For purposes of data protection, NACO published draft guidance on data sharing in 2018, data protection in 2019 and in 2020 published an interim document on data management combining the previous two draft documents.[41] However, it is unclear if a final version of the 2020 document has been notified. A model *HIV and AIDS Policy for Establishments* was notified in May 2022.[42]

State governments are tasked with notifying state-wise rules under the Act, to (mainly) provide measures for treatment and prevention of HIV in accordance with the guidelines of the central government, procedures relating to the ombudsman and the recording of pseudonyms in legal proceedings (section 49). The central and state governments also perform executive roles under the Act. State governments are to appoint one or more ombudsmen to ensure speedy redressal of complaints (section 23). The ombudsman reports to the state and central governments on the number and nature of complaints received, and action taken (section 28).

Despite such an extensive and detailed legal framework in place, most respondent interviewees noted that the provisions of the Act have rarely been invoked and that affected communities are largely unaware of the rights within and provisions of the Act. Awareness campaigns related to the Act have only recently started; NACO has released a booklet on the Act in Hindi[43] and English[44] with top-line

---

[40] National AIDS Control Organisation. (2019). *HIV and TB interventions in Prisons and Other Closed Settings: Operational Guidelines.* Available at: http://naco.gov.in/sites/default/files/HIV-TB%20in%20Prisons%20and%20OCS%20-Operational%20Guidelines.pdf

[41] National AIDS Control Organisation. (2020). *Draft NACP Data Management Guidelines 2020 under National AIDS Control Programme.* Ministry of Health and Family Welfare. Available at: http://naco.gov.in/sites/default/files/Draft%20NACP%20Data%20Management%20Guidelines%202020.pdf

[42] National AIDS Control Organisation. (2022). HIV & AIDS Policy for Establishments, 2022. Available at: https://naco.gov.in/sites/default/files/HIV_and_AIDS_Policy_for_Establishments_2022_0.pdf

[43] See, National AIDS Control Organisation. (undated). HIV & AIDS Act Booklet – Hindi Version. Available at: http://naco.gov.in/sites/default/files/HIV%20AIDS%20Booklet%20-Hindi%20version.pdf

[44] See, National AIDS Control Organisation. (undated). HIV & AIDS Act Booklet – English Version. Available at: http://naco.gov.in/sites/default/files/HIV%20AIDS%20Booklet%20-English%20version.pdf

messages about the provisions Act. In 2021 NACO released a series of detailed videos[45] in Hindi and English on key provisions of the Act and in December 2022 launched an online campaign with short videos specifically on HIV-related stigma and discrimination with the hashtag #AbNahiChalega alerting PLHIV that they can file complaints of discrimination with their state ombudsman.[46]

2.1.4 Grievance Redress Systems

Before the *HIV Act*, cases of discrimination and other rights violations based on HIV status would be filed in a court of law, and would take several years to reach resolution. The Act introduced state-level HIV Ombudsmen and Complaints Officers as an alternative to litigation. In addition, for PLHIV wanting to approach a court of law, the Act also incorporated safeguards like anonymity and confidentiality during and after litigation at the court level. Under the Act, any aggrieved person can approach one of three authorities: the Complaints Officer if the violation occurred at the establishment level (section 21); the Ombudsman at the state level in case of violations in healthcare settings (section 23), or a court of law directly (section 34).

2.1.4.1 Complaints Officers in Establishments

Every establishment comprising over one hundred persons (and every healthcare establishment comprising over twenty persons) must appoint a Complaints Officer in the manner stipulated by the *HIV/AIDS Rules, 2018 (*section 21).[47] Violations that a Complaints Officer may entertain can be related to informed consent, confidentiality, discrimination, and a safe working environment generally. Section 9 of the rules prescribe the manner of appointing such an officer.

The Complaints Officer can be any senior ranking person of the establishment, and may be aided by an Additional Complaints Officer.[48] They must be continually trained and sensitised to issues such as HIV prevention, care, support and treatment, human sexuality, sexual orientation and gender identity, drug use, sex work, people vulnerable to HIV, stigma and discrimination, principles of the greater involvement of PLHIV, strategies of risk reduction, and so on.[49] The officer may accept complaints made within a limitation period of 3 months, which may be extended by 3 more in special circumstances. The complainant must follow the format prescribed in the Rules, but can submit the complaint via telephone, post or email. The Complaints Officer is responsible for creating a webpage or organisational email ID within a month of their appointment.[50] A register of complaints must be maintained with sequential entries of all complaints received. The officer has to dispose of the case within 7 days of receiving it, or in emergency cases, on the same day. Orders they can pass include asking the establishment to rectify the violation, making the defaulter undergo training, counselling and sensitisation, or directing the establishment to institute disciplinary proceedings. They may then produce a reasoned written order within 10 days of deciding an outcome. The Complaints Officer shall report to NACO biannually on the status and details of complaints in a format notified by the central government.[51] The establishment shall also publish this information in their annual reports, on their website.

Correspondence with respondent interviewees who take up cases of employment discrimination towards PLHIV revealed that they had not come across a single appointed Complaints Officer in their

[45] National AIDS Control Organisation. (2021), HIV & AIDS Act, 2017: Videos. Available at: https://www.youtube.com/playlist?list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W
[46] National AIDS Control Organisation. (2022), Stop HIV and AIDS Discrimination – Awareness Campaign: Videos. Available at: https://www.youtube.com/results?search_query=%23abnahichalega
[47] *HIV & AIDS (Prevention & Control) Rules, 2018.*
[48] Section 9(1), *HIV Rules, 2018.*
[49] Section 9(2) & 14, *HIV Rules, 2018.*
[50] Proviso, Section 10(3), *HIV Rules, 2018.*
[51] National AIDS Control Organisation. Reporting Format-Complaints Officer. Available at: http://naco.gov.in/sites/default/files/Reporting_Format_Complaints_Officer_1.pdf

years of practice and were resorting to courts of law to seek redress. In a list of Complaints Officers published by NACO, there is a disproportionately low number of private establishments that have an Officer appointed.[52] The recent notification of the Model HIV & AIDS Policy for Establishments may see better implementation of this requirement.[53] This policy has emanated from the obligation of the central government under section 12 of the Act to notify the same, albeit four years since its coming into effect. It applies to "establishments" as defined in section 2f of the Act, which includes all public and private bodies operating in India. The policy bases itself on the guiding principles of non-discrimination, consent and confidentiality, and accessible grievance redress systems.[54] The *HIV & AIDS Rules, 2018* stipulate who may entertain internal complaints and provide lawful and speedy redress. The Policy clarifies that an aggrieved person within an establishment may choose to circumvent the Complaints Officer and approach the state HIV Ombudsman at their own preference. As it is a recently notified document, it remains to be seen to what extent this Policy is adopted, especially in the sphere of private employment.

2.1.4.2 Ombudsman

<u>Qualifications and Experience of the Ombudsman</u>
Section 23 of the Act mandates each state to appoint an ombudsman of such qualification and experience as the state government deems fit, or appoint any of its senior officers to the post. Till date, 29 states and union territories have appointed the HIV/AIDS ombudsman.[55] Analysis of the eligibility criteria for 10 states/UTs as laid down under the states' rules was undertaken for this paper (see Table 1). These rules can be classified into two parts. First, states which provide multiple options for appointment as the ombudsman. For example, the state rules of Karnataka, Manipur and Nagaland allow retired district judges, healthcare providers, professors, activists or government officials to be appointed as the ombudsman.[56] In practice, they have appointed government officials from the Health and Family Welfare departments. Second, states which provide only one option for appointment as the ombudsman. The rules in Gujarat, Madhya Pradesh and Tamil Nadu appoint senior ranking government officials to the post.[57] Assam and Jharkhand appoint divisional commissioners, who exercise jurisdiction only over their region or division in the state.[58] In Punjab and West Bengal, civil surgeons and Chief Medical Officers serve as ombudsmen.[59]

Table 1: Qualification criteria for ombudsman in ten states as per the state HIV/AIDS Rules

State	Rule	Qualification of ombudsman
Assam	4(a)	Divisional Commissioners from all five divisions of Assam
Gujarat	4(1)	Regional Deputy Director, Health and Medical Services (ex officio)
Jharkhand	4	Divisional Commissioners from all five divisions of Jharkhand

[52] National AIDS Control Organisation. State-wise list of Complaints Officers. Available at: http://naco.gov.in/sites/default/files/Statewise%20List%20of%20Complaints%20Officer.pdf
[53] Id. at 43
[54] With regards non-discrimination, Section 1(1) states that no person affected by or living with HIV shall be treated unfairly at, terminated from, or denied employment. It holds that an employer may make reasonable accommodations to continue employing the PLHIV, and only terminate them in extraordinary cases by furnishing written evidence of their inability to continue being employed.
[55] National AIDS Control Organisation. (2022). Statewise List of Ombudsmen. Available at: http://naco.gov.in/sites/default/files/State%20wise%20list%20of%20Ombudsman-Final.pdf
[56] Rule 5(1), Karnataka HIV/AIDS (Ombudsman and Legal Proceedings) Rules; Rule 4, Manipur Rules; Rule 4, Nagaland Rules.
[57] Rule 4(1), Gujarat; Rule 4(2), Madhya Pradesh; Rule 5(1), Tamil Nadu.
[58] Rule 4(a), Assam; Rule 4, Jharkhand.
[59] Rule 4, Punjab; Rule 3, West Bengal.

Karnataka	5(1)	Retired District Judge or Senior Officer of State/Central government with a minimum of 10 years' working experience in Law/Pub health/Health delivery, or a qualified healthcare provider/physician with a minimum of 20 years' working experience, or retired professor of a government medical college with 10 years' working experience, or person who has served 1 year as the principal/director of a government medical college, or a person working with an NGO of similar experience.
Madhya Pradesh	4(2)	Project Director of MPSACS
Manipur	4	Retired District & Sessions judge or person possessing a minimum of 10 years' working experience or extensive knowledge in Law/Pub health/ Health delivery, or a qualified healthcare provider/physician with a minimum of 10 years' working experience, or a person working with an NGO of similar experience.
Nagaland	4	Retired District & Sessions judge or person possessing a minimum of 10 years' working experience or extensive knowledge in Law/Pub health/ Health delivery, or a qualified healthcare provider/physician with a minimum of 10 years' working experience, or a person working with an NGO of similar experience.
Punjab	4	Civil surgeons from five divisions in Punjab
Tamil Nadu	5(1)	Person not below the rank of Joint Secretary, Department of Health and Family Welfare, Tamil Nadu
West Bengal	3	Chief Medical Officers of respective districts in West Bengal. For Kolkata: State Family Welfare Officer, Health and Family Welfare Department, West Bengal

Even in states where the ombudsman is appointed without any state rules, the position is filled by government officials.[60] In Himachal Pradesh, Odisha, Bihar, Sikkim, Uttarakhand and Nagaland, the ombudsman is the Director or a Senior Officer of the states' Health and Family Welfare Department. In Andhra Pradesh he is the administrative head of SACS, and in Haryana and Uttar Pradesh the ombudsman office comprises 5-6 divisional commissioners.

The design of any public authority performing an adjudicatory role, in this case the HIV/AIDS ombudsman, must protect the neutrality, impartiality and independence of the institution. However, section 23 of the *HIV Act* and the corresponding state rules, by appointing government officials or health service providers as the ombudsman, fall short on this account. This is even true of states where ombudsmen are appointed in the absence of rules. The Act confers rights, entitlements and services to persons affected by HIV/AIDS, which are delivered to them by public and private healthcare providers, public and private employers, and government institutions such as NACO, SACS, and the state health departments. In case of any grievance, an aggrieved person can file a complaint before the ombudsman against any of these entities. The pattern of appointment of ombudsman across states shows that they are either government officials or service providers themselves, increasing the

[60] *HIV Act* RTI responses on status of state ombudsman and state-wise list of appointed ombudsman, on file with C-HELP.

possibility of presiding over matters against the very institutions and professions that they may be representing. This compromises the neutrality, impartiality and independence of the ombudsman, who could well be a judge in his own cause. Moreover, the *HIV Act* and the state Rules contain no provision to ensure the independence of the ombudsman by insulating the office from the influence of the government, nor a system for managing conflict of interests if and when they arise.

Ideally, the law must lay down streamlined, clear and transparent selection criteria (including qualifications and experience) and selection procedures for appointing the ombudsman, and exclude government officials and active health services providers from being appointed to the post. Additionally, the law should put in place a system of managing conflicts of interests that may arise in the course of the ombudsman's duties.

Complaints procedure

Within the framework of the *HIV Act* and relevant state rules, the HIV Ombudsman receives and adjudicates upon complaints relating to violations of substantive rights under the Act, often relating to discrimination or mistreatment in healthcare settings. A reading of the parent Act and state rules presents the following findings. Under section 25 of the Act, state governments shall prescribe the procedure, format and manner in which to file a complaint with the Ombudsman. Ten states (Assam, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Manipur, Nagaland, Punjab, Tamil Nadu, West Bengal) allow a limitation period of 3 months from the date of the violation to file a complaint, which can be extended by another 3 months by the ombudsman under special circumstances. It is commonly required that all complaints must be made in writing, or be reduced to writing. Complaints can be made via post, email, telephone or the Ombudsman website. In Manipur, complaints can also be made over SMS or WhatsApp.

Section 26 of the Act stipulates that the Ombudsman shall pass an order within 30 days of receiving the complaint after hearing both parties, and shall give reasons for their decisions. Their inquiry procedure is left to state governments (section 25). In ten states, the Ombudsman is expected to act in an objective and independent manner in the course of inquiry. With regards to Ombudsman orders, in these states the Ombudsman can order for withdrawal or rectification of actions. Additionally in Gujarat and Karnataka, the Ombudsman can also direct the defendant to undergo counselling, partake in social service, or pass other specific directions. In all the states, the Ombudsman can pass interim orders in cases of medical emergencies without hearing either or both parties. In Gujarat, Jharkhand, Manipur, Nagaland, Punjab, Tamil Nadu and West Bengal, the Ombudsman has an express duty to inform both parties of their right to seek judicial review against the decision. Manipur and Gujarat rules also specify that throughout the process of inquiry and adjudication, the Ombudsman should act in a friendly manner towards the complainant.

In our analysis of the complaints' procedures in ten states, we find that the rules are deficient in informing and educating the parties of their right to seek judicial review against an ombudsman's decision. Assam, Karnataka, and Madhya Pradesh do not expressly require the ombudsman to inform the parties of their right to seek judicial review and the recourse they may take to raise an appeal. Right to appropriate redress and judicial review is set in stone as a principle of natural justice, and also enshrined in the Constitution in Articles 32 and 226.[61] Decisions made by the executive, or a quasi-judicial adjudicator such as the Ombudsman, can be reviewed by a court of law if they violate fundamental rights of an aggrieved party.[62] As explained by a respondent interviewee, aggrieved persons under the Act are ill-informed of their legal rights and recourse in case of a rights violation, and are often wholly oblivious of the grievance mechanisms set up by the Act. Further, neither the Act nor state rules specify the appellate authority one should approach in case the ombudsman's order is

[61] *Marbury v Madison* 5 US 137.

[62] Jain, M.P., and Jain, S.N. (2007). *Principles of Administrative Law: An Exhaustive Commentary, Chapter V - Judicial control over delegated legislation.* (6th ed.). New Delhi: Wadhwa and Company, Nagpur.

to be challenged. In such circumstances, the ombudsman should be duty-bound to inform parties of their right to appeal against his decisions and the forum they may approach to exercise it.

Section 11 of the Act states that HIV-related information of protected persons must be protected from disclosure. Under this provision, state rules confer the right to confidentiality of data and identity to the complainant. In Gujarat, Jharkhand, Madhya Pradesh, Manipur, Nagaland, Punjab, West Bengal and Tamil Nadu, the rules specify that the Ombudsman shall ensure confidentiality and protection of data in line with section 11 while holding inquiries and/or maintaining the register of complaints. Karnataka rules have an express provision stipulating that any related information or document disclosed to the Ombudsman in course of his duties must be kept confidential, unless specific consent to disclose is given by the complainant. Like in Karnataka, every state ombudsman must be cognizant of the sensitive and confidential nature of the cases brought to him and accordingly set up data protection and security measures. As noted previously, it is unclear if NACO has issued final guidance on data protection or management; in the meantime and in the absence of an overarching data protection legislation in India today, state HIV/AIDS rules should prescribe more detailed, robust and secure mechanisms to ensure protection of sensitive information that is recorded and maintained by the ombudsman, who should be held accountable for any compromise, disclosure or misuse of such information.

Transparency and accountability

Section 28 of the Act requires the Ombudsman to report to the state government every 6 months on the number and nature of complaints received, the action taken, and the orders passed in relation to such complaints. Though all state Ombudsman are bound by this obligation, state rules have created additional reporting requirements (see Table 2). In Gujarat, Manipur and Tamil Nadu, the Ombudsman must submit a quarterly report to the Health and Family Welfare Department, the Legal Department and the SACS on the disposal and pendency of cases for periodic review. In Karnataka, quarterly reports of orders must be additionally made to the state government. Aside from reporting, the Ombudsman must also maintain a complaint register under all ten states' rules. This register shall bear a record of all complaints filed against a sequential complaint number, time of filing and the outcome of the complaint. While maintaining the register, the Ombudsman must duly comply with data protection measures under section 11 of the *HIV Act*.

Table 2: Additional reporting requirements of HIV/AIDS Ombudsman under state rules

State	Rule	Additional Reporting Requirement
Gujarat	7(12)	Submit a quarterly report to Health and Family Welfare Department, the legal department and SACS on the disposal and pendency of cases for periodical review.
Karnataka	7(11)	Report on orders to the government every 3 months.
Manipur	7(i)	Submit a quarterly report to Health and Family Welfare Department, the legal department and SACS on the disposal and pendency of cases for periodical review
Tamil Nadu	10(o)	Submit a quarterly report to Health and Family Welfare Department, the legal department and SACS on the disposal and pendency of cases for periodical review.

The Act makes no reference to disclosure of the Ombudsman's financial or other personal interests in cases. However, in Karnataka, Manipur and Nagaland, the Ombudsman's term can be terminated if they acquire any financial or other interest that may prejudice their exercise of functions. The

Ombudsman is also not required to publish any material on the nature of complaints they receive, or any findings or conclusions drawn from complaints (if any). While this is not in violation of the Act, such publications improve the machinery and enable them to increase legal and administrative efficiency. Reporting requirements should be strengthened and made equal for all states, and an express provision on conflict of interest should be inserted in state rules.

2.1.4.3 Special Procedures in Court

In addition to the grievance redress bodies established under the Act, an aggrieved person may also approach a court of law for legal remedy. The Act guarantees certain protections that enable a complainant/applicant to avail of this path safely and equitably. Section 34 directs courts to suppress the identity of the applicant by using a pseudonym in the records, conduct proceedings in-camera, restrain the disclosure of identity by any other person, and resolve complaints expeditiously, on priority basis. Section 35 empowers the court to consider interim maintenance applications in light of hefty medical bills incurred by the applicant. Any person found to disclose the HIV status of the applicant or any information obtained about them in the course of the proceedings, shall be fined or imprisoned (section 39).

2.1.5 Comment

The *HIV Act* is a historically significant legislation in the Indian public health landscape. Rights enshrined under this law are holistic and unique, encapsulating the long-winding journey of HIV advocacy in India. Still there are key concerns with the version of the Act that was finally passed; in particular the exclusion of key populations like sex workers, MSM, transgender people and people who use drugs from protection from discrimination and other rights enshrined in the Act. A respondent interviewee noted that their inclusion at the drafting stage was premised on the critical understanding that discrimination against key populations drives them away from seeking health services increasing their vulnerability to HIV, and fuelling its spread. Respondent interviewees working with sex workers confirmed that sex workers face discrimination at every level of the health system. In procedures and surgeries, they are the last to be operated upon, and even less of a priority if they are seropositive. As with sex workers, respondent interviewees working with MSM and trans communities reported similar demotions to the bottom of the list when it comes to procedures and surgeries, and even outright denial of health services in some instances. If not for outreach workers being present at hospital premises to intervene and demand treatment for key populations, many would be turned away or left unattended for hours. Transgender persons face harassment on another count: over which wards and bathrooms they should be sent to – male or female. Key populations also face discrimination in other settings that are also covered by the *HIV Act*. Discrimination against people who use drugs is rampant in certain states. In Mizoram, for instance, private employers have advertised in newspapers stating explicitly that drug users may not apply for classified positions. For sex workers, MSM and transgendered persons, path-breaking decisions from the Supreme Court in recent years have recognised and upheld key fundamental rights; for people who use drugs however, judicial relief has been difficult to achieve.

In terms of the implementation of the *HIV Act* as it stands, of particular concern is the low level of awareness among the PLHIV community of the avenues for redress available through the Act. Much of the implementation of the Act is left to state governments, which includes the establishment and regulation of institutions such as the state ombudsman. Many states had not acted on this task until 2020-21; of the 29 that have now done so, it was difficult to find information from the states' own websites and gazettes. Some states have notified rules but not appointed an ombudsman, some vice versa, and others neither.

Furthermore, each state is expected to design its Ombudsman system in great detail – prescribing the eligibility and appointment of the Ombudsman, procedure for filing complaints, manner of inquiry and

adjudication, and reporting requirements. In our analysis, we find common deficiencies in the ten notified state rules that we studied. First, the eligibility criteria of an Ombudsman are disparate across states and favours government officials, thus compromising the independence and impartiality of the office. The rules require streamlining and a commonly agreed upon eligibility criteria which precludes, if not expressly excludes, government officials from taking up the post. Second, the manner of inquiry and adjudication as laid out by state rules should be drafted with due regard to the principles of natural justice and constitutional rights of parties. The Ombudsman should be obligated to inform parties of their right to judicial review should they find his decision unsatisfactory. In the course of adjudication, the Ombudsman should carefully consider the sensitivity of information stored with him and establish mechanisms to ensure data protection and security. Third, the state rules may further improve reporting and transparency mechanisms and specify the details expected from an Ombudsman's reports, which should ideally include number of cases taken up, nature and subject matter of the case, provisions of the Act invoked, outcome of adjudication and other relevant details.

Additionally, as noted in the case of the recent ART stock-out when states were briefly asked to make their own arrangements and ongoing concerns with access to clean needles and OST for people who use drugs, the potential adverse impact on people who need critical HIV prevention and treatment services of any shift to procurement by the state governments should be carefully examined before being implemented.

2.2 Mental Healthcare Act, 2017

2.2.1 History and Context

Mental health legislations were initially drafted with the objective of safeguarding the public from those who were considered 'dangerous' to society, i.e., any person suffering from a mental illness. The *Indian Lunacy Act 1912* (ILA 1912) was the first law that governed mental illnesses in India. It dealt with the reception, detention and custody of persons with mental illness in asylums, as well as the management of their estates. After independence, it was increasingly felt that the ILA 1912 focussed exclusively on custodial care and ignored the human rights of persons with mental illness. Several public interest litigations (PIL) underlined the need for mental healthcare reform. In 1981, the Supreme Court[63] upheld the right of persons with mental illness to live with dignity under Article 21 of the Constitution. It issued various directions to the state government to ensure that inmates of a protective home in Agra do not live in inhumane and degrading conditions. Other PILs raised concerns regarding persons with mental illness languishing in the Hazaribagh Central Jail in Bihar,[64] detention of mentally and physically challenged children in jails for safe custody,[65] the mismanagement of the Hospital for Mental Diseases located in Shahadra, New Delhi,[66] and the chaining of a person with mental illness in a mental hospital in Hooghly.[67]

Around the same time, international and national developments advocated a paradigm shift in mental healthcare from custodial care to community care. In 1991, the UN General Assembly adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which recognised that persons with mental illness have the right to life and a role in community.[68] Although India never ratified the UN resolution, the need for community care in mental healthcare was reflected in the National Mental Health Policy 1982 (NMHP), *Mental Health Act 1987*

---

63 *Upendra Baxi v State of Uttar Pradesh* 1983 (2) SCC 308.
64 *Veena Sethi v State of Bihar* 1982 (2) SCC 583.
65 *Sheila Barse v Union of India* 1986 (3) SCC 596.
66 *B. R. Kapoor v Union of India* 1989 (3) SCC 387.
67 *Chandan Kumar Banik v State of West Bengal* 1995 Supp (4) SCC 505.
68 United Nations (1991). *Principles for the protection of persons with mental illness and the improvement of mental health care.* General Assembly Resolution 46/119, dated 17 December 1991. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement

(MHA 1987) and the *Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995* (PWDA 1995).

In particular, the MHA 1987 repealed the draconian ILA 1912. It provided for the establishment of central and state mental health authorities, regulation of psychiatric hospitals and nursing homes, admission, detention and discharge of persons with mental illness from mental health institutions, management of their properties, and protection of their human rights. While some features of the MHA 1987 were welcome, it continued to focus on admission and treatment rather than community care, and was criticised for not dealing with important issues adequately such as the regulation of government mental hospitals and the human rights of persons with mental illness.[69] Additionally, the MHA 1987 was not implemented properly. In 1999, the National Human Rights Commission (NHRC) and the National Institute of Mental Health and Neurosciences (NIMHANS) released a report, noting severe deficiencies in the functioning of mental hospitals and rampant violations of the rights of persons with mental illness to appropriate treatment, rehabilitation and community life.[70]

In 2002, more than 25 mentally challenged persons were charred to death due to a fire in a mental asylum in Erwadi in Ramanathapuram district, Tamil Nadu. The deceased were unable to escape as they had been chained to poles and beds. The Supreme Court took *suo moto* cognizance of the incident, and directed every state and union territory to: (a) conduct a district-wise survey of all registered and unregistered bodies purporting to provide psychiatric or mental health care, and grant or refuse licence depending on whether minimum prescribed standards are fulfilled; (b) ensure effective implementation of the MHA 1987, PWDA 1995 and the *National Trust for Welfare of Person with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act 1999*; (c) file status reports on the constitution and functioning of state mental authorities; (d) setup central and state run mental hospitals; and, (e) undertake awareness campaigns, especially in rural areas, to educate people on laws relating to mental health, rights of persons with mental illness, the fact that chaining of mentally challenged persons is illegal and that mental patients should be sent to doctors and not to religious places.[71,72]

In 2006, the UN General Assembly passed the Convention of Rights of Persons with Disabilities (CRPD).[73] The CRPD explicitly includes persons with long-term mental illness under the definition of persons with disabilities. In particular, it recognises the right of persons with disabilities to the highest attainable standard of health, and enjoins state parties to ensure provision of free or affordable healthcare, habilitation and rehabilitation services and programmes.[74] It also recognises other rights, including the rights to life and liberty, individual autonomy, equality and non-discrimination, participation and inclusion in society, and freedom from exploitation, violence and abuse. The CRPD was ratified by the Indian government in 2007.

---

[69] See Trivedi, J. K. (2002). The Mental Health Legislation: An Ongoing Debate. *Indian Journal of Psychiatry, 44(2),* pp. 95-96. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2954355/; Antony, J. T. (2000). A Decade with the Mental Health Act, 1987. *Indian Journal of Psychiatry, 42(4)*, pp. 347-355. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2962734/

[70] See, National Human Rights Commission and National Institute of Mental Health and Neurosciences (1999). *Quality Assurance in Mental Health*. National Human Rights Commission.

[71] See, *In re: Death of 25 chained inmates in asylum fire vs Union of India*, 2002 (3) SCC 31. Available at: https://indiankanoon.org/doc/786018/

[72] The Supreme Court of India continued to monitor the central and state governments till the passage of the Mental Healthcare Act 2017. See, order dated 21 August 2017, *In re: Death of 25 chained inmates in asylum fire vs Union of India vs Union of India*, Writ Petition (Civil) No. 334 of 2001. Available at: https://main.sci.gov.in/supremecourt/2001/60092/60092_2001_Order_21-Aug-2017.pdf

[73] United Nations (2006). *United Nations Convention on the Rights of Persons with Disabilities*, General Assembly Resolution A/RES/61/106, dated 13 December 2006. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

[74] Ibid. Art. 25 and 26

These events paved the way for reforming the MHA 1987. A respondent interviewee explains that although the initial objective was to amend the MHA 1987, the need for a new law became evident in due course. The first draft of the Mental Health Care Bill (MHCB) was released around 2010-11. Thereafter, it went through various rounds of deliberations, including public consultations at the regional and national level. In 2013, the MHCB was introduced in the Rajya Sabha, seeking to recognise the right of persons with mental illness to affordable, quality and easily accessible mental health care and treatment, their capacity to make decisions related to their mental health care and treatment, decriminalisation of suicide and prohibition of electro-convulsive therapies. It provided for the regulation of mental health establishments and mental health professionals, establishment of central and state mental health authorities to monitor these entities, and mental health review bodies to deal with complaints regarding deficiencies in care and services. The MHCB was referred to the Standing Committee on Health and Family Welfare, which conducted widespread consultations with central government departments, state governments, public medical institutions, affected individuals, mental health practitioners, professors of psychiatry and disabilities studies, public health and community organisations.[75] The Standing Committee suggested few minor modifications to the MHCB, most of which were accepted by the Rajya Sabha. With its passage in the Rajya Sabha and the Lok Sabha, the MHA 1987 was repealed and the *Mental Healthcare Act 2017* (MHCA) was legislated.

2.2.2 Recognition of Rights

A respondent interviewee highlights that while the MHA 1987 focussed on the admission and treatment of persons with mental illness, the MHCA focuses on bringing them back into the community. The MHCA essentially regulates the delivery of mental health care and treatment, recognises the rights of persons with mental illness, and sets out the framework for the registration and monitoring of mental health establishments. Delivery of mental health care and treatment is regulated by mandating compliance with nationally and internationally recognised medical standards for the determination of mental illness (section 3); recognising the right of persons with mental illness to make mental health care and treatment related decisions (section 4); facilitating supported decision making through advanced directives (sections 5-13); setting out the process for appointment of nominated representatives and their rights and duties (sections 14-17); and, regulating admission, treatment and discharge from mental health establishments (sections 85-99). Further, the MHCA explicitly recognises the rights of persons with mental illness to access mental healthcare, community living, protection from cruel, inhuman and degrading treatment, equality and non-discrimination, access information regarding admission and treatment decisions, confidentiality of mental and physical health and treatment, restrict the release of information on mental illness to the media, access medical records, refuse or receive visitors and telephones, legal aid, and make complaints about deficiencies in services (sections 18-28). Finally, the MHCA prohibits establishments from providing mental health services without being registered under MHCA, mandates mental health establishments to fulfil prescribed standards of facilities, personnel and services, provides for regular inspection and audit of these establishments, and maintenance of the Register of Mental Health Establishments in digital format (sections 65-72).

In particular, the right to access mental health care under section 18 includes the availability of mental health services in sufficient quantity, affordable cost, good quality, easily accessible, non-discriminatory and acceptable manner. The range of services includes acute mental health services in health facilities, halfway homes, sheltered and supported accommodation, rehabilitation, child and old age mental health services. For the full realisation of this right, one key mandate of central and state governments is to integrate mental health services into general health care services at the primary, secondary and tertiary levels, and include them in all government health programmes. In

[75] Department Related Standing Committee on Health and Family Welfare (2013). Seventy Fourth Report on the Mental Health Care Bill, 2013. Rajya Sabha Secretariat, Parliament of India , paras 7-24. Available at: https://prsindia.org/files/bills_acts/bills_parliament/2013/Standing%20Committee%20Report_4.pdf

keeping with this, the central government has issued Operational Guidelines for Mental, Neurological and Substance Use Disorders Care at Health and Wellness Centres.[76] The guidelines set out a service delivery framework for the provision of mental health services at the individual, family and community level, primary health level, secondary health level and referral linkages. They also contain guidance on human resource and capacity building, budgeting and monitoring and supervision. However, implementation remains a problem in the provision of mental health and rehabilitation services. In 2021, the Supreme Court of India ordered the Government of Maharashtra to discontinue the practice of using beggars' homes or custodial institutions as halfway homes or rehabilitation centres for persons with mental illness.[77]

Respondent interviewees point to several reasons for poor implementation to ensure availability of mental health services at the primary health care level. First is irrational allocation of funds, where while in one year the amount is high, the next year it is inadequate. This is affected by the fact that the lion's share goes towards tertiary care where availability of mental health services is not an issue. The limited funds are either utilised inappropriately or not utilised at all, mainly because local authorities do not have clarity on how to use the money. While the operational guidelines contain provision for funding under the National Health Mission, state governments lack initiative and knowledge about preparing budgets to facilitate this. Second is the availability and training of the health workforce. There is a shortage of specialists at all levels, and most of the burden is being carried by community health workers. The training itself takes a biomedical approach while ignoring rights and psycho-social aspects of mental health care. Moreover, it is provided only once rather than continually. Third is the shortages in the availability of medicines at the primary level, continuity of supply chain and reluctance amongst healthcare workers to prescribe available medicines. Fourth, monitoring data is being collected for the sake of it, without any context or any system for identifying issues and improving the rollout of these services. There are also questions regarding the reliability of data as well as transparency on the extent and manner of collecting data. Specifically, a respondent interviewee felt that the MHCA or government mental health programmes are not tailored to the needs of queer and other marginalised communities, creating a reluctance to access these services.

2.2.3 Administrative Machinery

An overarching issue across different aspects of implementation of the MHCA, is a functional regulatory apparatus as envisaged under the law. This includes the Central Mental Health Authority, the State Mental Health Authorities and the Mental Health Review Boards.

2.2.3.1 Central Mental Health Authority

The MHCA establishes the Central Mental Health Authority (CMHA) to carry out the provisions of the law (section 33). The CMHA is primarily responsible for regulating mental health establishments under central control, including setting quality and service provision standards; registering and monitoring these establishments; and receiving complaints about deficiencies in the provision of services (section 43). Additionally, the CMHA is required to maintain and publish a register of all mental health establishments and professionals in the country; train law enforcement officials and health professionals on the MHCA; and periodically review the procedure for making advance directives (sections 12 and 43).

---

[76] National Health Mission. *Operational Guidelines for Mental, Neurological and Substance Use Disorders at Health and Wellness Centres: A part of Comprehensive Primary Health Care*. Ministry of Health and Family Welfare, Government of India. Available at: https://ab-hwc.nhp.gov.in/download/document/Final_MNS_Operational_Guidelines_-_Web_Optimized_PDF_Version_-_19_11_20.pdf

[77] Order dated 6 July 2021, *Gaurav Kumar Bansal v Dinesh Kumar*, Supreme Court of India, Comnt. Pet. (C) 1653 of 2018 in Writ Petition (C) No. 412 of 2016. Available at: https://main.sci.gov.in/supremecourt/2018/32117/32117_2018_35_14_28276_Order_06-Jul-2021.pdf

Section 34 of the MHCA envisages a well-structured CMHA, with checks and balances that ensure its wide-ranging powers are not misused. With 24 members in total, the composition of CMHA is diverse. It includes government representatives, mental health professionals, persons with mental illness, caregivers, non-governmental organisations providing mental health services and other persons relevant to the area of mental illness. Moreover, there is parity between members who are related to the government and those that are not, thereby ensuring that the central government is not biased towards selecting government officials.[78] Non-governmental members are selected through a fair and transparent process. They are chosen by a selection committee composed of the CMHA chairperson and two independent mental healthcare experts, through an open advertisement of vacancy and based on a predetermined criterion.[79] The MHCA also provides for a system for management of conflicts of interest. Under section 39, every member is mandated to disclose any personal interest, whether direct or indirect, in a matter under consideration before the CMHA. On doing so, the member will not have a role in the deliberations or decisions in respect of that matter. Finally, accountability of the CMHA is ensured through periodic financial audits and annual reports accounting for the activities of the preceding year (sections 59 and 60).

2.2.3.2 State Mental Health Authority

The MHCA established the State Mental Health Authorities (SMHAs), mirroring the design and functions of the CMHA at the state level (section 45). The SMHAs are primarily responsible for regulating mental health establishments under state control, including setting quality and service provision standards; registering and monitoring these establishments; and receiving complaints about deficiencies in the provision of services (section 55). Additionally, the SMHAs are required to maintain and publish a register of all mental health establishments and professionals in the state; train law enforcement officials and health professionals on the MHCA; and establish Mental Health Review Boards (MHRBs) within its jurisdiction (sections 55 and 73).

Like the CMHA, the composition of SMHAs is diverse and includes government representatives, mental health professionals, persons with mental illness, caregivers, non-governmental organisations providing mental health services and other persons relevant to the area of mental illness (section 46). However, unlike the CMHA, government representatives are in minority.[80] The process for selecting and nominating non-government representatives in SMHAs is identical to the process envisaged for non-government representatives in the CMHA.[81] The MHCA also envisages a system for management of conflict of interest, periodic financial audits and annual reports accounting for activities of the preceding year (sections 51, 63 and 64).

---

[78] There are 12 government representatives and 12 non-government representatives. Government representatives include Secretary or Additional Secretary in the Department of Health and Family Welfare; Joint Secretaries in the Department of Health and Family Welfare, Department of AYUSH, Department of Disability Affairs, Ministry of Women and Child Development, Ministry of Home Affairs, Ministry of Finance and Ministry of Law; Director General of Health Services; and Directors of 3 Central Institutions for Mental Health. Non-government representatives include a mental health professional, a psychiatric social worker, a clinical psychologist, a mental health nurse, 2 persons representing persons who have or had mental illness, 2 persons representing caregivers of persons with mental illness, 2 persons representing NGOs which provide mental health services and 2 persons relevant to the area of mental illness. See, Section 34 of the MHCA, and Rules 3 and 5, *Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules 2018*. Available at: http://bareactslive.com/ACA/act3187.htm

[79] See, Rules 6-8, *Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules 2018*

[80] There are 8 government representatives and 11 non-government representatives. Government representatives include Secretary or Principal Secretary in the State Department of Health; Joint Secretaries in the State Departments of Health, Social Welfare, Home, Finance and Law; Director of Health Services or Medical Education; and either the head of any state mental hospital or Head of Department of Psychiatry at a government medical college. Non-government representatives include one eminent scientist not in the service of the government, a mental health professional, a psychiatric social worker, a clinical psychologist, a mental health nurse, 2 persons representing persons who have or had mental illness, 2 persons representing caregivers of persons with mental illness, and 2 persons representing NGOs which provide mental health services. See, Section 46 of the MHCA, and Rules 3 and 5 of the *Mental Healthcare (State Mental Health Authority) Rules 2018*. Available at: http://bareactslive.com/ACA/act3187.htm

[81] See, Rules 6-8, *Mental Healthcare (State Mental Health Authority) Rules 2018*

2.2.4 Grievance Redress Systems

Mental Health Review Boards (MHRBs) under the MHCA are grievance redress bodies. Under section 82, the MHRBs are primarily responsible for receiving, adjudicating and deciding complaints related to the admission of persons with mental illness in mental health establishments, non-disclosure of medical records, deficiencies in care and services and violating the rights of persons with mental illness. Additionally, MHRBs are required to register, review, alter or cancel advance directives, appoint nominated representatives, and visit and inspect prisons.

In general, MHRBs deal with complaints between mental health establishments or professionals and persons with mental illness. The composition of MHRBs, under section 74, reflects both these interests. It includes two members from the medical community and two members who are persons with mental illness or caregivers or non-government organisations providing health services. Being an adjudicatory body, it includes a District Judge as its chairperson. Like the CMHA and SMHAs, all members of MHRBs are selected through a fair and transparent process.[82]

Sections 77-80 and 82-83 of the MHCA lay down the process for filing grievance applications and the process for adjudicating grievances. The process *specifies time limits* for deciding different kinds of complaints; *ensures confidentiality* of proceedings in so far as they are to be held in camera and external persons may attend only with the consent of the person with mental illness person and the MHRB chairperson; and *ensures enforceability* of orders by empowering the MHRB to impose penalties in the event of non-compliance.

2.2.5 Comment

Overall, the MHCA lays down a well thought out and modern regulatory framework. Unfortunately, implementation has been poor insofar as even the SMHAs and MHRBs have not been constituted in most states. An RTI response from the MoHFW states that as of 1 April 2022, MHRBs were constituted in only 8 states and union territories – Sikkim, New Delhi, Tamil Nadu, Chhattisgarh, Orissa, Maharashtra, Tripura and Chandigarh. A respondent interviewee notes that the problem of implementation is mainly due to the lack of political will of state governments. Various factors have acted as catalysts in states where the MHCA is being implemented. In some states, like Karnataka, Goa and Bihar, courts have played an important role. In other states, like Tamil Nadu and Kerala, civil society has played an active role. In Chhattisgarh, implementation has been driven by government officials. Another respondent interviewee feels it is only because of court intervention that the MHCA is being implemented.

Apart from implementation, there is also scope to improve the MHCA on three aspects of the law. For one, we note that the CMHA and SMHAs have both executive and adjudicatory roles. The same authority performing both these functions is against the rule of law and principles of natural justice. Under section 68, the CMHA or SMHAs can receive complaints regarding deficiency of services, inspect the concerned mental health establishments, and adjudicate based on the inspection. Essentially, the investigator and the judge are the same people, eroding fairness and impartiality of these authorities. It is important that the adjudicatory functions of CMHA and SMHAs should be separated from their other functions. The principle has been reiterated by the Financial Sector Legislative Reforms Commission and the Justice Sri Krishna Committee Report on Data Protection, as well as upheld by the Supreme Court in *Brahm Dutt v Union of India*.[83] Moreover, MHRBs are already tasked with

---

[82] See, Rule 18, *Mental Healthcare (State Mental Health Authority) Rules 2018*

[83] Committee of Experts under the Chairmanship of Justice BN Srikrishna (2018). *A Free and Fair Digital Economy Protecting Privacy, Empowering Indians*. Government of India, pp. 151-159. Available at: https://www.meity.gov.in/writereaddata/files/Data_Protection_Committee_Report.pdf; FSLRC (2013). *Report of the Financial Sector Legislative Reforms Commission (Volume 1)*. Government of India, pp. 37-38. Available at: https://dea.gov.in/sites/default/files/fslrc_report_vol1_1.pdf; *Brahm Dutt v Union of India* 2005 (2) SCC 431, para 6

receiving and adjudicating complaints regarding deficiency of services. This leads to multiplicity of authorities with overlapping functions, and is likely to complicate the process of grievance redress.

There is also scope to make the grievance redress process more accessible by allowing persons with mental illness to make an application in writing or online or orally or over the telephone, as per their convenience. At present, oral and telephonic complaints are allowed in exceptional circumstances only (section 77(4)).

Finally, keeping in mind the crucial role of civil society and courts in implementation, there is value in improving transparency and accountability of the CMHA, SMHAs and MHRBs. For instance, the CMHA and SMHAs should be mandated to make records of accounts and annual reports publicly available on their website. Similarly, MHRBs must maintain a high-quality electronic database about all aspects of complaints before it and provide online tracking of complaints. Finally, all these authorities should be bound to follow a consultative process for finalising any rules, regulations or guidelines issued under MHCA. These small changes will go a long way in generating awareness and strengthening the role of civil society. Institutional mechanisms that facilitate mobilisation of communities play a significant role in ensuring that the political class and bureaucracy effectively implement laws and policies.

Section 3: PUBLIC HEALTH LAWS AND THE RIGHT TO HEALTH IN INDIA: A STUDY IN CONTRASTS

Several states in India are currently considering state level right to health laws. In terms of rights-based state level health laws that have already been adopted, however, there are two examples the *Assam Public Health Act, 2010* and the very recently passed *Rajasthan Right to Health Act 2023*. As many provisions in the Assam Act also feature in extant drafts, a review of this law was included. However, instead of just a simple review, Section 3 juxtaposes analysis of the Assam law with that of the *Epidemic Diseases Act, 1897* as laws that provide starkly opposing conceptions of public health governance.

3. PUBLIC HEALTH LAWS AND THE RIGHT TO HEALTH IN INDIA: A STUDY IN CONTRASTS

3.1 Background

The landscape of public health is evolving. India is undergoing a demographic, epidemiological and environmental transition, adding to the triple burden of diseases, viz. communicable, emerging/ re-emerging infectious diseases and non-communicable diseases. Infectious diseases still persist as major health problems, evidenced by the COVID-19 pandemic. Further, acquired resistance of pathogens to antimicrobial medications such as antibiotics, is a major factor in re-emergence of infectious diseases, such as Drug Resistant TB. Climate change is now acknowledged as a factor in the emergence of infectious diseases.

This section reviews the implementation of two public health laws. At one end of the spectrum is the *Epidemic Diseases Act 1897* (EDA), a pre-Constitutional law that was enacted by the British to curb the spread of bubonic plague in Maharashtra, which spread to other parts of the country subsequently. Historian David Arnold describes the law as *"one of the most draconian pieces of sanitary legislation ever adopted in colonial India."* The heavy-handed measures that invited outrage and resistance included compulsory detention of plague suspects, destruction of houses and infected property, physical examination of persons including women at any time and anywhere, compulsory removal of patients to hospitals, unsanitary conditions in quarantine camps and forced inoculations.[84] Despite its colonial underpinnings that gave sweeping and unchecked powers to the government, the EDA has remained largely unchanged in India and recently also lent itself to COVID-19 management and control. At the other end of the spectrum lies the *Assam Public Health Act, 2010* which reflects the modern, rights-based approach to public health.

There is much to learn about the evolution of the fundamental premise of international law and cooperation on public health emergencies over time and its impact on the dominant legal approach to public health in India. The international legal framework developed from the first international sanitary conference in 1851 until WHO's adoption of the International Sanitary Regulations in 1951 is referred to as the ''classical regime''.[85] The EDA reflected the substantive legal approach to international infectious disease control developed since 1851.

The classical regime pursued protection against the international spread of infectious diseases through international legal obligations requiring that (1) States notify other countries about outbreaks of specified diseases, and (2) maintain adequate public health capabilities at "*points of disease entry and exit*" (e.g., sea ports and, later, airports). Quarantine of ships and travellers was a virtually universal national policy response to the threat of imported disease. It was very limited in terms of the public health risks addressed and was instead driven by the economic interests of the great powers. It was not geared towards trying to ameliorate the situations that caused epidemics, or to provide support to epidemic control measures, or to improve public health infrastructure in the affected countries. Unsurprisingly, the EDA mirrored this approach. Its provisions give sweeping and unfettered powers to the government to take harsh measures for disease control, and heavy focus on ports and later airports; with no provisions pertaining to prevention and mitigation, or public health infrastructure requirements.

As scholars of international health diplomacy have noted, a driving motivation behind international health cooperation in the late nineteenth and early twentieth centuries was to protect Europe and

[84] Arnold, D. (2000). *Science, technology and medicine in colonial India.* Cambridge University Press; 2000: p.143
[85] Fidler, D.P. (2003). Emerging Trends in International Law Concerning Global Infectious Disease Control. *Emerging Infectious Diseases. 9(3)*:285-90. doi: 10.3201/eid0903.020336

North America from the importation and spread of "*Asiatic diseases*''.[86] The government was chiefly interested in enforcing the international sanitary conventions, protecting trade, and allay any fears of diseases like plague and cholera spreading outside India, which would imperil trading interests.

At the 10th International Sanitary Conference in Venice in 1897, a trading embargo was proposed against India if containment actions were not taken.[87] This resulted in an aggressive enforcement of the law, which invited distrust by Indians and outrage and resistance towards high-handed action taken by the British. People protested strongly against the harsh containment measures and leaders of the time advocated for better sanitation and living conditions, increased government expenditure, and better public health facilities as means to control diseases.[88] Meanwhile, despite harsh measures the plague raged on. Unsuccessful attempts to curb the pandemic using massive government intervention resulted in the British modifying their strategy in favour of moderate measures such as creating awareness about sanitation, advocating voluntary measures, and setting up institutions for medical research.[89]

In 1909, the Punjab Plague Manual records *"The cardinal principle of all plague administration must be that no pressure or compulsion, […] is to be brought to bear on the people. Encouragement, persuasion and the provision of facilities for carrying out the measures advocated are the only legitimate means of influencing and guiding public opinion in the direction desired."*[90]

Although criticism and resistance to plague control measures lead to a gradual modification of government measures in practice, the EDA itself remained unmodified to reflect these understandings related to improving social determinants of health (sanitation, hygiene, living conditions, water), improving public health infrastructures and services, and principles of voluntariness, acceptability and rights. Yet, the counterview may have influenced the development of public health legislations in areas such as Tamil Nadu, which have public health measures focussing on social determinants of health.

In the international arena, several factors contributed to the eventual marginalisation of the "*classical regime*", particularly in the years after World War II. Scholars have identified some of the key factors that underscored the ineffectiveness and gradual irrelevance of the classical regime:[91]

a) The Constitution of the WHO which instead of revising the classical regime, moved to disease eradication efforts and promoting universal primary health care through the Health for All campaign launched in 1978;
b) Dramatic decrease in the political importance of the classical regime of controlling infectious diseases, as developed countries made significant strides in reducing infectious diseases within States, such as improvements in providing clean water and sanitation services, and widespread application of new medical technologies, such as vaccines.

---

[86] Howard-Jones, N. (1975). *The Scientific Background of the International Sanitary Conferences, 1851–1938*. World Health Organisation. Available at: https://apps.who.int/iris/bitstream/handle/10665/62873/14549_eng.pdf.?sequence=1 describing the motivations of European countries participating in international health cooperation as ''*not a wish for the general betterment of the health of the world, but the desire to protect certain favoured [especially European] nations from contamination by their less-favoured [especially Eastern] fellows."*

[87] Id. at 85

[88] Tumbe, C. (2020). *The Age of Pandemics (1817 - 1920): How they shaped India and the World.* Harper Collins Publishers India. p. 87 *"Tilak had bitterly contested the manner in which containment measures were carried out in Poona but at the same time had advocated for adoption of modern sanitary measures to combat the plague"*

[89] Ibid. p. 82

[90] Ibid.

[91] Fidler, D.P. (2005). From International Sanitary Conventions to Global Health Security: The New International Health Regulations. *Chinese Journal of International Law, Volume 4, Issue 2.* https://doi.org/10.1093/chinesejil/jmi029

c) The development of antibiotics and vaccines for many infectious diseases created resources not present when the classical regime emerged and proliferated. This produced the motivation and the need to use and disseminate such technologies globally; but the classical regime was not designed to support such an effort.

d) The emergence of three bodies of international law – international human rights law, international trade law and international environmental law, which provided more relevant frameworks to address pandemics locally and globally. There was an increased criticism of the regime's limited disease-specific approach to international infectious disease threats and its inability to keep up with new understandings of public health. The International Health Regulations (IHR) – first adopted at the World Health Assembly in 1969 – had little, if any, applicability to the crisis of emerging and re-emerging infectious diseases because most of these diseases were not subject to the IHR. The limitation and failure of the classical regime and early IHR is explained through the international effort to control the HIV/AIDS epidemic. Instead of IHR, public health officials adopted an alternative international legal strategy that involved application of international human rights law, in particular the ICESCR.

Experience with HIV/AIDS has shown the vital importance of human rights-based approaches to sustainable and effective pandemic control and management. Empowerment of affected communities, prioritising the rights of the most vulnerable, informed decision making, and building trust amongst the public and public health authorities are cornerstones of such an approach. However, the EDA conspicuously lacks any consideration of human rights and does not reflect advances in pandemic-related law and public health measures.

As a culmination of a decade long process which got accelerated by the SARS epidemic, WHO revised the IHR in 2005 to align it with the changing public health priorities in a globalized world, taking into account different types of threats to public health, varied information systems available and the need to enhance health systems capacities in developing countries to tackle existing and emergent epidemic prone diseases. The IHR 2005 mandates states to revise their legislation to align with it, including development of the necessary public health capacities and legal and administrative provisions. Further, it categorically states that the implementation of IHR shall be with full respect for the dignity, human rights and fundamental freedoms of persons in accordance with the Charter of the United Nations and the principles of international law

As evidenced by the COVID-19 pandemic, all the factors noted above are relevant to a legal and policy framework to prevent, control and mitigate disease outbreaks/ epidemics/ pandemics. Law-policy frameworks must make efforts to take infectious disease control in new directions – *health governance* – addressing and balancing public health objectives with norms found in human rights, environmental protection, trade and security.

3.2 Epidemic Diseases Act, 1897

3.2.1 Scheme of the Act

The EDA, under section 2, arms state governments with wide powers, including of inspection and segregation, during times or the threat of "*dangerous epidemic diseases*" to take measures it deems necessary to prevent or stop the spread of the disease. State governments can take or empower any person to take measures and prescribe temporary regulations by public notice to be observed by the public or by any person. They can take measures to inspect persons traveling by railways or otherwise, and segregate persons suspected to be infected in hospitals or temporary accommodation. The central government has the power, under section 2A, during times or the threat of "*dangerous epidemic diseases*", to take measures and prescribe regulations for inspection of any vehicle (including a bus, train, aircraft and ship) leaving or arriving at any port or aerodrome and for detention of persons intending to travel, as may be necessary. Under section 3(1), any person disobeying any regulation or

order made under the Act is deemed to have committed an offence punishable under section 188 of the IPC. Section 4 protects acts done in good faith by persons acting under the Act. The *Epidemic Diseases (Amendment) Act, 2020* under section 2B prohibits violence against a healthcare service personnel and causing of damage or loss to any property during an epidemic, and section 3(2) prescribes punishment for the same.

3.2.2 Role of Union and state government in implementation

The Indian Constitution prescribes the administrative framework for federalism and the relationship between the central and state governments in its Seventh Schedule. The subject matter of control of infectious diseases is placed in the concurrent list, which mandates a role of both the union and state governments. The EDA gives wider powers to the states than it does to the union government. While state governments are empowered to prescribe temporary regulations and inspect and segregate persons travelling in railways or otherwise, the union government has the power to inspect and detain persons in ships and ports only. As discussed above, there is a need to revise the Act to include comprehensive provisions for preparedness, control and mitigation. These functions need to be shared between the central and state governments in the spirit of cooperative federalism especially in the area of coordination of resources, manpower, and services.

Recent amendments to the Act introduced provisions for protection of healthcare service personnel from violence and harassment.[92] The EDA was used during the COVID-19 pandemic to shut down schools and offices, ban public gatherings, to record travel histories of suspected patients, create flu corners in government and private hospitals for screening suspected cases of COVID-19, enforce quarantine and isolation, and to grant authorization to District Magistrates to take coercive measures against individuals suspected/confirmed with COVID-19 who refuse home or institutional quarantine.[93]

The EDA does not stipulate any coordination mechanism between the union and state governments while dealing with a "*dangerous epidemic disease*" outbreak. It pivots on the coercive power of the State to take measures, reflecting its colonial authoritarian origins. However, such a scheme of operation is incompatible in a country governed by the Constitution, which establishes limits on executive power and upholds the rights of citizens.

3.2.3 Lack of a rights-based approach

Under international law and their right to health obligations, countries are obligated to prevent, treat and control epidemics.[94] Certain rights, such as freedom of assembly and freedom of movement, may need to be curtailed for an effective response. But as per the Siracusa Principles, any such limitations must meet the requirements of legality, non-arbitrariness, necessity, proportionality, be of limited duration, and be subject to review and remedy against its abusive application.[95] However, certain rights allow for no derogation, such as the right to life, freedom from torture, cruel, inhuman or degrading treatment or punishment, and freedom of thought, conscience and religion.[96] During public health emergencies, State obligations pertaining to the right to health, food, housing, education,

---

[92] *Epidemic Diseases (Amendment) Act, 2020*
[93] For example, *The Delhi Epidemic Diseases, COVID-19 Regulations 2020; The Mizoram Epidemic Diseases (COVID-19) (First Amendment) Regulations 2020; The Jharkhand State Epidemic Disease (COVID-19) Regulations, 2020*
[94] Article 12, International Covenant on Economic, Social and Cultural Rights
[95] United Nations Commission on Human Rights. (1984, September 28). The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights. E/CN.4/1985/4. Available at: https://www.refworld.org/docid/4672bc122.html
[96] Ibid., Arts. 58-60

water and sanitation, social protection and adequate standard of living persist.[97] The Supreme Court in *Jacob Puliyel v Union of India* held that restrictions imposed on bodily integrity and privacy to meet public health demands must meet the threefold requirement laid down in *K.S. Puttaswamy* – legality (that presupposes the existence of law), need (that the action meets a legitimate State aim), and proportionality (rational nexus between the object sought to be achieved and the means adopted to achieve them).[98]

The EDA's narrow and sole focus on powers of the government to control an epidemic fails to take into account the duties and responsibilities of the government to uphold the rights of citizens in a health emergency. The imperatives of consent, confidentiality, free speech and privacy are neglected, and there is no guidance to determine how and when to limit which rights. For example, the *Delhi Epidemic Diseases, COVID-19 Regulations 2020* issued under the Act, authorises coercive quarantine and isolation, and controls access to COVID-19 related information in the guise of controlling misinformation.[99] A medical practitioner was held liable under the EDA for refusing to get a cholera vaccination, with the Orissa High Court holding that the reason or intention for refusing vaccination was immaterial.[100] The EDA provides no forum for redressal of grievances and fails to provide procedural safeguards against abuse of power.

The Act also does not prescribe minimum standards for quarantine and isolation facilities, or guarantee non-discrimination in access to health facilities and treatment. This has contributed to situations where people fled quarantine facilities in Delhi and other cities during COVID-19, complaining of poor hygiene and sanitation, bad food and lack of physical distancing.[101] There were also instances of religion-based discrimination and forcible segregation of Muslims during the COVID-19 pandemic in India.[102]

Penal provisions, under the *Disaster Management Act 2005* (DMA), EDA and Indian Penal Code were used during COVID-19 to enforce public health measures such as quarantines, wearing of masks and lockdowns. In Delhi, failure to adhere to mandatory home or institutional quarantine made persons liable for prosecution and punishment with imprisonment and/or fine under the EDA and section 188 of the IPC.[103] Police have used excessive powers to enforce lockdowns, with reports of people buying essential commodities or migrant labourers being beaten or humiliated for being outside during curfew.[104] This criminal use of force by the police resulted in the deaths of at least 12 people in the

---

97 Office of the United Nations High Commissioner for Human Rights. (2020, April 27). Emergency Measures and COVID-19: Guidance. Available at: https://www.ohchr.org/sites/default/files/Documents/Events/EmergencyMeasures_COVID19.pdf

98 *Jacob Puliyel v Union of India* MANU/SC/0566/2022, para 49

99 Section 14 and Section 6 respectively

100 *J Choudhury v The State* AIR 1963 Ori 216 as reported in Goyal, P. (2020). The Epidemic Diseases Act, 1897 needs an urgent overhaul. *Economic and Political Weekly,* Vol. 55, Issue No. 45

101 Al Jazeera (2020, April 24). Indians try to flee 'unsanitary' coronavirus quarantine centre. Available at: https://www.aljazeera.com/news/2020/4/24/indians-try-to-flee-unsanitary-coronavirus-quarantine-centres; Jaiswal, A. (2020, April 27). Inadequate food, poor conditions, no information: Covid-19 suspects post videos to highlight what ails Agra's quarantine facility. *The Times of India.* Available at: https://timesofindia.indiatimes.com/city/agra/inadequate-food-poor-conditions-no-information-covid-19-suspects-post-videos-to-highlight-what-ails-agras-quarantine-facility/articleshow/75394612.cms

102 Sarkar, S. (2020). Religious discrimination is hindering the COVID-19 response. *BMJ;* 369. https://doi.org/10.1136/bmj.m2280

103 *The Delhi Epidemic Diseases, (Management of COVID-19) Regulations, 2020*. Available at http://health.delhigovt.nic.in/wps/wcm/connect/b85a42804ea94454ac47ad5dc9149193/ord130620.pdf?MOD=AJPERES&lmod=-1209071177&CACHEID=b85a42804ea94454ac47ad5dc9149193

104 Sircar, A. (2020, March 28). India's coronavirus lockdown is bringing out the worst in its police force. *Quartz India.* Available at https://qz.com/india/1826387/indias-coronavirus-lockdown-brings-police-brutality-to-the-fore/; Srinivas, R. (2020, May 16). COVID-19 lockdown | Police beat up migrant workers, send them to shelter homes later. *The Hindu.* Available at: https://www.thehindu.com/news/cities/Vijayawada/covid-19-lockdown-police-beat-up-migrant-workers-send-them-to-shelter-homes-later/article31599485.ece

early weeks of the COVID-19 pandemic.[105] Use of criminal law in health emergencies is largely counterproductive to the goal of ensuring health for all. It contributes to an environment of fear and panic, and creates disincentives for voluntary testing and treatment. Application of criminal law in epidemic control and management may be limited only to those exceptional cases of wilful spread of the disease, where intent to transmit the disease can be proved beyond reasonable doubt.

3.2.4 Relevance of the Disaster Management Act 2005

The DMA was used for a range of measures during the COVID-19 response, such as imposing lockdowns, constituting expert groups, procuring medical supplies and requisitioning infrastructure. Its DMA also led to centralisation of powers that hampered the functions of state governments and local authorities, and an over-reliance on police powers to enforce guidelines for isolation and lockdowns.[106]

"*Disaster*" is broadly defined in the Act and can cover situations of epidemics and pandemics.[107] The ambit of the DMA however, is to provide an overarching framework for disaster management and coordination mechanisms between different ministries in the event of a disaster, which will be overall coordinated by the Ministry of Home Affairs. Under the DMA, the Health Ministry is required to frame its plan detailing and ensuring its preparedness to provide health services to people in the event of a disaster, such as floods, cyclones, earthquakes.

The DMA does not take away the need for the health ministry to have its own legislative framework for outbreak/epidemic/ pandemic prevention, preparedness, control, response and mitigation, which is one specific type of a 'disaster'; for which the Health Ministry is the Nodal Ministry. Further, several aspects of a disease control framework lie outside the scope of the DMA. For instance, provisions related to prevention, public health infrastructure for surveillance, data sharing, early warning systems, developing a public health emergency plan detailing provision of quarantine and isolation facilities, minimum quality standards, to name only few of the core public health functions. The fact that regulation for pandemics and the DMA operate in overlapping yet distinct spheres is evidenced by the National Disaster Management Authority's recommendation that the Ministry of Health must repeal the EDA and substitute it by an Act that addresses public health needs and emergencies.[108]

3.2.5 Comment

Increasing global travel, connectivity, migration, urbanisation, deforestation, environmental degradation and global warming have increased the risks of global disease outbreaks. In order to contain and respond to these threats, public health practice has evolved to encompass a range of medical and non-medical measures for preventing, detecting and responding to epidemics and pandemics. India's ability to deal with epidemics proactively has long been hampered by the absence of a rights based legal framework that could support its public health activities and capacities.

The EDA is outdated in several respects. It focuses only on isolation and inspection of persons and premises once a "*dangerous epidemic disease*" outbreak has already occurred, neglecting measures for prevention and preparedness. Hence it does not provide legislative anchoring to these essential

---

105Krishnan, M. (2020, May 26). Police excesses for lockdown violation led to 12 deaths: Study. *Hindustan Times.* Available at: https://www.hindustantimes.com/india-news/police-excesses-for-lockdown-violation-led-to-12-deaths-study/story-qj5dZ68nxPBc3B0HbSBg3L.htm

106 Editorial (2020, May 9). COVID-19 and the National Disaster Management Act*. Economic and Political Weekly.*

107 S. 2(d): "disaster" means a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area

108 National Disaster Management Authority (2008). National Disaster Management Guidelines: Management of Biological Disasters. Available at: https://nidm.gov.in/pdf/guidelines/new/biological_disasters.pdf

government functions. For instance, establishment of early warning systems and its components – regulation of public health surveillance, notification, information systems, laboratory samples, analysis, assessment of risk, and reporting. The EDA is also silent on the role of the private medical sector in disease surveillance and response.[109]

The Act fails to define "*dangerous*", "*infectious*", or "*contagious diseases*", let alone an "*epidemic*". There is no substantiation in the Act on any criteria to determine that a particular disease needs to be declared as an epidemic; and how to respond to such a complex and dynamic situation in a calibrated, proportionate and careful manner. This absence of clarity/guidance impedes effective government action and inheres risk of arbitrariness in state action. The EDA also has no provisions on a public health emergency plan including access to health services; procurement, transport, stockpiling and distribution of drugs, diagnostics, materials and vaccines; communication planning/IEC; training of doctors and health care providers, universal precaution, disposal of medical waste and human remains, identification and designation of hospitals, sites for isolation and quarantine facilities, standards for isolation and quarantine facilities etc.

The EDA is also asynchronous with the public health system in India, which now has established institutions responsible for disease surveillance and response. While it states that "*any person*" may be empowered by the State to take "*such measures*", it does not specify which authority will designate a public health emergency, at the state or national level, nor does it establish which authority will be empowered to take action. Now, the Integrated Disease Surveillance Programme (IDSP) under the aegis of the National Centre for Disease Control (NCDC) is responsible for surveilling, detecting and responding to epidemic prone diseases, and the primary care system is responsible for preventing and controlling outbreaks.[110] However, the EDA, which pre-dates the IDSP or other governance structures, fails to make these linkages with existing institutions.

Further, India is bound under the IHR 2005 to take various measures to fulfil its duties to prevent and respond to public health risks that may cross international borders. It must develop, strengthen and maintain core public health capacities for surveillance and response, at the primary, state and national level. It has a duty to report a 'Public Health Event of International Concern' to the WHO. A core obligation, then, is to update national legislation to enable effective and continuous implementation of rights and obligations under the IHR, which the EDA abjectly fails to do.

3.3 Assam Public Health Act, 2010

3.3.1 Rights-based foundation for public health

The Assam Public Health Act, 2010 (APHA) is framed as a rights-based law, as articulated in its Preamble "*to provide for protection and fulfilment of rights in relation to health and wellbeing, health equity and justice, including those related to all the underlying determinants of health…*" The Preamble further recognizes the entitlement of every person to the enjoyment of the highest attainable standard of health and wellbeing as part of a life of dignity, and reiterates that the right to health is an "*inclusive right*" extending to socio-economic, cultural and environmental determinants of health.[111]

The right to health itself is further elucidated in Chapter III of the APHA, which lays down the many aspects that comprise it – an array of healthcare-related aspects (appropriate healthcare, trained personnel, essential and efficacious drugs), sexual and reproductive healthcare especially for women and girls, social determinants of health (food safety, safe drinking water, sanitation and environmental

---

[109] Rakesh. P. S. (2016). The Epidemic Diseases Act of 1897: Public health relevance in the current scenario. *Indian Journal of Medical Ethics, 1(3) Jul-Sep,* pp. 156-60.
[110] Ibid.
[111] Preamble, *Assam Public Health Act, 2010*

hygiene), family planning, and health institution accountability through regulation and quality assurance (section 5). Particular recognition is given to the right to information related to access to and use of healthcare facilities, services, conditions, technologies etc., and the right to information about one's own health status (section 6), which is made accessible in a comprehensible manner. Users of health services also have a right to medical records (section 7), and are ensured the rights to autonomy and informed consent (section 8), and to confidentiality and privacy (section 9).

Duties of users of healthcare services include providing accurate information about their health status to healthcare providers, complying with prescribed healthcare, releasing of liability for refusal to comply, and ensuring occupied healthcare premises are kept clean (section 10). The rights of healthcare providers include non-liability for services provided *bona fide*, in best interests of the user, with best professional capability, and with reasonable care; and to be treated with respect and dignity by the user (section 11).

With this framing the APHA recognizes certain aspects related to the right to health that emanate from international law commitments and global health policies. For example, enjoyment of the "*highest attainable standard of health*" is based on India's international obligations under the ICESCR, which in turn contains the aspects of availability, accessibility, acceptability and quality (AAAQ) that are reflected in various sections of the law (sections 5 & 6). Indeed, the "*socio-economic, cultural and environmental determinants of health*" as recognized by the Sustainable Development Goals are given their due as part of a holistic understanding of health under the APHA. Moreover, vulnerability and marginalization are also squarely factored in as requiring particular attention in the context of the disadvantages certain individuals or groups face "*on account of physical, social, economic conditions*" (section 2(v)). Crucially, the APHA's mandate covers all healthcare establishments – public and private (section 2 (h)).

3.3.2 Health related obligations

Chapter II of the APHA lays down obligations of the government in relation to health. Importantly, the law states that despite limits of available financial resources, the government shall take steps to 'progressively realize' the health and well-being of all persons in the state (section 3(1)).

This is an acknowledgement by the Assam Government of its legal obligations under the ICESCR which are complementary to its obligations under the statute and the Constitution of India. The General Comment No. 14 issued by the Committee on Economic, Social and Cultural Rights to guide member states on realizing the right to health, provides that every state must utilize maximum of its available financial resources to progressively realize the right to health. The progressive realization of the right to health means that every state has a binding, specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of rights. General Comment 14 guidance is routinely followed by Indian constitutional courts to interpret the law and issue appropriate directions to the central and state governments.[112]

The government is obliged to make adequate budgetary allocations for health as per globally accepted norms, ensure inclusive access to healthcare goods, services and facilities in the public, private or non-profit sector and prioritization of access by marginalized groups (section 3(1)(a-b)).

The law mandates the Assam Health and Family Welfare Department to coordinate with other non-health sector departments to ensure access to food, water, sanitation and housing, thereby, codifying access to social determinants of health in law (section 3(2)(a-d)).

[112] *Laxmi Mandal and others v Deen Dayal Harinagar Hospital & others* (2010) 172 DLT 9, *Milun Suryajani & Ors. v Pune Municipal Commissioner & Ors.* 2015 SCC Online Bom, *Sabu Joseph v State of Kerala,* WP (C) No. 10659/2021, order dt. 10.05.2021

Public health institutions are required as per the law to endeavour to adopt the Indian Public Health Standards (IPHS). The semi-government as well as private health establishments are required to review and apply such standards to suit the needs of people in Assam (section 3(3)(c) proviso).

The expansion of mother and child health services, including universal coverage of reproductive healthcare at the earliest, is identified as a priority for the government (section 3(3)(e)). The government is required to provide preventive healthcare measures against major infectious diseases (section 3(3)(f)).

The Assam government is further authorized to ensure availability, accessibility, acceptability and quality (AAAQ) of drugs, regulate healthcare establishments, undertake health impact assessment (HIA) of all new development projects and adopt periodically reviewed health policies, among others (section 4(a-u)).

The government's responsibility to monitor drugs as per AAAQ norms is yet another acknowledgement of Assam's legal commitments under international law, as provided in the ICESCR.

3.3.3 Implementation and Monitoring

Chapter IV of the Act lays down the implementation and monitoring mechanism, by establishing public health boards at the state and district levels, a health information system (HIS) and community-based monitoring (CBM).

Apart from composition of health department officials, the public health boards also comprise officials from non-health departments related to panchayati raj institutions, social welfare and tribes and backward classes as well as mandate representation of non-government organizations and public health experts (sections 12 and 15).

An integral component of the public health boards duties includes formulating and implementation of plans relating to access to social determinants of health and inter-sectoral coordination for the same, making available drugs under National List of Essential Medicines (NLEM), augmenting human resources for health and establishing monitoring committees to receive feedback on improving quality of healthcare services (section 14). The District Public Health Board is additionally mandated to organize annual hearings of beneficiaries of hospitals in order to improve healthcare services (section 16(a)).

The government is mandated to establish and maintain a HIS at all levels of public and private healthcare establishments, prescribe categories of data it shall collect for submission to state and national health departments and make reports based on such data available to members of public to strengthen their participation in decision making processes on health (section 17(i)).

An audit of medical records of all public and private healthcare establishments as well as financial audit of health systems at district and state levels is prescribed. These audits include compliance by all healthcare establishments with IPHS standards and engaging autonomous institutions to review progress made on key health parameters, effectiveness of health schemes and impact of costs of healthcare on poverty, among others (section 17(ii)).

The HIS and audits are mandated to include local people as active co-facilitators for enabling community-based monitoring (CBM), allowing people to articulate their needs, identification of key indicators and creating tools for monitoring of health systems and establishments (section 17(iii)).

These monitoring systems are directly linked to quality assurance systems and corrective decision making bodies so that monitoring can result in effective and accountable remedial action as well as inform policy making. The government is required to adopt a rights-based framework in undertaking these responsibilities and widely disseminating the reports among civil society organizations (section 18).

3.3.4 Comment

Despite a legal commitment to people's right to healthcare, the Assam government has faced major challenges in adopting preventive measures for major infectious diseases, ensuring availability of drugs and providing adequate sanitation in the time since APHA was enacted.[113] There is no reported data available in the public domain by the government to review the law's capacity to respond to such challenges. We undertake a legal review of APHA here to assess successes and challenges in healthcare delivery, based on limited literature available in the public domain. Attempts to contact and interview key informants were not fruitful.

Indian Public Health Standards

IPHS norms are classified in two categories – essential and desirable. For any healthcare facility to comply with IPHS, the essential standards of both the quality and quantity of services must be achieved in terms of availability of infrastructure, human resources for health, drugs, diagnostics and equipment for the level of facility.[114] Despite the APHA guaranteeing universalization of reproductive healthcare, fact-finding reports by local communities have documented how non-compliance of IPHS standards with respect to maternal healthcare services adversely impacts the fundamental right to health of women in districts of Assam due to lack of adequate maternity ward beds, intensive care units (ICU), patient sterilization rooms, clean toilets and ambulance services.[115]

Typically, as policy/guidelines the IPHS are understood to be recommendatory rather than mandatory, therefore, attempts at seeking judicial enforcement have often not resulted in binding directions from other High Courts.[116] However, some High Courts are increasingly enforcing IPHS norms on the basis that they contribute to the improvement in public healthcare infrastructure and thereby realization of the right to health under Article 21 read with Article 47 of the Constitution, which is a step forward in the rights-based application of law and policy measures.[117]

As APHA is the first law to statutorily codify them, it bears well to note to what extent the Assam Government and courts have enforced IPHS. Surprisingly, for a social welfare law that has been in force over a decade, there is very little litigation on APHA reported in the public domain. The only reported case directly focused on adjudication of APHA issues is a PIL seeking implementation of IPHS norms for the maternal and child healthcare programme, wherein the Gauhati High Court assessed the status of availability of maternity beds, ambulances, staff nurses, gynaecologists, radiologists, surgeons, paediatricians, architectural specifications and ICUs. After monitoring the government's steps on augmenting the infrastructural and human resources requirements, the court directed the government to periodically monitor and review compliance with IPHS norms strictly.[118] Therefore, it

---

113 Priyadarshini, S., 2016, Public health and healthcare still poor in Assam, *Down To Earth.* Available at:https://www.downtoearth.org.in/blog/health/assam-votes-2016-public-health-and-health-care-still-poor-in-the-state-52598

114 Indian Public Health Standards (IPHS) Revised Guidelines (2022), Ministry of Health and Family Welfare. Available at: https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=971&lid=154

115 Access to healthcare in post-liberalization India: A case study of Kanaklata Civil Hospital in Sonitpur, Human Rights Law Network. Available at: http://reproductiverights.hrln.org/wp-content/uploads/2016/02/Fact-Finding-Report-Kanaklata-Hospital-Assam.pdf

116 *Al-Falah University and Ors. v State of Haryana and Ors*., CWP No. 14076/2015 disposed of by order dt. 15.09.2015 (P&H HC); *Sharan Desai v District Surgeon*, WP No. 6704/2013 disposed of by order dt. 02.09.2013 (Kar HC)

117 *Deepak Ruwali v State of Uttarakhand*, WP(PIL) No. 12/2009 disposed of by order dt. 20.07.2018; S*tate of Nagaland v Moba Changkai*, WA No. 31(K) of 2019 disposed of by order dt. 25.05.2021

118 *Alin Mahanta v State of Assam*, PIL 118/2015, disposed of by order dt. 20.07.2017

can be reliably stated that IPHS has gained binding force in Assam (apart from the aforesaid developments) and is directly contributing to improvements in public healthcare infrastructure, due to APHA's codification of the same. Apart from this case, there is no reported data available in the public domain to review the law's performance.

Health Impact Assessment

HIA is conceptually modelled on the environment impact assessment (EIA), which is also statutorily recognized in India under the *Environment Protection Act, 1985*. It is a process to appraise the potential health impact of a policy, programme or project on the population, with a particular focus on vulnerable or disadvantaged groups, that provides a way to engage with members of the public affected by a particular proposal. An HIA helps decision-makers make choices about alternatives to prevent negative health consequences and to actively promote positive health outcomes. It is based on four interlinked values of democracy (promoting stakeholder participation), equity (impact on population), sustainable development and ethical use of evidence.[119]

In India, development projects are well-documented in causing adverse health consequences, such as outbreak of major infectious diseases in Jabalpur due to impounding of water in medium-sized dams, a similar experience in the Thar desert due to transportation of water through irrigation canals, and the industrial gas leak disaster in Bhopal.[120] The HIA, therefore, presents a useful tool in taking remedial action by anticipating future harms, which can be implemented successfully by a combination of legislative foresight, public will and a pro-active judiciary, as lessons of EIA demonstrate. However, there is no reported data available in the public domain to review APHA's capacity to enforce this mechanism.

Availability of trained medical personnel for rural areas

The Assam government passed the *Assam Rural Health Regulatory Authority Act, 2004* (ARHRA) to create a cadre of rural health practitioners (RHPs) to respond to the chronic shortage of trained human resources for healthcare in rural areas. The law granted powers to the government to establish a medical institution and introduce a 3.5-year Diploma in Medicine and Rural Health Care (DMRHC), in order to augment a committed workforce for serving rural healthcare needs, which is viewed as critical in improving the rural healthcare systems in Assam. During the period 2009-2013, health sub-centres (HSCs) are credited as better performing due to the role of RHPs in management of out-patient department services like diagnosis, referral and treatment for minor ailments, communicable diseases, non-communicable diseases, emergency cases and remarkable improvement in reproductive and child health services, which resulted in a gradual decline in overall mortality rates in a majority of high-risk districts of Assam.[121]

Despite this successful effort by the Assam government, the Gauhati High Court declared the complete scheme of the ARHRA unconstitutional on challenge by the state chapter of the Indian Medical Association in 2014.[122] The main ground of challenge was that the state-level ARHRA which was enacted on basis of Entry 25 , List III (Concurrent) of VII Schedule of Constitution[123] conflicted with the national level *Indian Medical Council (IMC) Act, 1956*, which was enacted on basis of Entry 66 , List I

[119] Health Impact Assessment, World Health Organization. Available at: https://www.who.int/health-topics/health-impact-assessment#tab=tab_1

[120] Ahuja, A., 2007, Health Impact Assessment in Project and Policy Formulation, *Economic and Political Weekly*, Vol. 42, Issue No. 35. Available at: https://www.epw.in/journal/2007/35/special-articles/health-impact-assessment-project-and-policy-formulation.html

[121] Lisam, S., 2015, Meeting the Primary Healthcare needs of Assam through introduction of a Mid-Level Health Worker: Lessons from India's experience with Rural Health Practitioners, Indian Journal of Forensic and Community Medicine. Available at: https://www.ijfcm.org/article-details/343

[122] *Indian Medical Association (Assam State branch) v State of Assam*, WP(C) No. 5789/2005 disposed of by order dt. 30.10.2014

[123] Education, including technical education, medical education and universities; subject to provisions of Entries 63, 64, 65 and 66 of List I; vocational and technical training of labour

(Union) of VII Schedule of Constitution[124] and was therefore unconstitutional for usurping powers of the central government. In a decision that wholly ignored the evidence of RHPs successes in improvement in rural health indicators on the ground, the court on this basis declared that the Assam RHPs would ostensibly be inadequately trained as they do not conform to IMC norms, thus, striking down the entire law and effort by the Assam Government in taking special measures to respond to rural health concerns.

As examined in depth in Working Paper 2 in this series,[125] it is now a settled position of law that powers of state governments in augmenting human resources for rural health under Entry 25, List III are exclusive from powers of the central government in determining standards of medical education under Entry 66, List I.[126] Therefore, the Gauhati High Court's decision and the scrapping of the RHPs cadre proceeds on an incorrect appreciation of Centre-State responsibilities in matters of health. The Supreme Court is currently hearing a batch of appeals[127] arising from the Guwahati High Court's decision and has the opportunity to affirm states' authority, as held in *Tamil Nadu Medical Officers' Association (TNMOA) & Ors. v Union of India & Ors*.

The Assam government subsequently passed the *Assam Community Health Professionals (Registration and Competency) Act, 2015* in order to regularize the qualifications and working conditions of the former RHPs and absorbed them at the HSC levels as paramedical personnel to assist medical officers. Notwithstanding the government's retreat on RHPs under pressure from the medical professionals' lobby, the APHA's powers in augmenting human resources for health, especially for rural healthcare services, needs assessment.

3.4 Implications for UHC

Article 12(C) of ICESCR states that the right to health includes the right to "*the prevention, treatment and control of epidemic, endemic, occupational and other diseases."* General Comment 14 to the Committee on Economic, Social and Cultural Rights substantiates this aspect of the right to health by stating that this requires, among others, setting up prevention and education programmes, system of urgent medical care, provision of relief and humanitarian assistance during emergencies, making available relevant technologies like vaccination, strong epidemiological surveillance and data collection on a disaggregated basis and the promotion of social determinants of good health.[128] State parties that develop legislation on pandemic control must conform to the IHR including its principles, as well as align with the right to health framework in ICESCR.

The rights-based approach to epidemic prevention and control is reflected in the Political Declaration on UHC as well, which states that UHC mandates *"promoting strong and resilient health systems, reaching those who are vulnerable or in vulnerable situations, and capable of effectively implementing the International Health Regulations (2005), ensuring pandemic preparedness and the prevention and detection of and response to any outbreak."* The Declaration stresses on coherent and inclusive approaches to safeguard continuing access to health services and essential public health functions, *"in line with humanitarian principles".*

UHC has been recognised to be an essential resilience measure for health systems to tackle disease outbreaks, as it promotes broad-based provision of health services and helps to ensure health seeking behaviour during normal times, which makes it more likely for individuals to seek timely care in times

---

[124] Coordination and determination of standards in institutions for higher education or research and science and technical institutions

[125] Sanap, S. and Bharadwaj, K. (2023). The Judiciary-Executive Interface in Areas of Health. *Centre for Health Equity, Law and Policy, ILS Pune, prepared for the Lancet Citizen's Commission on Reimagining India's Health System*

[126] *Tamil Nadu Medical Officers' Association (TNMOA) & Ors. v UOI & Ors*. (2021) 6 SCC 568

[127] *Baharul Islam v Indian Medical Association*, SLP No. 032592-032593/2015

[128] CESCR General Comment 14, para 16

of health emergencies. Gleaning lessons from the Ebola epidemic, it has been argued that building systems of UHC in all low-and-middle income countries is necessary for preventing a repeat of the Ebola experience.[129]

While the APHA takes the latter approach to public health, the EDA takes the opposite approach. Regrettably this latter approach found favour with the government during the COVID-19 pandemic while the APHA has languished with little to show in way of implementation.

There is a clear recognition of the need for the rehaul of the legal framework in relation to public health emergencies. The Law Commission Report has listed the EDA under '*Central Acts identified for re-enactment or review thereof*'.[130] The P.C. Jain Commission has recommended its repeal at Sl. No. 133 of Appendix A-1 (166 Central Acts recommended for repeal).[131] Later in 2014, the Prime Minister's Office set up a committee to identify Central Acts to be repealed or re-enacted. The Committee deliberated on the repeal of the EDA and indicated the need for it to be re-enacted to relate to current contexts.[132] The *National Disaster Management of Biological Disasters Guidelines 2008* also recommended that the MoHFW replace the EDA with a more relevant and comprehensive law to deal with different threats to public health, proactively and effectively.[133]

There have been legislative attempts at laying down a framework for management of public health emergencies. The *Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017* which intended to repeal the EDA. While this does show that the MoHFW is cognizant of the need to revise the EDA, the Bill disappoints on several fronts. It fails to stipulate essential public health functions from preparedness to mitigation (no mention of early warning systems and its components), public health surveillance, data sources, reporting, sharing while balancing rights of confidentiality, privacy and data security in using personally identifiable information. It does not follow a rights-based approach as it needs to balance the enhanced powers of the State during a public health emergency with principles of proportionality. It also does not lay down minimum standards for isolation/quarantine facilities. Worst of all it seeks to bar the jurisdiction of the courts, including writ petitions.

---

129 Wright, S. et al. (2015). A Wake-up Call, Lessons from Ebola for the world's health systems. *Save the Children*. Available at: https://resourcecentre.savethechildren.net/pdf/a-wake-up-call.pdf/

130 Obsolete Laws: Warranting Immediate Repeal, 2014, Law Commission of India Report no. 248, Government of India. Available at: https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2022/08/2022081643-1.pdf

131 Report of the Commission on Review of Administrative Laws (1998). Ministry of Personnel, Public Grievances and Pensions, Government of India.. Available at: http://darpg.gov.in/sites/default/files/Review_Administrative_laws_Vol_1.pdf

132 Prime Minister's Office (2014). Report of the Committee to Identify Central Acts which are not relevant or no longer needed or require repeal/re-enactment in the present socio-economic context. pg. 571. https://www.pmindia.gov.in/wp-content/uploads/2015/01/Extracts-of-the-Committee-of-the-Report-Vol.I-.pdf

133 National Disaster Management Authority (2008). National Disaster Management Guidelines. https://nidm.gov.in/PDF/pubs/NDMA/5.pdf

Section 4: IMPLEMENTATION OF HEALTH-RELATED GRIEVANCE REDRESS SYSTEMS

The most critical aspects in the implementation of UHC within a rights framework would be the issues of remedies and participation. In terms of remedies, General Comment 14 of the ICESCR states that any person or group whose right to health is violated should be able to approach the court or have access to other remedies and identifies a range of institutional mechanisms apart from courts such as ombudspersons, human rights commissions, consumer forums and patients' rights associations that should be involved in addressing these violations. If UHC in India relies largely on private hospitals and private insurance companies then the issue of grievance redress and accountability will require particular attention from policy makers. While there is significant literature and analysis on health-related grievance redress systems in India, particularly in relation to judicial systems, the implementation of recently established grievance redress mechanisms outside the system of courts and tribunals has yet to be examined. Section 4 explores the functioning of alternate grievance redress mechanisms under two laws (the *HIV Act* and the *MHCA*) and two programmes (National Health Mission – NHM – and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana – AB-PMJAY). In addition, this section also highlights examples of grievance redress mechanisms from other jurisdictions.

4. IMPLEMENTATION OF HEALTH-RELATED GRIEVANCE REDRESS SYSTEMS

The world over, healthcare services suffer from problems of information asymmetry and differences in the bargaining power of healthcare providers and patients (in terms of knowledge, expertise and other resources).[134] It is for this reason that healthcare providers have a fiduciary duty to act with professional diligence and exercise a 'reasonable standard of care'.[135] In turn, patients have access to grievance redress systems in case of complaints related to quality of care, such as unscientific, medically inappropriate, unethical and discriminatory practices. Grievance redress systems seek to empower individuals to enforce their right to health and protect their dignity, in an affordable, easily accessible and timely manner. In the larger context, they ensure accountability of healthcare delivery systems, while providing regular feedback on the quality of services being delivered and other systemic issues. It is crucial to understand the effectiveness of grievance redress systems in relation to UHC for these very reasons.

Grievance redress systems are certainly not unique to the health sector and have been deployed in other social sectors as well such as education, employment and food security (see Section 6). In recent years, grievance redress systems have sought to deploy technology in an endeavour to improve their accessibility and accountability. The grievance redress help desk, call centre and web portal under the National Health Mission and the district, state and national grievance redress agencies under the AB-PMJAY, are examples of this in the health sector. Existing literature on technology assisted grievance redress systems for public services in India, sheds light on factors influencing their adoption including ease of use, expectation of better performance, social influence, involvement of civil society groups to assist poor and marginalised groups in ensuring effective resolution, transparency on complaint status and workflow, and increased accountability.[136] To the best of our knowledge, similar examination of technology assisted grievance redress systems specific to the health sector has not yet been undertaken.

In this section, we provide an overview of the different types of grievance redress systems in the Indian health sector, and assess implementation of four of these systems.

4.1 Overview of grievance redress systems in Indian healthcare

In the Indian health sector, patients have access to a variety of grievance redress mechanisms. These systems can be broadly classified into three categories: sectoral, specialised and the judicial.

Sectoral

Grievance redress authorities have been set up across different sectors in Indian healthcare, including health insurers, healthcare professionals and hospitals. In the case of health insurance companies, the Insurance Regulatory and Development Authority of India (IRDAI) has set up two routes for grievance

---

[134] Arrow, K. (1963). Uncertainty and the Welfare Economics of Medical Care. *The American Economic Review, 53(5)*, pp. 941-973. Available at: https://assets.aeaweb.org/asset-server/files/9442.pdf

[135] *Indian Medical Association v VP Shantha* AIR 1996 SC 550. Available at: https://assets.aeaweb.org/asset-server/files/9442.pdf

[136] Chakraborty, D. et al. (2017). *Findings from a civil society mediated and technology assisted grievance redressal model in rural India*. In: Proceedings of the Ninth International Conference on Information and Communication Technologies and Development, November 2017. Article No. 2 (pp. 1-12). Available at: https://www.cse.iitd.ac.in/~aseth/civilsocietygrievanceredressal.pdf; Marathe, M. et al. (2016). *ICT-enabled grievance redressal in Central India: A comparative analysis*. In: Proceedings of the Eighth International Conference on Information and Communication Technologies and Development, June 2016. Article No. 4, pp. 1-11. Available at: https://dl.acm.org/doi/abs/10.1145/2909609.2909653; Rana, N. P. et al (2016). *Adoption of online public grievance redressal system in India: Toward developing a unified view*. Computers in Human Behaviour, 59, pp. 265-282. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0747563216300711

redress, the Integrated Grievance Management System (IGMS) and the insurance ombudsman.[137,138] In the case of healthcare professionals, patients can approach statutory professional regulators, like state medical councils and nursing councils, for disciplinary actions only.[139] As an example, aggrieved patients can approach the executive or disciplinary committee of the relevant State Medical Council to complain against doctors.[140] Any person aggrieved by the result of the ensuing proceedings may appeal either to the State Medical Council in some states like Delhi and Gujarat, or to the state/local government in other states like Rajasthan and West Bengal.[141] In addition to this, an aggrieved doctor may appeal to the Ethics and Medical Registration Board (EMRB) of the National Medical Commission (NMC) and thereafter the NMC.[142] In the case of health care facilities, there are no statutory grievance redress systems for patients aggrieved by the conduct or actions of hospitals.[143]

In addition to these, national health programmes, such as the NHM and AB-PMJAY, have developed their own grievance redress systems. Under the NHM, patients can register their grievances through the grievance redress help desk (in person), call centre (through a call on the helpline number) or web portal (online).[144] Registered grievances are referred to authorities at the appropriate level (facility, block, district or state). Complaints which require immediate support are to be resolved in real time. Others are to be resolved within seven days of receipt of the complaint and the result is to be communicated to the aggrieved party immediately.[145] The helpline can also be used to get information on preventive health measures, medical advice on common illnesses, counselling services by trained counsellors and information regarding nearby health facilities and services provided.[146]

The AB-PMJAY has set up grievance redress systems at the district, state and national levels.[147] This includes the District Grievance Nodal Officer (DGNO) and District Grievance Redressal Committee (DGRC) at the district level and the State Grievance Nodal Officer (SGNO), State Grievance Redressal

---

137 IGMS is an online complaints reporting system maintained by IRDAI. Persons whose complaints have not been addressed by the insurance company for 15 days can directly register their complaints with IRDAI under this system. The regulator then follows up with the insurance company to resolve the complaint. See, IRDAI IGMS website, available at: https://igms.irda.gov.in/loginph.aspx

138 An insurance ombudsman has jurisdiction over insurance claims below INR 2 million. See, *IRDAI Insurance Ombudsman Rules, 2017*. Available at: https://thc.nic.in/Central%20Governmental%20Rules/Insurance%20Ombudsman%20Rules,%202017..pdf

139 Professional regulators are not empowered to award monetary compensation to aggrieved patients.

140 If there is no State Medical Council in a particular jurisdiction, the aggrieved patient can approach the Ethics and Medical Registration Board of the National Medical Commission. See, Section 30, *National Medical Commission Act, 2019*. Available at: https://egazette.nic.in/WriteReadData/2019/210357.pdf

141 See, Section 23, *Delhi Medical Council Act, 1997*. Available at: https://www.indiacode.nic.in/bitstream/123456789/13633/1/delhi_medical_council_act1997_sw.pdf; Section 24, *Gujarat Medical Council Act*, 1967. Available at: https://www.indiacode.nic.in/bitstream/123456789/6048/1/gujarat_medical_council_act%2C_1967.pdf; Section 26, *Rajasthan Medical Act*, 1952, available at: https://www.indiacode.nic.in/bitstream/123456789/18776/1/the_rajasthan_medical_act%2C_1952.pdf; and Section 26, *Bengal Medical Act, 1914.* Available at: http://www.bareactslive.com/WB/WB491.HTM..

142 Section 30, *National Medical Commission Act 2019*

143 At most, laws regulating hospitals stipulate cancelling registration of hospitals. For example, the district registration authority to revoke registration of a hospital under two circumstances only, i.e., non-compliance with the conditions of registration or conviction of a person entrusted with the management of the hospital. See, Section 32 of the *Clinical Establishments (Registration and Regulation) Act 2010*. Available at http://www.clinicalestablishments.gov.in/WriteReadData/969.pdf. Other state-specific laws regulating hospitals also contain similar provisions. As an example, see sections 7 and 8 of the *Bombay Nursing Home Registration Act, 1949.* Available at: https://lj.maharashtra.gov.in/Site/Upload/Acts/8-The%20Maharashtra%20Nursing%20Homes%20Reg.%20Act.pdf

144 National Health Mission. *Guidelines for Establishing Grievance Redressal and Health Helpline*. Ministry of Health and Family Welfare, Government of India, p 14. Available at: https://nhm.gov.in/images/pdf/programmes/Grievance_Redressal_System/Guidelines_for_Establishing_Grievance_Redressal_and%20_Health_Helpline.pdf

145 Ibid., pp 15-17

146 Ibid., p 18

147 National Health Authority (2021). *Grievance Redressal Guidelines: Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB - PMJAY)*. Government of India, pp. 5-9. Available at: https://nha.gov.in/img/resources/OM-Grievance-Redressal-Guideline-Dec-2021.pdf

Committee (SGRC) and State Appellate Authority (SAA) at the state level. Stakeholders in the programme can register grievances either online (web portal, email) or offline (call centre, letter, in-person, etc).[148] Authorities at all levels also have the power to initiate *suo moto* proceedings. All complaints must be resolved in a timebound manner as stipulated in the guidelines. For instance the DGNO must resolve complaints within 15 days of receipt and the SAA must do so within 30 days. Final orders must be communicated to the complainant as soon as possible. All orders must be complied with and implemented within 30 days else the relevant authority may penalise the defaulting party. Notable features include mechanisms for time bound resolution of grievances, penalties for non-compliance with orders and reporting on the functioning of the system.[149]

Specialised
The Parliament has also enacted laws for specific health conditions. The HIV Act and the MHCA are examples of this. These specialised laws lay out grievance redress systems. Every state government is required to appoint one or more ombudsmen to resolve complaints in relation to acts of discrimination and provision of healthcare services for PLHIV.[150] Similarly, every SMHA is required to constitute a Mental Health Review Boards (MHRB) to resolve complaints of persons with mental illness (or their nominated representatives) against any mental health establishment; decisions of the board can be appealed before the relevant High Court.[151] In both cases, decisions of the grievance redress authorities are binding, and non-compliance can result in penalties.[152] Section 2 of this paper provides a detailed description and analysis of the grievance redress systems under both these laws.'

Judicial
Under this category, aggrieved persons directly approach the judiciary using one or more of the following routes: consumer courts, writ petitions or criminal complaints. The three forums are general redress systems dealing with all kinds of grievances, and not specific to the healthcare sector. In other words, these forums lie outside the healthcare regulatory system. Patients approach consumer and writ courts for enforcement of rights, taking corrective action and monetary compensation; and criminal courts in cases of medical negligence.

4.2 Assessing the functioning of grievance redress systems

An examination of implementation of four types of grievance redress systems in the Indian health sector, i.e., MHRB under the MHCA, the ombudsman system under the HIV Act, the national, state and district grievance redress officers and committees under AB-PMJAY, and the grievance redress help desk, call centre and web portal under the NHM has been undertaken for this paper. This selection has been made for two reasons. First, all four systems are nascent insofar as they were envisaged in 2017 or later, and hence their implementation is comparable. Second, there appears to be little in the existing literature on the implementation of these systems.

Keeping in mind that the four grievance redress systems are in incipient stages of implementation, three basic questions are apposite:

1. Have the grievance redress bodies been set up?
2. Are the grievance redress bodies functioning?
3. If yes, what kind of complaints are grievance redress bodies receiving?

To answer these questions, a literature review was conducted and data collected through Right to Information applications (RTIs). For the MHRBs and the NHM grievance redress system, information was sought from the MoHFW, as well as health departments of state governments. For the

[148] Ibid., pp. 9-13.
[149] Ibid., pp. 14-19.
[150] See Sections 23-26, *HIV and AIDS (Prevention and Control) Act 2017*
[151] See Sections 77 and 83, *Mental Health Care Act 2017*
[152] See Section 38, *HIV and AIDS (Prevention and Control) Act 2017*, and Section 82(4), *Mental Health Care Act 2017*

ombudsman system under the HIV Act, information was sought from NACO. For the grievance redress system under AB-PMJAY, information was sought from the National Health Authority. Table 3 provides details of the RTIs filed and responses received.

Table 3: Details of RTIs filed and responses received on grievance redress systems under MHCA, HIV Act, AB-PMJAY and NHM

Grievance redress body	Central government	Response received	State/UT governments	Response received
Mental Health Review Boards	Department of Health and Family Welfare, MoHFW	Constituted in 8 states/UT	8 states/UT, inc. Sikkim, Delhi, Tamil Nadu, Chhattisgarh, Orissa, Maharashtra, Chandigarh	5 states/UT, inc. Sikkim, New Delhi, Chhattisgarh, Orissa, Chandigarh
Ombudsman under the HIV Act	National AIDS Control Organisation	Detailed response on state-level data	–	–
AB-PMJAY	National Health Authority	Detailed response on state-level data	–	–
NHM	National Health Mission, Ministry of Health and Family Welfare	State-wise data with the respective states/UTs	36 states/UT	14 states/UT, inc. Nagaland, Delhi, Haryana, Kerala, Ladakh, Assam, Himachal Pradesh, Chandigarh, Arunachal Pradesh, Odisha, Sikkim, Punjab, Puducherry, and Uttarakhand[153]

Based on the RTI responses received, the three questions posed earlier on in the section are answered. A summary of our findings is provided in Table 4.

4.2.1 Have the grievance redress bodies been set up?

Of the four systems, the grievance redress system of AB-PMJAY appears the most widely established and has been set up in 33 states and union territories at the district level, and 35 states and union territories at the state level. This is followed by the ombudsman under the HIV Act, which has been constituted in 24 state and union territories. MHRBs have been constituted in only 8 states and union territories. For the NHM grievance redress system, we have information from 14 states and union

[153] In the case of Punjab, Odisha, Haryana, Kerala and Himachal Pradesh, information is received in respect of some, but not all, districts

territories. Of these, 6 states appear to have implemented all or some components of the system, including help desks, helpline and a web portal. These are Nagaland, Assam, Himachal Pradesh, Odisha, Punjab and Uttarakhand.

4.2.2 Are the grievance redress bodies functioning?

In order to examine whether the grievance redress bodies are functioning, we look at the number of complaints received and the number of complaints disposed of. The aim here is not to assess the quality or the nature of grievance redress, but simply whether these bodies are performing their functions. In comparison to the other systems, the AB-PMJAY grievance redress system has been fully operationalised, in so far as the requisite authorities have been set up at all levels, and there is regular receipt and disposal of complaints. It received a total of 1,24,636 beneficiary complaints at the district and state level, between 2018 – 2022. Out of these, 1,22,140 complaints have been disposed of. For the HIV ombudsman, 24 complaints were received in 8 states and union territories, between 2019-2021. Out of these, 22 complaints were disposed of. For the MHRBs, 2 complaints were received in New Delhi in 2020 and 2021. Neither of the 2 complaints appear to have been disposed of at the time the RTI response was given. For the NHM grievance redress system, discernible complaints data were received from Assam only. Here, a total of 2332 complaints have been received between 2019 and 2022. Out of these, 1652 have been disposed of.

4.2.3 If yes, what kind of complaints are grievance redress bodies receiving?

An enquiry into the nature of complaints received under the four grievance redress systems, provided information in respect of the grievance redress systems under the HIV Act, AB-PMJAY and NHM. The RTIs filed with respect to the MHCA did not provide information on the nature of complaints. It is also pertinent to point out that the information contained in the RTIs only provided categories of types of complaints. Information on the exact facts of the complaints or their resolution is not available.

In the case of AB-PMJAY, a large chunk of the complaints related to undue money being demanded by health care providers, such as for treatment covered under the scheme and printing e-card. Other major issues related to registration of eligible persons under the scheme, such as not providing beneficiary families with registration cards and issuing cards to the wrong families. Finally, we also found complaints relating to denial of treatment. In the case of the HIV Act, most complaints relate to discrimination and denial of healthcare and employment services, followed by unauthorised disclosure of HIV status. In the case of NHM Assam, complaints related to issues with delivery of healthcare services, the scheme itself and complaints against ambulance personnel and Accredited Social Health Activists (ASHAs).

Table 4: Findings on implementation of grievance redress systems under MHCA, HIV Act, AB-PMJAY and NHM

Research question	Mental Health Review Boards (MHCA)	Ombudsman (HIV Act)	DGNO/DGRC/ SGNO/SGRC (AB-PMJAY)	Help desk, helpline and web portal (NHM)
Have grievance redress bodies been set up?	8 states and UTs	24 states and UTs	District: 33 states and UTs State: 35 states and UTs	6 states and UTs

Are grievance redress bodies functioning?	2 complaints 0 disposed (New Delhi)	24 complaints 22 resolved (8 states and UTs)	124636 complaints 122140 resolved	2332 complaints 1652 resolved (Assam)
What kind of complaints?	NA	Discrimination Denial of services Disclosure	Money sought Registration Denial of treatment	Service delivery Scheme related Ambulance/ASHA

These findings highlight three main issues. First, implementation has been slow. Most of the grievance redress bodies have been set up at the end of or after 2019. Even after being constituted, most of these bodies are yet to start functioning. Second, there is no publicly available complaints management system which makes it difficult for aggrieved persons to monitor and check the status of their filed grievances. Third, there are no open or publicly available monitoring and reporting data to understand the functioning of these grievance redress bodies. While each of the systems are provided with detailed guidelines on monitoring and reporting, it is not clear how these have been implemented and how the data collected feeds back into the system. In the next section, we provide examples from the grievance redress systems in other countries, particularly their monitoring and reporting processes.

4.3 Other jurisdictions

It would be instructive to examine the grievance redressal systems in other countries, and understand the complaint management process, especially systems and processes for reporting and monitoring complaints, as well as how the monitoring system is used to improve healthcare delivery in these countries. Five countries, with different conceptions and models of grievance redress have been included in this review: Australia, Canada, United Kingdom, South Africa and Thailand. The selected countries differ in their levels of economic development and are at different stages in the evolution and progress of their healthcare journey with varying levels of UHC. Yet, all of them are considered to have well-functioning health systems, and present examples for designing and managing grievance redress mechanisms addressing different aspects of health systems (health practitioners, health organisations and health standards) and different approaches and levels of grievance redressal.

Governing health/ health security law(s) in each country were looked at to identify grievance redress bodies established by them or conferred powers on. Thereafter the structure and regulatory framework of these bodies were examined using their websites/ government portals to create a workflow-chart, tracing the journey of a complaint from start to finish. The journey includes procedure for filing a complaint, investigation and adjudication of complaints, process for filing appeals, monitoring the complaints management system and how the monitoring data is used to identify systemic gaps and improve healthcare delivery.

For purposes of this paper, the research focuses on grievance redress mechanisms dealing with consumer or patient complaints. It does not look at systems dealing with complaints of healthcare service providers, such as health facilities, insurance companies, or third-party administrators.

4.3.1 Australia

Grievance redress mechanisms in relation to Australia's health system are provided through state-level health laws and localised complaints authorities. Among them, New South Wales has one of the more comprehensive legislations, the *Health Care Complaints Act 1993*, by which it appoints a Health

Care Complaints Commission (HCCC).[154] The HCCC is tasked with resolving, investigating and prosecuting complaints relating to provision of health care. It is an independent body that accepts complaints against all health services and providers in NSW, which includes health organisations (such as public and private hospitals) and health practitioners (registered and unregistered).

The HCCC is spearheaded by a Commissioner, who is appointed by the state's Governor. The Commission then votes a member of its staff to the post of Director of Proceedings, who is not subject to the direction or control of the Commission once a complaint has been referred to them for consideration.[155]

A complaint may be made to the HCCC concerning a) the professional conduct of a health practitioner or b) a health service which affects clinical management or care of an individual client.[156] The complaint must be lodged in writing with the Commission – via an online portal, telephone, email or post. It may be made anonymously or otherwise, and in both cases the complainant can track its status through the HCCC website. It must include particulars of the allegations on which it is founded. The Commission staff may help a person make a complaint if needed. A complainant may withdraw any type of complaint at any time by furnishing a notice in writing to the Commission.[157]

Under the Act, the Commission is to manage each complaint fairly and expeditiously. Once the complaint is received, it is assessed *prima facie* on whether it requires investigation or not.[158] This assessment must conclude within 60 days of receiving the complaint. A written notice must be sent to the respondent, informing them of the grounds within the next 14 days.[159] The complaint is then investigated on merits. The first recourse is to attempt conciliation between parties and avoid imposition of penalties. If the matter cannot be reconciled, it then goes into prosecution to a court of law. If a complaint is referred to the Director, they must determine whether the matter requires a disciplinary hearing, and if so, conduct such disciplinary hearing. Complainants can track the progress of their complainant online regardless of their mode of filing the complaint.[160]

In the interest of remaining transparent and accountable, the HCCC presents annual reports to the Parliament of New South Wales outlining performance, complaint trends and initiatives implemented to improve service.[161, 162] As per the Act, the report is then reviewed by the Joint Parliamentary Committee on the HCCC.[163] As part of this review, the Committee conducts regular inquiries and provides formal reports to the parliament on the review process and outcome.[164] Through these reviews the Committee may make recommendations to or invite further information from the HCCC.[165] The Committee also conducts other periodic inquiries on matters of interest that may relate to the HCCC's conduct of business.

---

154 New South Wales *Health Care Complaints Act, 1993.* Available at: https://legislation.nsw.gov.au/#/view/act/1993/105
155 Section 90A and D, *Health Care Complaints Act, 1993.*
156 Section 7, *Health Care Complaints Act, 1993.*
157 Section 18, *Health Care Complaints Act, 1993.*
158 Section 3.1.a, *Health Care Complaints Act, 1993.*
159 Section 16, *Health Care Complaints Act, 1993.*
160 Track My Complaint, HCCC Website. Available at: https://www.hccc.nsw.gov.au/understanding-complaints/track-my-complaint
161 Latest Annual Report (2020-21), HCCC Website. Available at: https://www.hccc.nsw.gov.au/ArticleDocuments/75/HCCCAnnualReport2020-21.pdf.aspx
162 The annual report must contain the number and type of complaints lodged that year, sources of those complaints, number and type of complaints assessed and those referred for conciliation, results of conciliations, number and type of complaints investigated, results of investigations, a summary of the results of prosecutions, number and details of complaints disposed, and time taken in the complaints process.
163 Part 4, *Health Care Complaints Act, 1993.*
164 Committee on the Health Care Complaints Commission. Available at: https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=17.
165 A sample review: Committee on the Health Care Complaints Commission, Review of the Health Care Complaints Commission 2019-20 annual report, Report 2/57 – August 2021. Available at:

The complaints mechanism is continually improved through an active feedback loop. A Customer Engagement Framework of the Commission guides its approach to improve engagement with stakeholders.[166] Under this framework, the Commission holds consultations and actively seeks feedback to improve processes. The strategy is three-pronged: *inform* (making information available and accessible across a number of channels, such that it reaches target groups), *consult* (using consumer surveys and local Consultative Fora to gather insight), and *participate* (encouraging people to get involved with healthy delivery processes/systems). The HCCC website also invites public feedback through its website.[167]

4.3.2 Canada

While the provinces and territories in Canada's Medicare programme are responsible for administration and delivery of healthcare services and related grievance redressal, the focus for this paper is on the grievance redress system in one province, Ontario.

For Ontario, the Patient Ombudsman (PO) is a statutory body that has been set up under the *Excellent Care for All Act 2010* (ECAA).[168] It oversees complaints about patient care and healthcare experiences against public hospitals, long-term care homes, home and community care coordination. It is generally an office of last resort. It does not look into complaints about clinical decisions made by a "*Regulated Health Professional*" (physician, nurse, physiotherapist, etc).[169] The PO is not an independent officer of the legislature, and its general supervision falls under the purview of the Ontario Health Agency. This office is subject to oversight by the Ontario Ombudsman, an independent and impartial Officer of the Legislature who resolves complaints about government and public sector bodies.[170] The PO can be contacted through mail, by phone, fax, in-person or through its website, which has a form for submitting complaints.

To keep its services and operations up to speed, the PO aims to "*identify trends and emerging issues, from local to system level*", and "*share insights and information to guide improvements*."[171] Based on case-wise suggestions from the PO, "*Health Sector Organisations*" (public hospitals, long-term care homes and home and community care support services organizations, etc.) have made changes including policies changes and staff training.[172] This outcome of policy revisions is tracked in the Annual Report under "Outcomes to Formal Complaints".[173] The PO also mandatorily reports to the Ministry of Long-Term Care for reports of abuse, neglect or risk of harm.[174]

The PO also monitors complaints to identify emerging issues and provide recommendations, with the aim to encourage health sector organisations to review their policies and practices and improve patient and caregiver experiences. Some of the issues it has identified are lack of cross-sector

---

https://www.parliament.nsw.gov.au/ladocs/inquiries/2644/Final%20report%20-%20Review%20of%20the%20Health%20Care%20Complaints%20Commissions%202019-20%20annual%20report.pdf.

166 Customer Engagement Framework, HCCC Website. Available at: https://www.hccc.nsw.gov.au/ArticleDocuments/281/CustomerEngagementFrameworkAug2019.pdf.aspx.

167 Feedback, HCCC Website. Available at: https://ecomplaints.hccc.nsw.gov.au/feedback.

168 About the Excellent Care for All Act, Ministry of Health, Ontario. Available at: https://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx

169 Before You Make a Complaint, PO website. Available at: https://patientombudsman.ca/Complaints/Before-You-Make-a-Complaint

170 How We Work, Ombudsman Ontario website. Available at: https://www.ombudsman.on.ca/what-we-do/how-we-work

171Annual Report 2019/20 and 2020/21, p 9. Available at: https://www.ombudsman.on.ca/resources/reports,-cases-and-submissions/annual-reports

172 Ibid. p.18

173 Ibid. p. 21

174 Ibid. p. 19

communication and coordination, sexual assault in hospitals, and discrimination and lack of culturally specific care for Indigenous patients.[175]

The ECAA sets quality standards and their continuous improvement, based on best evidence and standards of care, as a goal of the healthcare system. It mandates incorporating patient feedback through patient surveys into hospital quality improvement plans. Executives are held responsible for delivering on these plans by payment of executive compensation that is linked to meeting the performance improvement targets as set out in the annual quality improvement plan.

4.3.3 United Kingdom

The Parliamentary and Health Service Ombudsman (PHSO) is a statutory office that combines the roles of the Parliamentary Commissioner for Administration (Parliamentary Ombudsman) and the Health Service Commissioner for England (Health Service Ombudsman), whose powers are set out in the *Parliamentary Commissioner Act 1967* and the *Health Service Commissioners Act 1993* respectively.

It is the last resort for individuals who have complaints about the National Health Service (NHS) in England acting unfairly or providing poor service. It is independent from the NHS, the government and Parliament. It is accountable to the Parliament, through the Public Administration and Constitutional Affairs Committee (PACAC).[176] The PHSO collects complaints through phone calls, emails, post, and webforms.

The PHSO recognises the importance of using feedback and lessons learned from complaints to improve service delivery, build trust and boost the reputation of the NHS. On investigating a complaint, it can ask an organisation to show how it will prevent it from happening again.

It also regularly publishes most of its casework, provides case summaries and lays insight reports before the Parliament. It publishes most of its decisions[177] one month after the final decision is made and provides it in a searchable database filtered by healthcare setting, medical condition, complaint issue and decision type.[178] Case summaries are also published to aid public and institutional knowledge of decisions and lessons learnt.[179]

The PHSO publishes Annual Reports which are laid before the Parliament every year and are available online. The Annual Report provides a view of the complaints worked on during the year, decisions made, types of decisions taken, time taken to reach a decision, recommendations made and compliances made with the recommendations, and data on who uses the PHSO’s services.[180] The Public Administration and Constitutional Affairs Committee (PACAC) of the House of Commons scrutinises the PHSO's annual report and other reports that it lays before Parliament. Where these reports highlight failures and gaps in administration, the PACAC may use these findings to hold the

---

[175] Ibid. pp. 25-40

[176] Parliamentary and Health Service Ombudsman Scrutiny 2020–21 report, Public Administration and Constitutional Affairs Committee. Available at: https://committees.parliament.uk/publications/22322/documents/168877/default/

[177] For example PHSO Case Decision: The Royal Wolverhampton NHS Trust,. Available at: https://decisions.ombudsman.org.uk/report/?id=7d6b58c1-0755-ed11-9562-0022483f42c5

[178] Complaints about the NHS in England, PHSO website. Available at https://decisions.ombudsman.org.uk/health/ ; See also, an example of a PHSO Case Decision. Available at: https://decisions.ombudsman.org.uk/report/?id=a86e1d8a-9e9c-ed11-aad1-6045bd0e7f68

[179] For example, the PHSO case summary on “Trust missed insulin dose, leading to diabetic ketoacidosis and heart attack”. Available at: https://www.ombudsman.org.uk/making-complaint/what-we-can-and-cant-help/how-we-have-helped-others/trust-missed-insulin-dose-leading-diabetic-ketoacidosis-and-heart-attack

[180] Annual Report and Accounts 2021-22, PHSO. Available at: https://www.ombudsman.org.uk/sites/default/files/HC%20526_Annual_Report_and_Accounts_2021_2022.pdf

government accountable.[181] In 2019 the PHSO laid a report on the lessons that can be learned from systemic failings at a particular NHS Trust before the Parliament. The PHSO report followed its investigations into the cases of two deaths at that institution. The PACAC then investigated the status of compliance by the NHS and the Government with the recommendations, and recommended steps for the NHS, the Department of Health and Social Care, and the Minister for Mental Health to take to remedy the situation.[182]

The PHSO also regularly publishes "insight reports" on the NHS which are learnings from cases, surveys and investigations on key issues. A report drew on learnings from 60 cases in a three-year span to pinpoint significant failings in care and support planning in NHS Continuing Healthcare and provided recommendations for change.[183] Such reports have led to legal and policy changes or spurred commitment to change. For example, a 2013 report on midwifery supervision and regulation led to the Government introducing legal changes to implement the recommendations.[184]

4.3.4 South Africa

In South Africa, the health-sector grievance redress system is governed by the Office of Health Standards Compliance (OHSC). This is an independent body established by *National Health Amendment Act, 2013* mandated to ensure compliance with minimum required health standards by both public and private health establishments in South Africa.[185,186] It prescribes 'Norms and Standards Regulations applicable to different categories of Health Establishments'[187] which all service providers must adhere to. The office's mandate includes considering, investigating and disposing of complaints relating to non-compliance with these norms in a procedurally fair, economical and expeditious manner. Citizens are invited to lodge complaints against any entity that violates these norms and their associated rights. Complaints are resolved by the OHSC through the Health Ombud and various other supporting departments.

The OHSC Board consists of 7 to 12 members, most of whom are selected on the basis of specified expertise in several areas of healthcare, law, finance and economics, the private and public healthcare systems, and quality assurance. One member represents organised labour and one is a representative of civil society organisations. Four bodies perform complaint management functions under the Board: Complaints & Assessment Centre; Complaints Investigators; Expert Panels; and Office of Health Ombud (OHO). The OHO is a statutory redressal body designed to be independent, impartial, and accountable. The Health Ombud is a "*suitably qualified and experienced South African citizen*"[188] appointed by the Board.

Complaints can be filed by calling a helpline displayed on the OHSC website or by registering online on the OHSC or Health Ombud website. The website is not very customer friendly as it contains little

---

181 Parliamentary and Health Service Ombudsman Scrutiny 2020–21 inquiry, Public Administration and Constitutional Affairs Committee. Available at: https://committees.parliament.uk/work/1503/parliamentary-and-health-service-ombudsman-scrutiny-202021/

182 Follow up on PHSO report: Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust, PACAC. Available at: https://publications.parliament.uk/pa/cm201919/cmselect/cmpubadm/31/31.pdf

183 Continuing Healthcare: Getting it right first time, PHSO. Available at: https://www.ombudsman.org.uk/sites/default/files/Continuing_Healthcare_Getting_it_right_first_time.pdf

184 A safer NHS for mothers and babies, PHSO. Available at: https://www.ombudsman.org.uk/about-us/how-our-casework-makes-difference/safer-nhs-mothers-and-babies

185 *National Health Amendment Act, 2013*. Available at: https://ohsc.org.za/wp-content/uploads/2017/09/NationalHealthAmendmentAct12of2013.pdf.

186 Office of Health Standards Compliance, Mandate. Available at: https://ohsc.org.za/who-we-are/#mandate.

187 Office of Health Standards Compliance, Norms and Standards Regulations applicable to different categories of Health Establishments. Available at: https://ohsc.org.za/wp-content/uploads/Norms-and-Standards-Regulations-applicable-to-different-categories-of-health-establishments.pdf

188 Section 81. *National Health Amendment Act, 2013*. Available at: https://ohsc.org.za/wp-content/uploads/2017/09/NationalHealthAmendmentAct12of2013.pdf

information on how to file a complaint and what outcome can be expected. Complaints may be written or oral. They may be filed against an act or omission by a person employed by a health establishment or any facility providing a health service.

The OHSC follows a complex approach of complaints management. The complaint is received by the Complaints & Assessment Centre, where it is logged, registered, and a reference number is issued against it. It goes through preliminary screening, where it is either sent to a health service provider to resolve or a case file is prepared and sent off for assessment. The complaint is assessed – and based on available information – is either summarily resolved or forwarded for further investigation. The investigation on merits begins at this stage, conducted by Complaints Investigators. After receiving investigation reports, the Ombud starts preparing their findings. This is not an adversarial process, but the Ombud may seek representation from either party, require testimonies or evidence, or interrogate parties and/or their witnesses. The Ombud may rely on inputs from the expert panel if necessary. They then report their findings and recommendations on actions to be taken to the OHSC. Both parties must be informed of the outcome. The OHSC implements said actions and monitors the respondent for a period of time to ensure compliance and reduce repetition of errors. Appeals may be filed with the Minister of Health within 30 days of the final order, who appoints an independent Ad Hoc Tribunal to hear the matter.

To ensure a transparent system, the Ombud must prepare a detailed report one month after the end of each financial year, on the conduct of business, affairs and functions of the OHO for the year, which is sent to the Health Minister for tabling at the South African Parliament.[189]

4.3.5 Thailand

The *National Health Security Act 2002* (NHSA) constitutes three bodies to oversee its implementation and ensure quality in health services across Thailand – the National Health Security Office (NHSO – administrative body), the National Health Security Board (NHSB – executive and legislative body), and the Quality and Standards Control Board (QSCB – regulatory and adjudicatory body).[190]

The NHSO is headed by the Secretary-General, who is appointed by the NHSB via a selection committee. They must possess knowledge, expertise and experience appropriate for the position. The appointee must have no political affiliations nor hold government office. The QSCB, on the other hand, is a mix of government officials, medical professionals, civil society, health experts, and private members. The QSCB establishes Investigation Units comprising representatives of state agencies working in medicine, public health and law and civil society.

An aggrieved person may approach the NHSO with a complaint via a hotline, letters, fax, e-mails or in-person; 126 independent complaint units, "*where a complainant can conveniently submit complaints free from the complainee's interference*"[191] as required by the NHSA are located across 70 provinces.[192] The units also provide preliminary aid to beneficiaries who have faced mistreatment. Complaints may be lodged by anyone whose right to health service has been violated as under the NHSA.[193] Subject-matter of complaints may include quality of service, health information and data systems, and claiming benefits. Once the complaint is received, the NHSO will conduct an inspection and if it finds merit in the complaint, will refer the matter to the QSCB for investigation. If the inspection prima facie

---

[189] See Office of the Health Ombud, Annual Report 2019-20. Available at: https://healthombud.org.za/wp-content/uploads/2021/02/OHO-Annual-Report-2019-20-v8.pdf.

[190] *National Health Security Act, 2002*. Available at: https://eng.nhso.go.th/assets/portals/1/files/NHS%20ACT_book_revised%20Apr5.pdf.

[191] Section 50(5). *National Health Security Act, 2002*. Available at: https://eng.nhso.go.th/assets/portals/1/files/NHS%20ACT_book_revised%20Apr5.pdf

[192] NHSO Annual Report 2021. Available at: https://eng.nhso.go.th/assets/portals/1/files/nhso%20report%20fiscal%20year%202022%20-%20Copy.pdf

[193] Section 59, *National Health Security Act, 2002.*

indicates that the service unit has not committed a wrongful act, the NHSO must dispose of the complaint and notify the complainant within 15 days. In case the findings of the inspection by the NHSO reveal that a service unit fails to comply with the health service standard as required, it must ask the QSCB to appoint an Investigation Unit in the matter.[194]

The Investigation Unit conducts investigation on complaints and provides opinions to the QSCB. An investigation must be completed within 30 days. During this process, the unit is regarded as a competent official under the Thai Criminal Code and has powers to request the respondent, the complainant, or any relevant person to make representations. Upon completion of the investigation, the unit submits the matter together with its opinions to the QSCB for further consideration. The QSCB must issue an order within 30 days from receiving matter from the unit. Upon receipt of the order, the complainant or respondent has the right to appeal against the order with the NHSB within 30 days. The rules and procedures for submitting the appeal and the procedures for considering and deciding thereon are provided by the NHSB. The ruling of the NHSB will then be final and binding, and the NHSB is required to notify the QSCB of the outcome/action to be taken.

To ensure transparency and accountability, the NHSO produces an annual report on performance and obstacles encountered in the operation of the NHSB and the QSCB for dissemination to the public.[195] In its 2021 Annual Report, the NHSO lay forth the number and breakdown of complaints received: 5276 complaints were received of which 76 percent were resolved within 25 days.[196] The primary grounds for complaints were healthcare units not providing treatment that the person was eligible for, inconvenience while using services, overbilling and the failure of healthcare units to provide the prescribed standard of care. An interesting aspect of NHSO's work has been conducting satisfaction surveys among citizens, providers and other stakeholders: in 2021, 97.11 percent of patients gave the health programme the highest satisfactory score in contrast to 75.99 percent of service providers who gave the highest score. As noted in the report, "*certain managerial aspects may not satisfy the needs of the providers; the NHSO understands the challenges it faces to satisfy different target groups.*" [197]

4.4 Implications for UHC

This section provided an overview of four health-related grievance redress systems in India – for mental health, HIV, the AB-PMJAY and NHM – and factors influencing their implementation. As a general observation, they have not been implemented to their full capacity. Most of the grievance redress bodies have been set up at the end of or after 2019. Even after being constituted, many of these bodies are yet to start functioning. In the context of UHC, two key findings stand out.

First, there is a need for transparency in the functioning of grievance redress bodies. While each of the systems assessed are provided with detailed guidelines on monitoring and reporting, it is not clear how these have been implemented and how the data collected feeds back into the system. For each system, there are reporting obligations at each level, district, state and central, but this monitoring and reporting data is not openly and publicly available. The Canadian and UK systems are instructive in this regard. The Canadian Patient Ombudsman has established a robust monitoring system to identify repetitive issues and use this data to provide recommendations, with the aim of encouraging healthcare organisations to review their policies and practices and improve patient and caregiver experiences. The UK Parliamentary and Health Service Ombudsman has a regularly updated website with easy-to-access and easy-to-read information on cases, case summaries and decisions. The PHSO also regularly publishes "*insight reports*" on the NHS that includes learnings from cases, surveys and investigations on key issues.

---

[194] Section 57, *National Health Security Act, 2002.*
[195] Section 26(13), *National Health Security Act, 2002.*
[196] NHSO Annual Report 2021. Available at:
https://eng.nhso.go.th/assets/portals/1/files/nhso%20report%20fiscal%20year%202022%20-%20Copy.pdf
[197] Ibid.

Second, the grievance redress bodies are not accessible to individuals they are meant to cater to. For one, there is no publicly-available and easily-accessible information on the existence of these bodies, or a guide on filing complaints. Healthcare providers are also not obligated to provide this information to people accessing their services. Where complaints have been filed, there is no publicly available complaints management system. This makes it difficult for aggrieved persons to monitor and check the status of their filed grievances. In contrast, in New South Wales, Australia, the system makes it easy to access the grievance redress system. The website itself has many guides and explainers, along with helplines and interactive menus. One can also track the status of their complaint through a tracking system. Similarly, both the Australian administration and that in South Africa conduct awareness campaigns to make citizens aware about their grievance redress systems. The provision of multiple modes for filing complaints in Thailand as well as independent complaint units to safeguard against any pressure or influence of the health facility or service provider can serve as useful examples for facilitating the filing of complaints.

Section 5: IMPLEMENTATION OF COMMUNITY PARTICIPATION IN HEALTH PROGRAMMES

People's participation is considered a key principle of the right to health. According to General Comment 14, "*promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.*" In Discussion Document 1, the historic role of people living with HIV (PLHIV) in working with the government programme and in holding it accountable has been highlighted. In other sections of this paper, well documented peoples' participation in the drafting and implementation of health and social sector laws are also highlighted. Less well known or documented have been mechanisms of participation that have been introduced through health policies and programmes. Section 5 examines the implementation of key mechanisms of participation that have been included in the NHM and the AB-PMJAY.

5. IMPLEMENTATION OF COMMUNITY PARTICIPATION IN HEALTH PROGRAMMES

"Nothing About Us, Without Us" is the political slogan of disability rights movements, which conceptualised the principle that no law/policy must be framed by governments without the full and direct participation of affected groups. Now, this principle is adopted by marginalised communities everywhere across social, economic and political contexts to centre democratic values at the heart of law/policy making in order to shape better societies.

The strengthening of health governance is increasingly recognised as a cornerstone of UHC and community participation is a core component of health governance, as it builds accountability of governments to the people. This is important as *"[g]overnments who can be held accountable to their populations are more likely to ensure inclusive health systems*."[198] A critical mass of frameworks for assessing health governance now include governments' ability to convene and ensure 'participation' or 'population voice' in health policy-making and decision-making.[199] The emerging consensus *"actively calls upon governments and the international community to 'work with citizens in designing UHC' and be 'responsive to public demands through participatory multi-stakeholder governance.'"*[200] Community participation in health is widely recognized as both a basic right of people and central to the success of development efforts. It views people as active participants and not passive beneficiaries, therefore, making development processes equitable.[201]

As per India's obligations under international law, the right to health extends to the full participation of the population in all health-related decisions like implementation of programmes or framing of legislation at the community, national and international levels.[202] The Alma Ata Declaration states that a focus on hospital-based programmes is inadequate for achieving public health goals and that there is a need to promote empowerment, health promotion, collective action and community participation.[203]

Indian policymakers have deliberated on participation of local communities in political decisions on health in the context of rollout of UHC. In a review of health systems around the world, participation is widely reported to have a positive impact on health outcomes, reducing information asymmetries and strengthening social capital and deepening democratic processes.[204]

---

[198] Greer, S.L and, Méndez C.A. (2015). Universal health coverage: a political struggle and governance challenge. *Am J Public Health*;105 Suppl 5:S637–S639. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4627521/
[199] Barbazza, E. and Tello, J.E. (2014). A review of health governance: definitions, dimensions and tools to govern. *Health Policy*;116:1–11. Available at :https://pubmed.ncbi.nlm.nih.gov/24485914/; Siddiqi, S. et al. (2009). Framework for assessing governance of the health system in developing countries: gateway to good governance. *Health Policy*;90:13–25; Available at: https://pubmed.ncbi.nlm.nih.gov/18838188/; Baez-Camargo, C. and Jacobs, E., (2011), *A framework to assess governance of health systems in low income countries*. Basel: Basel Institute on Governance. Available at: https://baselgovernance.org/sites/default/files/2018-12/biog_working_paper_11.pdf; Brinkerhoff, D. and Bossert, T.(2008). *Health governance: concepts, experience, and programming options*. Washington DC: USAID; Available at: https://www.hfgproject.org/wp-content/uploads/2015/02/Health-Governance-Concepts-Experience-and-Programming-Options.pdf; Kickbusch, I. and Gleicher, D. (2012). *Governance for health in the 21st century*. Copenhagen: WHO Regional office for Europe. Available at: https://apps.who.int/iris/handle/10665/326429; Mikkelsen-Lopez, I. et al, (2011). An approach to addressing governance from a health system framework perspective. *BMC Int Health Hum Rights;11:13*–24. Available at: https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-11-13; USAID (2012) *The health system assessment approach: a how-to manual*. Version 2. Available at: https://www.hfgproject.org/wp-content/uploads/2015/02/HSAA_Manual_Version_2_Sept_20121.pdf
[200] Bump, J. et al. (2016). Implementing pro-poor universal health coverage. *Lancet Glob Health, 4:e*14–16. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00274-0/fulltext
[201] Oakley, P. (1989). *Community involvement in health development: An examination of the critical issues.* World Health Organisation. Available at: https://apps.who.int/iris/handle/10665/39856
[202] General Comment No. 14, International Covenant on Economic, Social and Cultural Rights (ICESCR)
[203] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978
[204] Planning Commission of India, 2011, High Level Expert Group Report on Universal Health Coverage for India, Chapter 6: Community Participation and Citizen Engagement. Available at: https://nhm.gov.in/images/pdf/publication/Planning_Commission/rep_uhc0812.pdf

5.1 Overview of community participation in health policies

Health planning is generally considered a technical subject, primarily the domain of health officials with minimal involvement of community representatives. However, the National Rural Health Mission (NRHM) 2005 recognized community participation as essential for realizing the goal of 'health for all' by mandating that the reform process would have to touch every village and every health facility and this would come about only when the community is adequately empowered to take leadership in health matters.[205] It conceptualised community participation as embedded in decentralised health planning and to further convergent action on health and social determinants with active participation of local communities, community based organisations (CBOs), NGOs and Panchayati Raj Institutions (PRIs), local elected representatives as essential to its success.[206] In addition to NRHM's focus on higher public expenditure on health, district management of health programmes and reorienting medical education to better serve needs of rural health concerns, community participation is mandated by the recognition that health promotion efforts lead to overall social and economic development. NRHM proposes structures and processes of community participation which seek to forge partnerships between central, state and local governments, involve PRIs in management of primary healthcare programmes, create platforms for promoting equity and social justice and promote intersectoral convergence between health and non-health departments, and they work towards the common goal of improving availability and access to high quality healthcare by people, especially for those residing in rural areas, the poor, scheduled caste and scheduled tribes (SC/ST), women and children.

This section assesses the structures and processes of community participation under NRHM i.e., Rogi Kalyan Samitis (RKS), Community-based Monitoring (CBM) and Village Health Sanitation and Nutrition Committees (VHSNC), by undertaking literature review and interviews with key respondent interviewees to understand the lessons and challenges in operationalizing these structures and processes at scale. The recently introduced Jan Aarogya Samiti (JAS) is also briefly described, but not examined in depth, as it is premature to comment on its implementation at this stage. How effective these structures are in institutionalising voices of local communities in healthcare planning and delivery, and factors that support and impede their better functioning are examined, with recommendations proposed on improving the same. In particular, the NRHM models on representation of local communities within the aforesaid bodies is examined, and whether community participation is viewed as a singular event that is accomplished by merely granting formal recognition to these bodies with initial support (financial, technical and political) or practiced as a long-term process which is granted sustainable support and capacity-building on a regular basis, as emphasised under NRHM 2005.

The National Urban Health Mission (NUHM) was launched in 2013 and along with NRHM was subsequently subsumed into the broader National Health Mission (NHM) in 2013. The mandate of community participation and the aforesaid models have continued under NHM.

5.2 Assessing the functioning of community participation mechanisms

5.2.1 Rogi Kalyan Samiti

Rogi Kalyan Samitis (RKS) were introduced in 2005 as a forum to improve functioning and service provision in public health facilities and ensure access to equitable, high-quality services with minimal financial hardship to users. They were to be constituted in every District Hospital (DH), Sub District Hospital (SDH), Community Health Centre (CHC) and Primary Health Centre (PHC). The RKS is staffed with local government representatives (district magistrate, local member of Parliament,

---

[205] Ministry of Health and Family Welfare, Framework of Implementation (2005-2012), National Rural Health Mission, Government of India. p. 29. Available at: https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf

[206] Ibid.

representatives from PRIs and urban local bodies, representatives and members of departments of women and child development, sanitation, social welfare etc.); medical representatives (medical superintendent, civil surgeon, chief medical officer, district AYUSH officer, representatives from local medical colleges); and local communities (two or three eminent citizens and two civil society representatives). As is evident from the composition, RKS bodies disproportionately lean in favour of government and medical representatives, with community participation finding inadequate representation.

Participation of local staff along with representatives of the local population is considered of prime importance to improve accountability.[207] The RKS have been tasked with a range of functions: to enable community participation in improving in-patient welfare at the facility level; ensure compliance with minimum standards and protocols of treatment; supervise implementation of national health programmes; monitor compliance with respect to right to medical records, access to healthcare services, acceptability of medical services; to ensure a safe and healthy hospital environment; operationalise grievance redress mechanisms including a prominent display of the "Charter of Patient Rights" and address complaints promptly, among other functions. [208] Guidelines provide that capacity building and orientation of members shall be organised annually to enable the RKS to function optimally as units of community participation.[209]

RKS are provided untied funds under NHM, which can be used for providing medicines and diagnostics for poor patients, acquisition of equipment, furniture, ambulance, repairs and maintenance of the public health facility and transportation for referral services, among others. However, RKS are also permitted to raise funds by seeking donations or loaning funds from financial institutions and charging user fees. But they must ensure that no user fees are levied on essential medical services like childbirth, childhood malnutrition or infectious diseases like HIV, TB, malaria etc.

An early national assessment of RKS performance conducted in 2010 by representatives of state governments, public health experts and civil society organisations revealed significant variance in their functionality across states. Although RKS brought a new sense of financial authority for generating and spending local resources, in the interest of the patients in particular, the experts highlighted several issues and gaps to be addressed in the constitution and implementation of RKS.[210]

Interviews with respondent interviewees revealed that RKS composition does not truly serve community participation, as community representatives are very few and marginalised groups are not equitably represented. One respondent interviewee stated that persons from Dalit and transgender communities typically do not find any representation in RKS committees even today. Community participation is limited to token representation (of some influential persons like the village pradhan and ward member) and since they are nominated, they feel obliged to favour the nominating person, thereby undercutting the objective of participation of local communities for accountability. Due to this lopsided composition, the implementers of the programme become the evaluators too. Experts were of the opinion that a participatory wide-based process is more desirable, and mechanisms for replacing representative democracy by participatory approaches need to be worked out. There is also very low awareness about the role and functions of RKS in the wider community, underscoring the need for creating awareness to build ownership within the community and ensuring accountability towards them, which could also strengthen the voice of community representatives in RKS.

[207]Ministry of Health and Family Welfare, 2015, Guidelines for Rogi Kalyan Samitis in Public Health Facilities, Government of India. Available at: https://nhm.gov.in/New_Updates_2018/communization/RKS/Guidelines_for_Rogi_Kalyan_Samities_in_Public_Health_Facilities.pdf
[208] Ibid.
[209] Id. at 207
[210] Elamon, J., et al. (2010). *Strengthening Rogi Kalyan Samitis - Experiences.* National Health Systems Resource Centre (NHSRC)

Respondent interviewees revealed that RKS members were not aware of the range of their functions and roles, particularly with respect to equity concerns and governance mechanisms related to patient welfare, operationalising convergence at this level and supervising implementation of e-health programmes. This clearly underscores the need for regular training, monitoring and supportive supervision. Respondent interviewees also recommended that the function must go beyond facilitating curative care and administrative upkeep, to include action on health promotion at the community level. There also needs to be training on equitable fund utilisation – most RKS funds are spent on procurement of instruments, laboratory equipment and for repair and maintenance of hospital buildings, while very little money has been spent on purchasing medicine.

Though challenges related to timely fund disbursal and utilisation have improved over the years, they still remain a problem in several states. A comparative study of RKS in low and high performing health facilities in Pune District revealed that in low performing facilities, RKS were more concerned with purchasing basic material requirements, repairing and beautification; while in high performing facilities, RKS set up an agenda addressing community health needs by the provision of medicine, drinking water facilities, and organisation of outreach services.[211] Similar findings on spending patterns were reported in a 2012 assessment of RKS in Manipur, Meghalaya and Tripura.[212] A 2009 study in Uttarakhand, found that only 53 percent of the available funds were utilised, of which most expenditure was on construction/ maintenance of buildings (32.70 percent), furniture (14.25 percent), electronics/ electricals (14.03 percent), fuel (12.98 percent) and comparatively much less on medicines (7.30 percent), lab facilities (2.19 percent), provision of clean water, sanitation (4.58 percent) and IEC (0.61 percent).[213]

As a strategy to mobilise resources at local levels, RKS in most states started levying user fees for most services, which has led to the exclusion of the poor. A respondent interviewee states that the token mechanisms of waivers for persons belonging to the below poverty line (BPL) category are inadequate as guidelines are arbitrary and ineffective in mitigating the impact of user fees on patients who cannot afford to pay for health services. As a result, the levy of user fees by RKS bodies has the disastrous effect of denial of healthcare for the poor and violates the fundamental right to health.[214] Respondent interviewees cautioned against this practice and advised for a proper evaluation of the impact of user fees on access to services. However, no such national evaluation has been carried out to date. The High-Level Expert Group on UHC in 2011 strongly recommended discontinuation of user fees on appreciation of evidence that it causes inequities, impedes access to care, and is not an effective source of resource mobilisation.[215] The National Health Policy (2017) seeks to transition from levy of user fees to assured free drugs, diagnostics and emergency services for all in public healthcare institutions. However, the policy shift still needs to reflect on the ground. This prompts the question that if RKS were truly representative of local communities and marginalised groups, would it have decided to levy user fees for services.

The 73rd amendment to the Indian Constitution in 1992 sought to decentralize power to PRIs at district, block and village levels. However, respondent interviewees noted that integrating PRIs and *gram*

---

211 Adsul, N. and Kar, M. (2013). Study of Rogi kalyan samitis in strengthening health systems under national rural health mission, District Pune, Maharashtra. *Indian J Community Med*;38:223-8. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3831692/

212 Regional Resource Centre for North Eastern States (RRC, NE) (2012). *Assessment of Rogi Kalyan Samiti (RKS) in the States of Manipur, Meghalaya and Tripura*. Ministry of Health and Family Welfare, Government of India. Available at: https://www.rrcnes.gov.in/study_report/Compiled_RKS%20Report_Final.pdf

213 Rawat, C.M.S. et al. (2009) A rapid appraisal of rogi kalyan samitis in Uttarakhand. *Indian J Public Health*. Available at: https://pubmed.ncbi.nlm.nih.gov/20108883/?dopt=Abstract

214 Kurian, O. C. et al (2011), *Mapping the Flow of User Fees in a Public Hospital, Mumbai*: CEHAT. Available at: http://www.cehat.org/go/uploads/Publications/R82%20UserFee.pdf;
Duggal, R. and Jadhav, N. (2018). User charges onslaught on public health services. *Economic and Political Weekly*, Vol. LIII, Issue No. 4. Available at: https://www.epw.in/journal/2018/4/commentary/user-charges-onslaught-public-health-services.html

215 Id. at 204, p. 104

sabhas within RKS was challenging for many states (except Kerala). The Kerala Institute of Local Administration, an autonomous institution formed with the mandate of promoting socio-economic development by fostering local self-governance, merits attention for undertaking special measures to implement constitutional guarantees of health at the community level.[216] It acts as the government's nodal body on research and training of elected representatives of local government bodies and facilitation of decentralization planning in areas of natural resource management, palliative care and solid waste management with a focus on SC/ST communities, women and children.

A National Working Group on NHM (2012-2017) observed that RKS needs to be re-structured to improve community participation, transparency and accountability, which can directly translate into better access and quality of care for patients.[217] It observed that RKS needs active participation from PRIs in order to mobilize local communities and increase focus on patient welfare rather than merely manage disbursement of untied funds.

The 12th Common Review Mission Report of 2018 reveals that a vast majority of states report the constitution of RKS and the holding of regular meetings. However, increased focus is needed towards governance, mandate, revenue and capacity-building. Specifically, few state governments reported delays in receipt of untied funds which led to only partial utilization of funds for local activities. Such institutional challenges reiterate the need to streamline disbursal of untied funds in a timely manner, focus efforts on periodic capacity-building on adequate utilization of untied funds, among others.[218] The aforesaid findings on compliance with RKS constitution norms, challenges in utilization of untied funds and lack of periodic capacity-building are further corroborated by countrywide RTI data from the period 2019-2022.[219]

5.2.2 Village Health, Sanitation, Nutrition Committees (VHSNCs)

Village Health, Sanitation and Nutrition (the last was added as a component in 2011) Committees (VHSNCs) are a key intervention to ensure participation to enable communities to shape health planning, policies and systems. VHSNCs are constituted at the revenue village level and act as sub-committees under the Gram Panchayat. Each committee should have a minimum of 15 members, consisting of a) PRI members, b) people working on health-related issues, c) local communities, d) beneficiaries, and e) underrepresented and vulnerable sub-groups from the community, among others.[220] The VHSNC chairperson must be a woman or individual from a SC/ST and elected member of the gram panchayat. The local ASHA acts as member secretary and convenes the committee meetings. Each VHSNC is allotted INR 10,000 as untied funds, credited to VHSNC bank accounts, for spending on local health needs and related issues. The committee is required to meet at least once a month.

Among the primary tasks of VHSNCs are: a) creating awareness of health services and entitlements in the community, b) developing village health plans (including on SDH), c) identifying local health and nutrition-related issues and acting as a bridge between the community, the authorities and the formal health system, d) monitoring healthcare service delivery in healthcare facilities in their local areas, e) functioning as grievance redress fora and communicate to service providers any incidences of deficiency of services, f) facilitating *jan samvads* or *jan sunwais* and g) providing support and

---

[216] Kerala Institute of Local Administration. Available at https://www.kila.ac.in/

[217] Planning Commission (2011). Strengthening of Community Processes under NRHM, Report of the Working Group on National Rural Health Mission (NRHM) for the 12th Five Year Plan (2012-2017), Government of India, pp. 36-42

[218] National Health Mission (2018). 12th Common Review Mission Report, Ministry of Health and Family Welfare, Government of India. Available at: https://nhsrcindia.org/sites/default/files/2021-03/12th%20Common%20Review%20Mission-Report%202018.pdf

[219] Copies of RTI applications filed in April 2022 and responses from State NHMs. On file with C-HELP.

[220] National Health Mission, Handbook for Members of Village Health Sanitation and Nutrition Committee, Ministry of Health and Family Welfare, Government of India. Available at: https://nhm.gov.in/images/pdf/communitisation/vhsnc/Resources/Handbook_for_Members_of_VHSNC-English.pdf

facilitating the work of community health workers like ASHAs who form a crucial interface between the community and health institutions.

Health planning in India, especially at the district and sub-district levels, has traditionally been top-down and monopolised by the bureaucracy. The NRHM reforms sought to promote decentralised bottom-up planning with active participation of local communities. Aware that VHSNCs would require significant and sustained capacity-building, the NRHM envisaged a strong role for NGOs/CBOs to train and build capacity over a period of time. While the MoHFW developed guidelines in early 2006 on the structure and functions of these committees and provided funding and support for training from national to state levels, subsequent evaluations reported that many of the 5,00,000 VHSNCs across India were functioning poorly.[221] The architecture and working of VHSNCs varies widely across India and remains subject to local variables, as suggested by literature and key-informant interviews.

VHSNCs are responsible for formulating Village Health Plans (VHPs) which are forwarded upwards through the PHC, block and district levels to develop the District Health Action Plan (DHAP). In practice, village level health planning is not properly underway owing largely to lack of capacity-building of VHSNC members. Further, instead of being year-round, in Maharashtra, the process typically starts from the period of October-December; whereas states generally submit project implementation proposals by the following January to the NHM. Clearly, there is little time for a VHP to be formulated and then for it to be incorporated in block and thereafter district health plans. This is critiqued by both former bureaucrats and civil society representatives as flawed, since geographically and demographically larger states are unable to comprehensively undertake community processes within this short period. A respondent interviewee recommends that health planning must be a continuous process around the year in order to develop health plans which are truly representative of people's needs.

One of the critical structural problems with VHSNCs is their inadequate or inappropriate composition.[222] While the guidelines mandate that VHSNCs should be broadly representative, studies reveal that often VHSNCs are constituted without meeting this mandate.[223] In particular, there is a lack of representation from teachers and ASHAs[224] and inadequate participation of health, sanitation, and nutrition departments.[225] Inappropriate composition tends to undermine the VHSNC's awareness

---

[221] National Health Mission, Common Review Mission reports *(1st in 2007 to 10th in 2016),* National Health Systems Resources Centre. Available at: https://nhsrcindia.org/practice-areas/kmd/common-review-mission-crm-reports; Srivastava, A. et al. (2016). Are village health sanitation and nutrition committees fulfilling their roles for decentralised health planning and action? A mixed methods study from rural eastern India. *BMC Public Health,* 16:59. Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2699-4#:~:text=Conclusions,with%20the%20wider%20health%20system; Kumar, V. et al. (2016). Health planning through village health sanitation and nutrition committees. *Int J Health Care Qual Assur,* 29:703–15. Available at: https://pubmed.ncbi.nlm.nih.gov/27298066/

[222] Alexander, K. et al. (2016). *Ending Open Defecation in India: Insights on Implementation and Behaviour Change for Swachh Bharat Abhiyan.* Woodrow Wilson School of Public and International Affairs, Princeton University. Available at: https://spia.princeton.edu/sites/default/files/content/India%20Workshop%20Report_FINAL_2.25.2016.pdf

[223] Bajpai, N., et al. (2008). *"Scaling up Primary Health Services in Rural Tamil Nadu: Public Investment Requirements and Health Sector Reform*", Earth Institute, Columbia University. Available at: https://academiccommons.columbia.edu/doi/10.7916/D8R49XMW;
An Assessment of the Status of Village Health and Sanitation Committees in Bihar, Chhattisgarh, Jharkhand and Orissa, 2008, Public Health Resource Network. Available at: http://phrsindia.org/wp-content/uploads/2015/03/Village_Health-and-Sanitation-Committee.pdf; Singh, R, and Purohit. B., (2012). *"Limitations in the Functioning of Village Health and Sanitation Committees in a North Western State in India."* International Journal of Medicine and Public Health 2 (3). Available at: https://ijmedph.org/article/139

[224] Semwal, V. et al. (2013). Assessment of village health sanitation and nutrition committee under NRHM in Nainital district of Uttarakhand*. Indian Journal of Community Health. 25.* 472-479. p. 475. Available at: https://www.iapsmupuk.org/journal/index.php/IJCH/article/view/358

[225] Ibid.

of village health needs.[226] Further, existing social power structures impede effective participation, impacting functioning of VHSNCs.[227]

Similar to findings related to RKS, several studies have also revealed a low level of awareness among VHSNC members of their roles and responsibilities.[228] There is also low awareness of the fact that VHSNCs are entitled to untied funds, often leading to corruption or to under-utilisation of funds.[229] Role confusion among VHSNC members is rampant, some not even being aware that they were on the committee.[230] Literature suggests that villages with weak VHSNCs conducted no awareness campaigns nor formulated annual VHPs.[231] While as per the guidelines, the VHSNC is supposed to meet at least once a month, a number of surveys and research studies reveal severe shortfalls in monthly meetings;[232] some VHSNCs reported meeting only once in a year.[233]

In a national study examining the correlation between local democracy and its impacts on public health interventions, researchers found that VHSNCs operating closer to district headquarters were more active as self-governance mechanisms to strengthen the political agency in village health care decision-making.[234] The study noted that functional VHSNCs increased the probability of maternal healthcare utilisation, driven by an improved use of public health facilities for deliveries, ante- and post-natal care.

In a study of the functioning of VHSNCs in Karnataka, where the researchers were actively engaged in building capacities within the VHSNCs, it was discovered that in the study villages, VHSNCs served as vital social spaces for creating awareness among low-income communities about the spread of diseases.[235] In particular, the study observed a significant decrease in the incidence of diarrhoeal diseases in the study villages since 2012, while the occurrence of intersectoral collaboration between ex-officio VHSNC members from various line departments, non-governmental members, the gram panchayat, and ordinary households increased parallelly.[236]

A respondent interviewee notes that in Chhattisgarh, 18,500 VHSNCs out of 19,180 (96 percent) are regularly monitoring village level services. VHSNCs raised various issues relating to violence against women, disability, tobacco use, climate change, access to safe drinking water and other issues relating to government schemes. Another respondent interviewee corroborates this finding and adds that the VHSNCs in Chhattisgarh are functioning well because the state government is focussing on capacity building and training. Further, states that have stronger decentralisation through PRIs and where

---

[226] Id. at 223, Singh, R. and Purohit, B. (2012)
[227] Scott, K. et al. (2017). Beyond form and functioning: Understanding how contextual factors influence village health committees in northern India. *PLOS ONE,* Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0182982#sec015
[228] Id. at 221
[229] Singh, C.M. et al. (2009). Assessment of utilization of untied fund provided under the national rural health mission in Uttar Pradesh. *Indian journal of public health.* 53. 137-42. Available at: https://pubmed.ncbi.nlm.nih.gov/20108876/
[230] Ibid.
[231] Sharma, S. et al. (2021). Assessing Community Health Governance for Evidence-informed Decision- making: A Cross-sectional Study Across Nine Districts of India. *International Jounral of Health Governance.* Available at: https://www.emerald.com/insight/content/doi/10.1108/IJHG-05-2021-0051/full/html
[232] Das, M. et al. (2016). An assessment of the functioning of the Village Health Sanitation and Nutrition Committee in the rural areas of Kamrup district, Assam. *International Journal of Medical Science and Public Health* | 2016 | Vol 5 | Issue 10 p. 2053. Available at: https://www.ijmsph.com/fulltext/67-1456548570.pdf?1661293981
[233] Id. at 223, Singh, R. and Purohit, B., (2012)
[234] Costa-Font J. and Parmar D. (2021). *Does local democracy improve public health interventions? Evidence from India.* Wiley Online Library. Available at: https://doi.org/10.1111/gove.12606
[235] Patel, D. (2020). *'The potential of India's Village Health Committees in containing the spread of diseases'.* International Development London School of Economics Blog. Available at: .https://blogs.lse.ac.uk/internationaldevelopment/2020/05/15/the-potential-of-indias-village-health-committees-in-containing-the-spread-of-diseases/
[236] Ibid.

NGOs play an active role in capacity-building and handholding, VHSNCs performed better. Respondent interviewees gave examples of Kerala, Maharashtra and Odisha.

A two-year implementation research project called 'Strengthening Village Health Committees for Intensified Community Engagement at Scale' (VOICES)[237] in 2017, introduced a revised institutional support package to strengthen VHSNCs. The support included expanded membership and ensuring norms for equitable participation (gender, caste), aligning VHSNCs with decentralised government, and implementation support through NGO facilitation.

The study made a case for the need and potential for VHSNCs performing better with some institutional support. Lessons learnt include a) despite increased community participation, exclusion related to caste and residence in small hamlets within larger villages persisted. Although membership of women increased, existing social and gender norms often prevented women from taking up leadership roles. The study recommended that while these reforms are crucial, sustaining meaningful representation from marginalised populations requires greater advocacy, support and facilitation, as well as a longer time frame to alter the deep-seated power relations that define who has voice in communities; b) alignment of the VHSNC with the gram panchayat enabled a form of constitutional legitimacy that in turn invoked accountability from health service providers; c) NGOs played a crucial role in building capacity of and facilitating VHSNCs to develop as viable community platforms taking up action around local priorities and issues, including environmental and social determinants of health; and d) strengthening institutional capacity at state and district level is critical to implementing and monitoring VHSNCs at scale. The study concluded that "*the expectation of scaling up community committees within a context where governance and particularly decentralised governance is still evolving needs to be tempered. Nonetheless, the strategic deployment of funds and existing NHM personnel could pave the way for improved and more equitable community engagement and, ultimately, to positive health outcomes.*"[238]

5.2.3 Jan Arogya Samiti

Under Ayushman Bharat-Health and Wellness Centres (AB-HWCs), Sub-Health Centres (SHCs) and PHCs are being transformed to Health and Wellness Centres to provide Comprehensive Primary Health Care (CPHC) services. As a part of this transition, a new institutional mechanism/ platform called Jan Arogya Samiti (JAS) is being constituted at both the SHC and the PHC levels. At the PHC level, the existing RKS are being reconstituted as JAS.[239]

The main functions of the JAS include – to serve as an institutional platform for community participation in management and governance of facilities with a view to ensure accountability for health service delivery; to mentor, support and engage the VHSNC in its work and utilisation of its funds as well in health promotion activities; facilitate activities pertaining to social accountability in coordination with VHSNCs; and set up a grievance redress mechanism and undertake regular patient satisfaction surveys.[240]

The composition of the newly conceptualised JAS is similar to the RKS at the PHC level. It includes representation from VHSNC, which will further its objective of integrating VHSNC with the health system. However, representation from civil society continues to be miniscule – two persons. The failure to increase community and civil society participation is a missed opportunity, particularly as

---

[237] Ved, R. et al. (2018). Village Health Sanitation and Nutrition Committees: reflections on strengthening community health governance at scale in India. *BMJ Global Health.* Available at: https://gh.bmj.com/content/bmjgh/3/Suppl_3/e000681.full.pdf

[238] Ibid.

[239] National Health Mission, Community Ownership of Health & Wellness Centre, Guidelines for Jan Arogya Samiti, Ministry of Health and Family Welfare, Government of India. Available at: https://ab-hwc.nhp.gov.in/download/document/Jan_Aarogya_Samiti_Web_Compressed.pdf

[240] Ibid.

the JAS is an attempt to reinvigorate community ownership and participation. In fact, the supplementary module on JAS for community health officers explains the rationale for JAS as *"people have both a right and a duty to be involved in the decisions that affect their lives."*[241] It is also disappointing that the JAS at the HWC-SHC has no representation from civil society at all.

Under Ayushman Bharat, an annual untied fund of INR 50,000 is provided for the SHC level AB-HWCs and INR 1,75,000 for PHC level AB-HWCs. These funds will be available to the JAS to be utilised as per norms. Ensuring basic amenities and services to the patients and citizens and supporting community level health promotion are two cornerstones for prioritising expenditures from untied funds.[242] Interestingly, the guidelines on JAS mandate it to *"ensure that no user fees or charges are levied for any healthcare services being provided in AB-HWC."*[243] This is a welcome change from the previous RKS guidelines. However, it is unclear if this direction will be applicable only to the JAS at the PHC level AB-HWCs or whether it will also cover district hospitals or community health centres where some RKS are reportedly charging user fees.

A respondent interviewee reveals that the JAS are being given the role of supervising VHSNCs, among others, to support them to function better. However, another respondent interviewee remarked that governments have not paid attention to other systemic reasons that have impeded optimum functioning of VHSNCs. The respondent interviewee suggests that instead of creating new bodies like JAS, governments must focus on strengthening panchayati committees as participation of local elected representatives is indispensable to improving community participation and health delivery. Unfortunately, in the past four years, the budget line for PRIs has been removed from the NHM State Programme Implementation Plans. The JAS guidelines mention that since JAS are new bodies, their members would need sustained capacity-building, something that the government has not been able to achieve with the existing RKS and VHSNCs. It remains to be seen how the government ensures such capacity-building and to enable JAS it in turn, to mentor the VHSNC.

5.2.4 Community-based Monitoring

NRHM's community based monitoring (CBM) places people at the centre of the process to assess whether health needs and rights of the communities are fulfilled, with the intended outcome of increasing community participation to improve responsive functioning of the public health system. CBM views local communities as active subjects rather than passive objects in the monitoring and planning of the public health system. The process can provide feedback on need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring systems are directly linked to corrective decision-making bodies from PHC to state levels.[244]

Before launching nationally, 9 states implemented a pilot phase of CBM, facilitated by NGOs, in 1620 villages of 324 PHCs which was spread across 108 blocks and 36 districts, from August 2007 to March 2009. A notable finding of the pilot's assessment suggested that active engagement of local communities with the health departments through various models of community participation was

---

[241] National Health Mission, Jan Arogya Samiti, Supplementary Guidelines for Community Health Officers. Ministry of Health and Family Welfare, Government of India. Available at: https://nhsrcindia.org/sites/default/files/2021-07/Supplementary%20Module%20for%20Community%20Health%20Officer%20on%20Jan%20Arogya%20Samiti.pdf

[242] Id. at 239

[243] Id. at 239

[244] National Rural Heath Mission, Manager's Manual on Community Based Monitoring of Health Services under NHRM, Ministry of Health and Family Welfare, Government of India, p 8. Available at: https://www.copasah.net/uploads/1/2/6/4/12642634/managers_manual.pdf

shown to have resulted in increased utilization of services and greater accountability in the facilities, including for SC/ST communities and women.[245]

The provision for Monitoring and Planning Committees (MPC) has been made at village, PHC, block, district and state levels, which involves a three-way partnership between healthcare providers/ system, community-based organisations and PRIs. The composition of the MPCs at every level includes a representation of the three-way partnership who are allocated funds under NHM, as provided in the guidelines.[246] The monitoring process begins with a village report card being prepared by the VHSNC after consulting village records (ASHA records or Auxiliary Nurse Midwives – ANM – records or the Village Health Register) and also by conducting interviews and meetings with potential beneficiaries (such as women who are pregnant or have undergone childbirth in the recent past) to understand the community members' experiences and problems faced, as well as assess the extent to which key services are being delivered effectively. The MPC at each level reviews and collates the reports coming from the committees dealing with units immediately below it. MPCs at all levels are also mandated to develop health plans incorporating the plans from village level upwards. They are also supposed to constitute and undertake CBM and periodical *jan sunwai*s, the findings of which would also inform planning.[247] CBM is an unprecedented policy initiative as no similar community monitoring activity in other social sectors has been proposed and implemented on a countrywide scale before. It is the first time the government institutionalised community monitoring of health services on a major scale.

Independent and external assessments of CBM were undertaken in Maharashtra to study its effects on public healthcare delivery and the interaction between communities and the public health system since its launch after the pilot phase. They noted that the CBM interventions significantly contributed to strengthening health services and improving quality of care. They also recognized their potential to mobilise communities to demand services and to create positive pressure on the system to become more responsive and accountable. These evaluations strongly validate the benefits of the CBM process in pilot phase districts, where the process is now well-rooted.[248]

Maharashtra is cited as a successful case study of decentralised health planning in the context of creating platforms for dialogue between various stakeholders and improved data collection on health indicators.[249] Over time, this has rebuilt people's faith in the public health system in an era of increasing privatisation; sustained pressure by local communities through CBM mechanisms has made the public health system more accountable and responsive to people's needs. However, public health groups note that while formal spaces for participation are necessary, as health planning occurs in the

---

[245] National Rural Health Mission Advisory Group on Comunity Action (AGCA), Review of Pilot Phase of Community Monitoring: A Report, Ministry of Health and Family Welfare, Government of India, Available at: https://nrhmcommunityaction.org/wp-content/uploads/2017/06/Pilot_Phase_of_Community_Monitoring_Activities_at_National_Level_A_Review_Report.pdf

[246] Id. at 244, see Annexure 4

[247] Id. at 244, p. 8

[248] Khanna, R. and Pradhan, A. (2013). *Evaluation of the process of community based monitoring and planning of health services in Maharashtra, NRHM Advisory Group on Community Action (AGCA)*, SATHI. Available at: https://nrhmcommunityaction.org/wp-content/uploads/2016/11/Evaluation.pdf; Gadgil, M. and Chandekar, P. (2013). *Evaluation of community based monitoring and planning of health care services under National Rural Health Mission, Maharashtra.* Pune, State Health System Resource Centre. Available at: https://nrhmcommunityaction.org/wp-content/uploads/2017/01/Pilot_Phase_Report_on_the_Community_Based_Monitoring_and_Planning_Programme_in_Maharashtra.pdf

[249] Shukla, A. and Sinha, S.S. (2014). Reclaiming public health through community-based monitoring, The case of Maharashtra, India, SATHI. Available at: https://www.municipalservicesproject.org/publications/OccasionalPaper27_Shukla-Saha_Reclaiming_Public_Health_through_CBM_Case_Maharashtra_India_Aug2014.pdf

context of highly unequal power relations, sustained efforts at capacity-building are essential to transform health planning.[250]

In Kerala, Orissa, Maharashtra, Karnataka and Tamil Nadu where CBM is implemented with active participation of local elected representatives and communities, governments have reported positive outcomes in terms of reduced out of pocket expenditure (OOPE), lower maternal mortality rate (MMR) and infant mortality rate (IMR), according to a respondent interviewee. Active participation of local communities in the maternal death review (MDR) and child death review (CDR) processes in tribal districts of Nandurbar, Amravati and Gadchiroli in Maharashtra have resulted in strengthening of sexual and reproductive health programmes as it compelled the state government to invest resources in appointment of ANM, residential doctors to perform night deliveries and organizing maternal health camps on a regular basis. Consequently, referral services have strengthened, MDR-CDR indicators have improved and a culture of accountability of healthcare staff has evolved over time which has translated into overall improvement in general healthcare services in Maharashtra, as noted by a respondent interviewee.

Barring the exceptional performance of the aforesaid states, CBM has witnessed an overall downward curve after the pilot phase implementation due to lack of political will to upscale its success on a national level, observes a respondent interviewee. Even for the better performing states, governments were actively investing resources and reporting compliance with the community processes. However, post 2013-14, slashed budgets for CBM on a central level has decreased state governments' commitment and lowered local communities' morale, as corroborated by another respondent interviewee.

5.3 Other Jurisdictions

The High-Level Expert Group (HLEG) on UHC in India in 2011 reviewed the status of community participation in India and acknowledged that to facilitate local health planning, implementation and monitoring, the role of both the local elected bodies and civil society has been critical. However, it also acknowledged that community participation efforts in India have been mixed due to various factors, as discussed in the foregoing sections. It also identified some additional gaps, including inadequate articulation in the law to support mechanisms of community participation in planning and administering health services, and absence of an urban equivalent of a framework for participation. The HLEG reviewed participatory models in other countries, particularly Thailand and Brazil, as providing pointers for reform of community participation in India. On lines of the Thailand and Brazil models, the HLEG recommended, among other things, transformation of existing VHSNCs into participatory Health Councils at five levels: 1) village/ mohalla; 2) block / taluka / town / MLA constituency; 3) district; 4) state and 5) national.[251]

5.3.1 Health Assemblies – Thailand

The Thai experience derives largely from health reforms introduced in the late 1990s that created a socio-political environment which was more conducive to citizen-state engagement.[252] A long and sustained period of collective citizen consciousness was cultivated in subsequent years, culminating in the first National Health Assembly in the early 2000s.[253]

---

[250] Shukla, A. et al. (2014). *Using community-based evidence for decentralised health planning: insights from Maharashtra, India, Health Policy and Planning.* Available at: https://academic.oup.com/heapol/article/33/1/e34/2907858

[251] HLEG (2011). *High Level Expert Group Report for Universal Health Coverage in India*. Planning Commission of India

[252] Rajan, D. et al (2019). *Institutionalising Participatory Health Governance: Lessons from nine years of the National Health Assembly model of Thailand.* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6703293/

[253] Ibid.

The *National Health Act 2007*, was a landmark legislation which secured participation as the basic orienting principle and practice in health policy-making in Thailand. The Act constituted the National Health Commission Office (NHCO) with the mandate to hold annual health assemblies. There are three types of health assemblies in Thailand: National Health Assembly (NHA), Area-based Health Assembly (provincial), and Issue-based Health Assembly.[254]

At the NHA's foundation is the concept of the '*triangle that moves the mountain*' – the vertices of the triangle equally representing knowledge sector (academia, think tanks, research institutions), people's sector (civil society, communities – health and non-health) and government sector (policy makers, technocrats and politicians).[255] The core principle of NHA is to bring together the three groups of the triangles. (combining top-down and bottom-up approaches) to discuss critical policy issues to achieve progress and reform; a mutual understanding is thus fostered within the structured NHA process. The NHA is thus intended to practically galvanise public participation in policy formulation and implementation. In the proceedings of the NHA, *"all constituencies have equal speaking rights. Varying points of view are welcomed, and every attempt is made to put all sides on equal footing,"* [256] through continuous capacity-building and awareness raising work.

The NHA is a year-round policy process, not a one-time event. This has allowed it to steadily improve in quality. NHA resolutions are passed on consensus and are not binding.[257] The NHA aims to achieve influence and compliance through the legitimacy its broad stakeholder base lends to its resolutions. If a consensus is not reached, the agenda item is deferred to allow more time for discussions in a bid to finally reach a consensus.[258] NHA resolutions are submitted to the National Health Commission and then to the Cabinet. Until 2022, 14 assemblies have resulted in 90 resolutions that have been implemented with issues ranging from antibacterial resistance to waste management.

5.3.2 Health Councils – Brazil

The 1980s saw a broad movement across Brazil to increase public participation in government as part of the larger democratisation movement, leading to the first presidential election in 1985 and the Constitution in 1988.[259] Article 198 of Brazil's Constitution established that the health system would be constructed through the participation of the community[260] and guaranteed a universal right to healthcare (Article 196).[261]

The 1990 Health Statute[262] set up permanent policymaking health councils that operate at all levels of government (municipal, state and national), "*to bring together civil society groups, health professionals, and government officials in the discussion of health policies and health system resource*

[254] National Health Assembly. National Health Commission Office, Thailand. Available at: https://en.nationalhealth.or.th/nha/
[255] Rajan D, et al. (2017). *(2008- 2016) The triangle that moves the mountain: Nine Years of Thailand's National Health Assembly.* World Health Organization. Available at: https://apps.who.int/iris/handle/10665/260464
[256] Ibid.
[257] Ibid.
[258] Ibid.
[259] Gragnolati, M. et al. (2013). *Twenty Years of Health System Reforms in Brazil: An Assessment of the Sistema Unico de Saude'*. The World Bank. pp. 47-50. Available at: https://documents1.worldbank.org/curated/en/909701468020377135/pdf/Twenty-years-of-health-system-reform-in-Brazil-an-assessment-of-the-sistema-unico-de-saude.pdf
[260] Brazil's Constitution of 1988 with amendments through 2017. Available at: https://www.constituteproject.org/constitution/Brazil_2017.pdf?lang=en
[261] Ibid.
[262] The Health Organic Law/Law 8.080 and Law 8.142

allocation."[263] The statute also mandated regular participatory conferences aiming to engage large numbers of citizens in setting the health agenda.[264]

Community representatives account for 50 percent of the composition of Health Councils while the rest of the representation comes from health system professionals, managers, and service providers.[265] Unlike participatory models in most other countries, the Health Councils are legally empowered to deliberate on health policies, inspect public accounts, demand accountability, influence resource spending.[266] Today they are present in 98 percent of Brazilian cities, demonstrating their popularity and their potential to help ensure that health policies are in line with citizen preferences. Some municipalities have also created local Health Councils in hospitals, "*exhibiting extensive capillarity of community participation in Brazil from local to national levels.*"[267]

5.3.3 Lessons and challenges

Vital lessons that have bearing for the Indian experience emerge from the Thai and Brazilian efforts. They include:

1. Both the Assemblies and Councils have been useful platforms to bring a wide and inclusive range of stakeholders together to discuss complex health challenges on a regular basis, to increase awareness, to empower communities, and to operationalise some of the citizens' demands.
2. Statutory basis for the participatory bodies in both countries provides an anchoring in the legal architecture of the country and thus, a sustainable long-term perspective. They have become an institutionalized fixture, despite changing governments and politics, with implementation reported to be robust.
3. Both Assemblies and Councils maintain a strong community character with a sizable representation from communities and NGOs, which in turn permits for equitable representation and a significant voice.
4. In both countries the bodies are constituted at all levels of government.
5. The Health Assemblies in Thailand have demonstrated their capacity and effectiveness in engaging with issues of social determinants of health (Health In All Policy)
6. The process followed, particularly in Thailand, is year-long and continuous which ensures robust and effective participation and deliberation and consensus-building on health policies.

To be sure, these mechanisms are still faced with a number of challenges including a) ensuring a sustainable link to decision-making at the highest political levels so that resolutions/ recommendations are accorded priority and implemented by the health sector; b) ensuring that all marginalised communities are equitably represented including the poor, illiterate populace (in Brazil, the membership guidelines inhibit full inclusivity as they are seen as disproportionately favouring only well-organized civil society groups); c) sustaining a high level of community participation through regular capacity-building on technical issues while preventing over-technification of issues, which weaken the community component and encourage the dominance of government officials in agenda-setting and decision-making.

These experiences demonstrate that even when good models of community participation (inclusive, at all levels) are institutionalised in law or otherwise, they will always remain process intensive

---

[263] Martinez, M.G. and Kohler, J.C. (2016). *Civil society participation in the health system: the case of Brazil's Health Councils. Global Health* 12, 64. Available at: https://doi.org/10.1186/s12992-016-0197-1

[264] Mayka, L. (2019). *Brazil's Health Councils: Successful Institution Building through Sweeping Reform.* In *Building Participatory Institutions in Latin America: Reform Coalitions and Institutional Change*. pp. 98-139. Cambridge: Cambridge University Press. Available at: https://doi.org/10.1017/9781108598927.004

[265] Rocha M.B., et al. (2021). Community Participation: Lessons and Challenges of 30 years of health councils in Brazil. *J Glob Health* 2021;11:03061.

[266] Municipal Health Councils, Brazil. Available at: https://participedia.net/case/15

[267] Kohler, J.C. and Martinez, M.G. (2015). Participatory health councils and good governance: healthy democracy in Brazil?. *International Journal for Equity in Health.* DOI 10.1186/s12939-015-0151-5

requiring sustained institutional support, acceptance and integration in wider health systems and the highest decision-making levels, regular capacity building, and involvement of communities and stakeholders like NGOs/CBOs and PRIs.

5.4 Implications for UHC

While community participation under NHM was envisioned to promote local democracy by encouraging people's voices in health governance, the effectiveness of the models across different regions in India is stymied by a variety of systemic as well as local factors. Positive correlation between community participation and better healthcare outcomes, particularly in areas of district health action planning, social determinants of health, promotion of rational drug use and health communication, as documented by studies, suggest the unutilised potential of institutions like the RKS, CBM and VHSNC to promote public health. Periodic capacity building of members, better linkages with PRIs, more people-centric focus and adequate funding are vital focus areas, which need improvement to realize NHM's mandate of community participation.

Independent and government evaluations of RKS, CBM and VHSNC reveal that community participation under NHM is often practiced as a singular event without long-term commitment by political representatives, availability of financial resources and technical guidance. However, as several reviews as well as key informants recommend, for community participation to impact transformation of the public healthcare system, undertake decentralized health planning and seek greater accountability from healthcare providers, governments must undertake sustained efforts to invest financial resources, offer technical guidance and promote active leadership from political representatives. Therefore, the recommendations of the Working Group on NHM (2012-2017) on higher budgetary allocation for community processes and state-level efforts at regular capacity building must be reckoned with.[268]

The integration of PRIs within community participation models is vital for decentralizing healthcare delivery.[269] Notably, 60 percent of resources allocated to PRIs and urban local bodies are planned for strengthening sanitation, solid waste management, drinking water, rain water harvesting and water recycling, among other social determinants of health.[270] According to respondent interviewees, these developments are inadvertently politicizing healthcare at the grassroots, as local communities are increasingly mobilizing now to advocate with PRI leaders for increased utilization of *zila parishad* funds for health related services.

In addition to reiterating the findings and recommendations of the studies, the HLEG recommended that political commitment to community participation would be actionable by a legislative mandate. There is sufficient precedent for statutory provisions on community participation in India: *gram sabhas* are empowered to undertake social audits of MNREGA works,[271] parents/ guardians of children attending government schools are part of school management committees[272] and marginalized communities and/ or persons engaged with food, nutrition and rights of the poor are empowered with grievance redress and accountability roles for state governments on food security schemes and programmes.[273] Enshrining political commitment to community participation by law in relation to healthcare and UHC would therefore not only be unexceptional but also integral in realising positive health outcomes.

---

[268] Id. at 214
[269] National Health Policy (2017), Ministry of Health and Family Welfare, Government of India.
[270] XV Finance Commission, Report for 2021-2026
[271] Section 17 (Social audit of work by Gram Sabha), MGNREGA
[272] Section 21 (School Management Committee) and Section 22 (School Development Plan), RTE Act
[273] Section 16 (State Food Commission) and Section 29 (Setting up Vigilance Committees), NFSA

Section 6. IMPLEMENTATION OF SOCIAL SECTORS LEGISLATIONS: LESSONS FOR UHC

The rights-based approach in legislation has not been limited to health. Several widespread and long- standing social movements in India have culminated in rights-based policies and programmes with some resulting eventually in the enactment of national legislations guaranteeing socio-economic rights. Many of these laws, pre-date the rights-based health laws and there is considerably more literature and experience with these laws that could provide important lessons for the effective rollout of UHC in India. Section 6 reviews the implementation and impact of three social justice legislations: *Mahatma Gandhi National Rural Employment Guarantee Act 2005* (MGNREGA), *Right of Children to Free and Compulsory Education Act 2009* (RTE Act) and the *National Food Security Act 2013* (NFSA) with a view to identify implications for UHC.

6. IMPLEMENTATION OF SOCIAL SECTORS LEGISLATIONS: LESSONS FOR UHC

Several widespread and long-standing social movements in India have culminated in rights-based policies and programmes as well as the enactment of national legislations guaranteeing socio-economic rights. These legislations are prominently articulated in rights-based language. The *Right to Information Act 2004* (RTI Act), the *Mahatma Gandhi National Rural Employment Guarantee Act 2005* (MGNREGA), *Forest Rights Act 2006* (FRA), *Unorganised Worker Social Security Act 2008* (UWSSA), the *Right of Children to Free and Compulsory Education Act 2009* (RTE Act) and the *National Food Security Act 2013* (NFSA) are some examples that have emerged in the past two decades. Several of these laws emerged from strong civil society participation in law-making.[274]

Many parallels can be drawn across these legislations that are relevant for the discourse on UHC. For one, these legislations are rooted in long-standing rights-based movements. They impose a positive obligation on the State to guarantee a socio-economic right and set out the framework to govern key aspects for its realisation, including availability, accessibility, acceptability and quality. For example, the RTE Act enjoins the State to guarantee the right to primary education by ensuring that schools are available in all neighbourhoods, they are accessible irrespective of gender, financial and other status, acceptable in so far as they provide a safe environment to children, and the quality of education imparted is of acceptable standard. Similarly, the NFSA enjoins the State to guarantee the right to food security by ensuring availability and accessibility to basic food grains for an active and healthy life. Further, these legislations raise important issues related to the principle of progressive realisation of rights[275] as these laws prescribe different criteria such as income level, gender, etc. for the exercise of rights and steps towards universalisation have met with mixed responses. Finally, these legislations promote accountability and transparency of the government through mechanisms such as grievance redress and community engagement.

Various articulations of UHC have been rooted in the right to health.[276] In this regard, the experience of other social justice movements and rights-based legislations provide important lessons for the formulation of a roadmap for UHC.

Hence, it is apposite to pose the question:

What conditions facilitate the implementation of rights-based legislations?

This section seeks to answer to this question by reviewing the implementation and impact of three social justice legislations: MGNREGA, RTE Act and NFSA. In analysing the implementation of these laws, the focus is on issues related to resource availability (examining both financial and human resources), administrative machinery (including centre-state arrangements), transparency and accountability mechanisms and the role of technology. In addition, key issues specific to one or more of these laws that could be relevant to discussions on UHC such as specific community engagement mechanisms, regulation of the private sector, eligibility for services and ensuring quality. These issues are relevant because an effective UHC programme will require the central government to mobilise financial, infrastructure and human resources; set up an accountable and transparent administrative

---

[274] Srikumar, M. *The National Advisory Council Model: When the Civil Society was Heard in Policymaking in India*. Berkman Centre for Internet and Society, Harvard University. Available at: https://cyber.harvard.edu/sites/cyber.harvard.edu/files/Publish_Madhulika%20Srikumar.pdf (accessed on 22/06/2022).

[275] Art. 2(1) of the International Covenant on Economic, Social and Cultural Rights enjoins member states to, “take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”

[276] For an authoritative interpretation of the right to health, see UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, E/C.12/2000/4 (11 August 2000).

machinery for implementation; negotiate appropriate arrangements with state governments especially on matters in the State list of the Constitution's Seventh Schedule; negotiate terms of participation with the private health sector; ensure appropriate quality of health service delivery; consider the extent to which technology will play a role and importantly, consider how to implement the 'U' in UHC.

6.1 Mahatma Gandhi National Rural Employment Guarantee Act 2005 (MGNREGA)

6.1.1 Overview

MGNREGA is considered the world's largest public works programme.[277] It is a pioneering legislation that constitutes an important step towards enshrining and instrumentalising the right to work. MGNREGA traces its roots to the *Maharashtra State Employment Guarantee Act of 1977*, which in turn owed its existence to a strong grassroots mobilisation in the state after a drought which pushed 70 percent of the state's rural population into poverty.[278] Several employment generation and relief programmes have preceded MGNREGA, such as National Rural Employment Programme (1980-89), Jawahar Rozgar Yojana (1989-99), Sampoorna Grameen Rozgar Yojana (since 2001) and the National Food for Work Programme (since 2004). But MGNREGA represents a significant departure from the past, as it is a legal entitlement to demand and obtain work, is significantly larger in terms of budgetary, geographical and population coverage, and is rights-based.

Notably, MNREGA's origins lie in committed activism by civil society groups and individuals emphasising the need for rural employment opportunities and demanding transparency and accountability in wage payments through government schemes. This campaign ran alongside one for the Right to Information, with many organisations such as the Mazdoor Kisan Shakti Sangathan (MKSS) being vocal on both these issues, along with individuals involved in seeking the right to food, and other socio-economic rights. Efforts that began by organising workers engaged in government drought relief programmes led to movement-building for the creation of MGNREGA. Demands for decent work, full wages, and dignity, were characterised by slogans such as "*Har haath ko kaam do*" "*Kaam ka poora daam do*", and "*Poora kaam, poora daam.*" Some individuals involved in the campaign also served on the National Advisory Council (NAC) to the then central government, being instrumental in not only shaping the core structure of the scheme, but also being advocates for the people's needs. While differences with the government led to some parting ways with the NAC – such as on the issue of making MGNREGA wages equal to the minimum wage and ensuring proper implementation at the local level – they continued to participate in the law's implementation through sustained engagement with the government and legislatures, and ensure its grounding in a rights-based approach. Diligent and widespread civil society efforts have therefore been at the heart of devising MGNREGA and persisting in ensuring a process for planning and monitoring to ensure robust implementation.[279]

---

[277]Press Trust of India (2015, July 5). MGNREGA world's largest public works programme: World Bank. *The Times of India.* Available at: https://timesofindia.indiatimes.com/india/mnrega-worlds-largest-public-works-programme-world-bank/articleshow/47978976.cms; Singh S. (2016). Evaluation of world's largest social welfare scheme: An assessment using non-parametric approach. *Evaluation and program planning*, 57, pp. 16–29. Available at: https://pubmed.ncbi.nlm.nih.gov/27153391/

[278] Narayan, S. (2022). Fifteen Years of India's NREGA: Employer of the Last Resort? *Indian Journal of Labour Economics*, 65(3); Chatterjee, V. (2020, July 2). Public Works: Lessons from History. *Business Standard.* Available at: https://webcache.googleusercontent.com/search?q=cache:https://www.business-standard.com/article/opinion/public-works-lessons-from-history-120070201851_1.html

[279] Participatory Research in Asia. (March 2021). *15 Years In: The MGNREGA Story*, Occasional Paper. Available at: https://www.pria.org/knowledge_resource/1621863093_1618822426_1618816284_15%20years%20in-the%20mgnrega%20story1.pdf

MGNREGA was particularly instrumental during the COVID-19 pandemic, and saw a record high demand for work when migrant workers returned home due to lockdowns between 2020-21.[280] The number of workers under the scheme crossed an unprecedented 11 crores in 2020-21, for the first time since the Act's introduction. It was a 41.75 percent increase from the previous year.[281] While there was a significant unmet work demand, a study conducted in eight blocks in four states (Bihar, Karnataka, Maharashtra and Madhya Pradesh) found that among households who found work, both pre- and post-COVID, it was observed across blocks that increased earnings from MGNREGA compensated 20 to 80 percent of income loss.[282] Data also indicated an increase in demand for jobs under MGNREGA after demonetisation, pointing to its critical role as a social security net during times of crisis.[283]

MNREGA's approach to enhancing livelihood security amongst the rural poor is based on the provision of a minimum of a hundred days of "wage employment in every financial year to adult members of households" who volunteer and apply for unskilled manual work (section 3). MGNREGA guarantees certain protections to workers, including the right to apply for work and get work within fifteen days (section 7), the right to an unemployment allowance when work is not allotted within fifteen days (section 7), right to receive wages within two weeks (section 3) and the right to receive compensation when the state fails to pay the wages on time (clause 30 of Schedule II). The Act also entitles workers to free medical treatment, including hospitalisation where necessary, in cases of injuries arising out of work (Paras 25-26 of Schedule II). Compensation is also to be paid to workers or their legal heirs in cases of death or permanent disablement (Para 27 of Schedule II).

While MGNREGA focuses on livelihood security, its intent and impact extend to related determinants of health and life of individuals and communities, such as environment, migration and gender. Thus, the objectives of this law include the creation of durable assets and natural resource management by focusing on works related to water conservation and harvesting, drought proofing, irrigation canals, and renovation of traditional water bodies (clause 4 of Schedule I of the Act); addressing rural to urban migration;[284] strengthening local government;[285] and economic empowerment of women by providing that at least one-third of workers are to be women (clause 15 of Schedule II of the Act).

For its implementation, MGNREGA envisages a participatory governance model. It sets out detailed provisions for ensuring participation of workers in the planning and implementation of works (sections 13-16); promote transparency and accountability at all levels of implementation through measures such as mandatory disclosure of critical information (section 23), social audits (section 17), and grievance redress mechanisms (section 23(6) and clause 29 of Schedule I).

For this paper, MGNREGA was analysed on five aspects which are pertinent to UHC planning and implementation: availability of resources, administrative machinery (in particular decentralisation and

---

[280] Sharma, H. (2022, February 9). Report on MGNREGS: Raise guaranteed days of work, says House panel, *The Indian Express*. Available at: https://indianexpress.com/article/india/report-on-mgnregs-raise-guaranteed-days-of-work-says-house-panel-7763434/

[281] Newsclick (2021, April 3). Over 11 Crore Workers Under MGNREGS in 2020-21 as COVID-19 Lockdown Forced Return Migration. Available at: https://www.newsclick.in/Over-11-Crore-Workers-Under-MGNREGS-in-2020-21-as-COVID-19-Lockdown-Forced-Return-Migration

[282] Azim Premji University (2022) Employment Guarantee during Covid-19: Role of MGNREGA in the year after the 2020 lockdown. *Centre for Sustainable Employment, Azim Premji University and NREGA Consortium*. Available at: https://cse.azimpremjiuniversity.edu.in/wp-content/uploads/2022/10/MGNREGA_Covid_Survey_Report_Final.pdf

[283] Press Trust of India (2016, December 30). Demonetisation pushes demand for work under NREGA. *Financial Express.* Available at: https://www.financialexpress.com/economy/demonetisation-pushes-demand-for-work-under-nrega/491693/

[284] Nandy, A. et al. (2021). India's Rural Employment Guarantee Scheme–How does it influence seasonal rural out-migration decisions?. *Journal of Policy Modeling*, 43(6), 1181-1203

[285] Ministry of Rural Development & Center for Wage Employment and Poverty Alleviation at National Institute for Rural Development. (June 2014) Frequently Asked Questions on MGNREGA Operational Guidelines, p.6. Available at: https://nrega.nic.in/Circular_Archive/archive/nrega_doc_FAQs.pdf

involvement of local governments), accountability and transparency, the use of technology and social audits as a critical and unique community feature of the Act.

6.1.2 Availability of Resources

MGNREGA is a 'core of the core' Centrally sponsored scheme and receives the first charge on available funds for the National Development Agenda, with the Centre providing 90 percent of the costs to the states.[286] Core schemes on the other hand, such as National Health Mission and National Rural Drinking Water Mission, receive Central and State Government funding on the basis of 60:40 ratio, which means greater state contribution to funding.[287]

As per Section 22 of the Act, the Central Government is responsible for financing 100 percent of the amount required for payment of wages for unskilled manual work, and up to 75 percent of the material cost of the state-level Schemes including payment of wages to skilled and semi-skilled workers, and up to six percent of the total cost of the scheme towards administrative expenses. The State Government is responsible for meeting the cost of unemployment allowance and 25 percent of the material cost which includes payment of wages to skilled and semi-skilled workers.

The national budget estimate for MGNREGA for every financial year is prepared on the basis of expected costs to be incurred on a person-day wage employment as submitted by every state, and assessed and approved by a national level Empowered Committee. This includes wages, material cost and administrative costs. The wage to material ratio per person-day wage expenditure is 60:40.[288] The budget is based on anticipated employment generation and can be revised any time during the year based on actual demand for sanction of work.[289] Central funds are normally released in two tranches, with the first tranche accounting for expected expenditures for the first six months of the financial year. The amount released in the second tranche depends on unspent balances and actual performance against the agreed labour budget.[290] A respondent interviewee viewed this as an efficient system to ensure smooth supply of funds.

While the Act imposes financing obligations on the Centre and is dependent on Central funds for its functioning, continued shortfalls in allocation have been noted since the programme's inauguration in 2005.[291] Budget allocations have lagged behind actual expenditures, resulting in funds running out mid-year which in turn lead to slowdown of work and a delay in wage payments to workers.[292] It has also been seen in the last few years that more than 20 percent of the initial budget allocations have

---

[286] Press Information Bureau (2016, August 3). Cabinet approves recommendations of the Sub-Group of Chief Ministers on Rationalisation of Centrally Sponsored Schemes. Available at: https://pib.gov.in/newsite/PrintRelease.aspx?relid=148299; Batra, S. (2021, December 30). At pre-Budget meet, states cite Covid, ask Modi govt to raise share in Centre-sponsored schemes. *The Print.* Available at: https://theprint.in/economy/at-pre-budget-meet-states-cite-covid-ask-modi-govt-to-raise-share-in-centre-sponsored-schemes/791770/

[287] Niti Aayog (2015, October). *Report of the Sub-group of Chief Ministers on Rationalisation of Centrally Sponsored Schemes.* Available at: https://www.niti.gov.in/sites/default/files/2019-08/HIGHLIGHTS.pdf

[288] Ministry of Rural Development & Center for Wage Employment and Poverty Alleviation at National Institute for Rural Development. (June 2014) Frequently Asked Questions on MGNREGA Operational Guidelines, p. 54. Available at: https://nrega.nic.in/Circular_Archive/archive/nrega_doc_FAQs.pdf

[289] Ibid.

[290] Ministry of Rural Development. (2013). *Mahatma Gandhi National Rural Employment Guarantee Act, 2005: Operational Guidelines 2013*, 4th Edition, p. 99. Available at: https://nrega.nic.in/Circular_Archive/archive/Operational_guidelines_4thEdition_eng_2013.pdf

[291] Kulkarni, A. (2021, December 15). MNREGA funds allocation: Honouring the work-on-demand guarantee. Ideas for India. Available at: https://www.ideasforindia.in/topics/poverty-inequality/mnrega-funds-allocation-honouring-the-work-on-demand-guarantee.html

[292] Munjal, D. (2023, January 31). Explained | The funding and demand for MGNREGA. *The Hindu.* Available at: https://www.thehindu.com/business/Economy/explained-the-funding-and-demand-for-mgnrega/article66454860.ece

gone towards clearing arrears from previous years.[293] In the 2022-23 budget, Rs. 60,000 crore was allocated to the Act, comprising 0.2 percent of GDP, which was the lowest in the history of the programme and far below the 1.6 percent of GDP estimated to be required for the Act.[294] Civil society groups involved in monitoring the implementation of the Act believe a minimum of Rs. 2.72 lakh crore is required for implementation of the Act.[295] There had been a sharp increase in allocations between 2020-21 in face of the COVID-19 pandemic, reaching Rs. 1.11 lakh crores, but allocations have declined after that peak.[296] Shortage of funds has resulted in undermining the core objectives of the Act, as states have resorted to giving fewer days of work to fewer households.[297] Responding to concerns expressed in the media about the budget cuts in the 2023-24 budget, the Central Government issued a clarification stating that it would release additional funds when requested, and that MGNREGA being demand driven, the release of funds to states is a continuous process.[298] However, critics have pointed out that demand for jobs is higher than what the budget allocations account for, and the budget shortfalls contribute to high unmet demand for work and delays in wage payments, violating provisions of the Act which guarantee work and payment of wages within 15 days.[299]

In 2018, the Supreme Court of India expressed views on financial allocations under MGNREGA, stating that, "*if there is some sort of a cap or an unreasonable reduction in the funds made available to the State Governments it is really for the concerned State Government to object to the cap and non-availability of funds.*"[300] However it refused to accept the Central Government's "blanket statement" that securing funds for implementation was the responsibility of the states, and stated that expeditious and sufficient availability of funds should be the objective as it is for a "good socio-economic cause", and highlighted the role of the Central Government in facilitating better availability of funds. As has been noted, while MGNREGA was meant to be demand driven by labourers' needs, insufficient and delayed financing from the central government have inverted the programme, making it top-down and entirely dependent on supply. Instead of allocating work when a demand for it is made, work is allocated only when funds are available.[301]

Under Section 18 of the Act, the state government is responsible for appointing technical staff and other officers as necessary for the effective implementation of the Scheme. The staff includes *Gram Rozgar Sahayaks*, Data Entry Operator, Technical Assistant, Junior Engineers, Computer Assistants and Accounts Clerks. A Comptroller and Auditor General (CAG) audit report of Punjab in 2023 shows an acute shortage of important officials such as work manager, accounts manager, district coordinator and grievance redressal coordinator. The report noted that because of the shortfall in the staff, irregularities in scheme implementation were noted, such as non-maintenance of records, delay in

---

[293] Bhatnagar, GV. (2023, February 1). 'Bloodbath': Activist Nikhil Dey on Budget Cuts to MGNREGA. *The Wire.* Available at: https://thewire.in/government/nikhil-dey-mgnrega-budget-cut-2023

[294] Sharma, A. (2023, April 6). MGNREGA under attack from the Narendra Modi government. *Frontline (The Hindu).* Available at: https://frontline.thehindu.com/the-nation/spotlight-mgnrega-under-attack-from-the-narendra-modi-government/article66684747.ece

[295] Ajith, N. and Narayanan, R. (2023, February 7). The demand for MGNREGS work is unmet. *The Hindu.* Available at: https://www.thehindu.com/opinion/op-ed/the-demand-for-mgnregs-work-is-unmet/article66478041.ece

[296] Bhatnagar, GV. (2023, February 1). 'Bloodbath': Activist Nikhil Dey on Budget Cuts to MGNREGA. The Wire. Available at: https://thewire.in/government/nikhil-dey-mgnrega-budget-cut-2023

[297] Narayanan, R. (2023, April 29). Technocratic Subversion of MGNREGA.*Economic and Political Weekly.* Vol. 58, Issue No. 17. Available at: https://www.epw.in/journal/2023/17/editorials/technocratic-subversion-mgnrega.html

[298] Ministry of Rural Development. (2023, February 3). Clarifications of Union Rural Development Ministry on budget cut to MGNREGA. Available at: https://rural.nic.in/en/press-release/clarifications-union-rural-development-ministry-budget-cut-mgnrega

[299] Bhatnagar, GV. (2023, February 1). 'Bloodbath': Activist Nikhil Dey on Budget Cuts to MGNREGA. *The Wire.* Available at: https://thewire.in/government/nikhil-dey-mgnrega-budget-cut-2023; Sharma, A. (2023, April 6). MGNREGA under attack from the Narendra Modi government. *Frontline (The Hindu).* Available at: https://frontline.thehindu.com/the-nation/spotlight-mgnrega-under-attack-from-the-narendra-modi-government/article66684747.ece

[300] *Swaraj Abhiyan v Union Of India* (2018) 7 SCC 591

[301] Sharma, H. (2022, February 9). Report on MGNREGS: Raise guaranteed days of work, says House panel. *The Indian Express.* Available at: https://indianexpress.com/article/india/report-on-mgnregs-raise-guaranteed-days-of-work-says-house-panel-7763434/

disposal of complaints, and improper preparation of the labour budget.[302] A similar situation of inadequate manpower was noted in Bihar, Rajasthan and Odisha.[303] While a comprehensive evaluation of all states' appointment of manpower required for MGNREGA is beyond the scope of the paper, it can be seen that insufficient availability of human resources has created hurdles in the effective implementation of the Act.

6.1.3 Administrative Machinery

Decentralisation is a key tenet of MGNREGA, particularly the involvement of *gram panchayats* as per section 16. It envisages a bottom-up process of planning and implementation of works. Primary responsibility for planning, implementation and supervision of works has been given to *panchayats*, at the district, intermediate and village levels (section 13). *Gram panchayats* are responsible for identifying projects in their area, according to recommendations of the *gram sabha* and *ward sabhas*, and for executing and supervising the works sanctioned by the Programme Officer (section 16). The *gram panchayat* also has the responsibility of preparing a development plan and a shelf of possible works, in consultation with the ward and *gram sabha*. Monitoring of works within the *gram panchayat* is to be done by the *gram sabha*, which also conducts regular social audits of the projects (section 17). District level *panchayats* are responsible for supervising and monitoring projects taken up at the block and district level, and finalizing and approving block-wise shelf of projects to be taken up (section 13). Block level *panchayats* have to supervise and monitor projects taken up at the village and block level, and approve block level plans (section 13).

The Programme Officer, who functions at the *panchayat* block level, is responsible for prompt payment of wages and unemployment allowance, dealing with complaints, monitoring projects taken up by *gram panchayats* and other agencies within the block, and for ensuring that demand for employment is met with work opportunities through sanctioned projects (section 15). At the district level, the District Programme Coordinator is responsible for assisting the district *panchayat*, giving the necessary administrative sanctions, coordinating and supervising the Programme Officers, redressing grievances of applicants, and periodically inspecting works in progress (section 14).

The central and state level employment guarantee councils largely have a supervisory, review and monitoring role under the Act. The councils are required to review the monitoring and redressal mechanisms, suggest improvements, promote dissemination of information about the schemes under the Act, monitor the implementation of the Act and prepare annual reports to be laid before the parliament or state legislature (sections 11 and 12).

Significant challenges have been documented in ensuring that devolution of decision-making is effective. Key initiatives for decentralisation incorporated in the Act have been thwarted by a lack of capacity. For example, *panchayat samitis* tasked with developing perspective plans in Maharashtra are not trained to do so for an exercise that requires technical expertise. Such training is required if village functionaries are to plan sustainable and effective MGNREGA projects.[304]

---

[302] Government of Punjab (2023). Report of the Comptroller and Auditor General of India on Performance Audit on Implementation of Mahatma Gandhi National Rural Employment Guarantee Scheme in Punjab, pp. 95-96. Available at: https://cag.gov.in/uploads/download_audit_report/2022/REPORT~1-064071f344dfbf4.83585179.pdff

[303] Government of Bihar. (2021). Report of the Comptroller and Auditor General of India on General, Social and Economic Sectors for the year ended 31 March 2019, p. 68. Available at: https://cag.gov.in/uploads/download_audit_report/2018/Report%20GS%20&%20ES%20ENGLISH%202019%20(15-07-2021)%20FOR%20PRINT-061026862eefb90.03127055.pdf; Government of Rajasthan (2018). Report of the Comptroller and Auditor General of India on Local Bodies, p 24. Available at: https://cag.gov.in/uploads/download_audit_report/2018/Report_No_2_of_2018_-_Local_Bodies_Government_of_Rajasthan.pdf; Government of Odisha (2018). Report of the Comptroller and Auditor General of India on Local Bodies for the year ended March 2017, pp 17-18. Available at: https://cag.gov.in/uploads/download_audit_report/2018/English_Report%20No1%20of%202018(LBs).pdf

[304] Maske, S. (2015). Issues and challenges in implementation of MGNREGA: A case study from Maharashtra. *Indian Journal of Sustainable Development*, 1(1), 32-38. Available at:

The Act has also been hampered due by the lack of MGNREGA staff dedicated to consolidating a "*bottom-up, people-centred architecture*" that is not "*carried out on an 'additional charge' syndrome*."[305] This has led to *gram panchayats* not having access to qualified guidance to assist in decision-making that devolves to them in actual terms. This despite operational guidelines of MGNREGA laying out a vision that comprises resource centres at the national, state and district levels with the competence to train and build capacity of panchayats. Added to this, "*there is also a lack of a training plan or strategy at the state and national levels, with natural implications for quality… a lack of cohesion and shared sense of purpose across the board. This is seriously impacting the quality of outcomes on the ground."*[306]

In Jharkhand the experience has been of increased centralization – *gram panchayats* have little say in controlling scheme funds with the block administration taking such decisions, resulting in an unresponsiveness to the work demands of workers.[307] While MGNREGA entitles *gram panchayats* to identify schemes for implementation based on a participatory prioritisation exercise with the populace, the Jharkhand the Ministry of Rural Development imposed its own targets for 2016-17, and the state government relegated schemes identified through the people's participatory process.[308]

6.1.4 Accountability and Transparency

Section 23 of the Act is dedicated to transparency and accountability measures in its implementation, including identifying responsible authorities for proper utilisation and management of funds, maintenance of books of accounts, payment of wages directly to the workers, and handling of complaints. A respondent interviewee noted that MGNREGA was unique in that it incorporated the *panchayati raj* system within it from the outset, and this brought in people's planning with the hope and intention of embedding accountability and transparency. But the actualisation of the various measures has met with challenges. A report of the CAG on the scheme's performance between 2007 and 2012 made observations that were telling in relation to accountability – it noted a lack of transparency in the release of funds, a shortfall of information, education, and communication expenditure, and a failure to maintain records.[309]

The Supreme Court has held that timely payment of wages and compensation for delayed payment of wages is a statutory obligation under MGNREGA on both the state and central governments, and bureaucratic delays or red tape cannot be peddled as an excuse to deny payment of wages to the workers.[310] Any administrative inefficiencies or deficiencies or laxity would need to be managed by the state and central government. The court directed the central government, in consultation with state governments and Union Territory administrations to prepare an urgent time-bound mandatory programme to make the payment of wages and compensation to workers. It also held that this was not only in the interest of workers who have expended unskilled manual labour but also in furtherance of the rule of law. The Supreme Court has also held that delay in payment of wages acts as a

---

https://www.researchgate.net/publication/307866987_Issues_and_Challenges_in_Implementation_of_MGNREGA_A_Case_Study_from_Maharashtra

[305] MGNREGA: Opportunities, Challenges and the Road Ahead Second Report of the National Consortium of Civil Society Organizations on MGNREGA. Available at: https://im4change.org/state-report/india/36.

[306] Ibid.

[307] Dutta, S. (2016, November 22). Excessive Centralisation by Modi Government is Undermining MNREGA. *The Wire*. Available at: https://thewire.in/government/centralisation-mnrega-undermining

[308] Ibid.

[309] Ministry of Rural Development. (2013). Report of the Comptroller and Auditor General of India on Performance Audit of Mahatma Gandhi National Rural Employment Guarantee Scheme, pp 22-30, 29 and pp 96-102. Available at: https://cag.gov.in/cag_old/content/report-no-6-2013-performance-audit-mahatma-gandhi-national-rural-employment-guarantee-scheme

[310] *Swaraj Abhiyan v Union Of India* (2018) 7 SCC 591

disincentive for people intending to avail of the benefit of the Act, and since delayed payments affect rights of tens of thousands of workers, it is a clear Constitutional breach.[311]

The most recent large-scale assessment of MGNREGA implementation occurred in the form of the 20th Report of the Parliamentary Standing Committee on Rural Development and Panchayati Raj (2021-2022) of the 17th Lok Sabha, which was presented in February 2022.[312] The committee noted that an unjustifiable delay in payment of wages – the very essence of the legislation – persists, with seemingly no one being held accountable for this failure. It called upon *"the Department of Rural Development to 'pull up its socks' and take all possible measures to wipe off the wage liabilities as soon as possible."*[313] The Committee also expressed concern about the failure to pay workers delay compensation, which wage seekers are entitled to receive payment of in case they are not engaged in work. It noted that, *"there is inordinate delay in payment of wages and despite that, the payment of delay compensation allowance is not at all adhered to strictly… this non-adherence to the provision of the Act regarding payment of delay compensation as a 'breach of trust' of the goal of the scheme … and thus, vehemently recommend the Department of Rural Development to ensure stricter compliance."*[314] The committee further expressed grave disappointment at the "*blatant violation of the provision of unemployment allowance*" in the law, again calling upon all concerned to deliver as per the spirit of the law.

While the above reflects refreshing candour by the Parliamentary Committee in revealing significant loopholes in a vital social justice legislation, and castigating those responsible at the ministerial level, it also reveals that very little seems to be in effect to ensure localised, accessible and equitable accountability and transparency in MGNREGA.

Grievance Redressal

A key mechanism for accountability is grievance redress. As per section 19 of MGNREGA, the State is to determine the block and district level grievance redress systems. Under section 23(6), the programme officer is responsible for registering and disposing of complaints within seven days of receipt, and for forwarding the complaint to any other authority where necessary. Clause 29 of Schedule I lays down the appeal procedures and other requirements that constitute an effective grievance redressal mechanism. One day in a week is to be fixed when all officials shall be necessarily present for receiving grievances at ward/*gram panchayat*/block and district levels. Complainants are to be issued dated receipts for complaints accepted in writing, phone, internet and orally by all personnel authorized to receive complaints. Enquiry through spot verification, inspection and disposal is to be completed within seven working days, and on completion of the enquiry, immediate steps are to be taken by the concerned authority to redress the grievance within 15 days. Failure to dispose of a complaint within seven days shall be considered a contravention (section 25).

The District Programme Coordinator will ensure that a First Information Report is lodged if *prima facie* evidence of financial irregularity is noticed. Appeals against the orders of the *gram panchayat* shall be made to the Programme Officer, those against orders of the Programme Officer made to the District Programme Coordinator, and upwards to the District Programme Coordinator, the State Commissioner (NREGS), the Divisional Commissioner (NREGS) and the State Grievance Redressal Officer. All appeals are to be made within 45 days of issuance of the order, and appeals are to be disposed of within 45 days. The *MGNREGA Operational Guidelines 2013* provide guidance to states on

[311] *Swaraj Abhiyan v Union Of India* (2016) 7 SCC 498

[312] Standing Committee on Rural Development and Panchayati Raj, 17th Lok Sabha, Ministry of Rural Development. (2022, February). Critical evaluation of National Rural Employment Guarantee Act. Available at: https://eparlib.nic.in/bitstream/123456789/845518/1/17_Rural_Development_and_Panchayati_Raj_20.pdf

[313] Ibid., recommendation 4, p. 73.

[314] Ibid., recommendation 9, p. 78.

formulating grievance redress mechanisms, including modes for registering complaints, timelines for disposal of complaints, appeal procedures and information to be furnished to the complainant.[315]

The central government also has the power, under section 27(2), to investigate any complaint it receives regarding lack of effective implementation or improper utilisation of funds under MGNREGA, and to stop the release of funds if no appropriate remedial measures are instituted for proper implementation within a reasonable period of time. Pursuant to this, the central government issued a detailed Standard Operating Procedure (SOP) for handling grievances, noting that state governments are failing to take timely remedial action against complaints.[316] The SOP categorises complaints into four types – petitions,[317] complaints regarding procedural violation of guidelines,[318] those relating to effective implementation of the Act,[319] and complaints involving financial irregularities.[320] It also prescribes different authorities, timelines, and procedures for dealing with each kind of complaint. Where states do not submit a satisfactory or timely Action Taken Report, the central government is empowered to recommend remedial measures including stoppage of funds and a CBI enquiry.

As per clause 30 of Schedule I, an Ombudsperson has to be appointed for each district to receive grievances and to enquire into them and pass awards. As of March 2022, 375 Ombudspersons have been appointed against 715 possible appointments.[321] Now the appointment of Ombudspersons has been linked to release of central funds to states. Those states which do not appoint Ombudspersons in 80 percent of their MGNREGA districts will not receive such funds.[322]

Ineffective and inadequate grievance redress mechanisms and lack of state initiative in setting up processes have long plagued MGNREGA.[323] A study found that in Karnataka, lack of adequate publicity of grievance redress mechanisms among wage-seekers contributed to low uptake of entitlements.[324] A respondent interviewee noted that grievance redress under MGNREGA in Jharkhand has been successful largely in those cases where workers have collectively raised complaints or when certain bureaucrats have committed to following up on complaints. There is concern that the complaint

---

315 Ministry of Rural Development. (2013). *Mahatma Gandhi National Rural Employment Guarantee Act, 2005: Operational Guidelines 2013*, 4th Edition. Available at: https://nrega.nic.in/Circular_Archive/archive/Operational_guidelines_4thEdition_eng_2013.pdf, pp. 121-123

316 Ministry of Rural Development. (2012, September 7). *Standard Operating Procedure (SOP) for operationalising provisions of Section 27(2) of MGNREGA.* Available at: https://drive.google.com/file/d/1WQJoj0sW-5P6SDBMhTJ90iePH7ol3VWn/view?usp=sharing

317 Petitions are "*general/ non-specific statements on the implementation of the Scheme and general observations/ suggestions on the improvement.*" For example: increasing the number of days of work, inclusion of new category of works. See p. 2 of SOP

318 These would include "*Irregularities, which are born out of deficiencies like lack of capacity building, shortage of staff, lack of planning etc. [..] These include allegations where no criminal intent is involved, such as delay in completion of works etc. or random cases of a nature where lack of management capacity appears to be the major cause.*" See p. 2 of SOP

319 These are "*complaints relating to large scale and prolonged deviation from the main provisions of the Act*" such as non-involvement of *gram sabha* in the selection of works, not conducting Social Audits, delay in payment of wages, non-availability of work site facilities like crèche, drinking water, first aid etc. See p. 3 of SOP

320 This involves "*Any allegation relating to possible or actual loss to the exchequer and where criminal intent is involved*". See p. 3 of SOP

321 Lok Sabha Unstarred Question no. 3196. Available at: http://164.100.24.220/loksabhaquestions/annex/178/AU3196.pdf

322The Economic Times. (2022, February 27). States that don't appoint MGNREGA ombudsperson in at least 80 per cent districts won't get funds. Available at: https://economictimes.indiatimes.com/news/india/states-that-dont-appoint-mgnrega-ombudsperson-in-at-least-80-per-cent-districts-wont-get-funds/articleshow/89872789.cms

323The Economic Times. (2012, July 22). Ineffective grievance redressal a stumbling block: MNREGA. Available at: https://economictimes.indiatimes.com/jobs/ineffective-grievance-redressal-a-stumbling-block-mnrega/articleshow/15089372.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst ; Press Trust of India. (2015, December 22). MGNREGA: Par'l panel unhappy over lack of grievance redressal. Available at: https://www.business-standard.com/article/pti-stories/mgnrega-par-l-panel-unhappy-over-lack-of-grievance-redressal-115122200951_1.html (2015)

324 Salian, P. V., and Leelavathi, D. S. (2014). Implementation of MGNREGA in Karnataka: issues and challenges. *Journal of Rural Development*, 33(3), 261-279: p.275

mechanism is not conducive to individual complaints. The respondent Interviewee noted that the officer responsible for lodging grievances under MGNREGA at the block or district level is also involved in implementation and this could be a factor in discouraging lodging of grievances. This, the respondent Interviewee noted, was not the case in NFSA where the grievance redress officer has no role in the implementation and this perhaps makes it easier for complainants to approach the officer.

The aforementioned Parliamentary Standing Committee also commented on the scant number of complaints of corruption and irregularities filed under the Act, in stark contrast to what it had evinced from those who have shared ground realities. The committee expressed doubt about the numbers shared by the Department of Rural Development. It stated that "*Either 'all is well' or the mechanism of complaints and their redressal machinery is inaccessible to the aggrieved beneficiaries. It also reflects that the Department of Rural Development is completely oblivious of the real situation associated with the implementation of MGNREGA and raises questions over the National Level Monitors (NLM) of the Department. It is high time that the facts surrounding the scheme are explored, ascertained and accepted by the … Department of Rural Development before striving to reach towards solution to reduce anomalies and malpractices that is certainly having a detrimental effect on the success of the scheme.*"[325]

An observation of the committee which is particularly scathing is in relation to the appointment of Ombudspersons, an essential accountability feature of the Act. While expressing "*utmost concern and anguish*" it noted the failure of the Department of Rural Development to comply with appointment of Ombudspersons – only 263 of 715 having been appointed as "*completely unacceptable and show a very grim picture of the coordination between the Centre and State nodal agencies*."[326] The committee recognised the ombudsperson's office as "*a potent platform*" for aggrieved workers to seek grievance redress, and the vacancies a sign of "*callousness*", which cannot be justified.[327] In a context where the law is plagued with poor implementation, workers have little hope for speedy and fair redressal of their grievances since a crucial office has not been filled in the vast majority of districts.

6.1.5 Use of Technology

Over the years, various technological tools have been integrated in the implementation of MGNREGA and in some ways have become central to the Act's administration. The use of online/computer-based systems, by both workers and the administrative machinery, is based on an assumption that such systems are essential for effective monitoring of MGNREGA, increasing transparency and availability of records, and curbing corruption. This section focusses on three tools that have been deployed over the years i.e., Management Information System (MIS), also called NREGA Soft; Aadhaar-based Payment Systems (ABPS); and the National Mobile Monitoring Software (NMMS).

Management Information System (MIS)
The Ministry of Rural Development mandates the use of its Management Information System (MIS) software for submission of all financial, physical and employment reports by States.[328] Details of job cards issued, muster rolls, and wage and material payments can be found on the database.[329] The MIS is meant to ensure "data authenticity, transparency, quick report generation and easy accessibility"

---

325 Id at 292, recommendation 31 at p. 95
326 Ibid. Recommendation 30 at p. 93
327 Ibid.
328 Government of Meghalaya, State Rural Employment Society. (n.d.) *Management Information System,* Available at: https://megsres.nic.in/management-information-system; Aggarwal, A. (2017). Tyranny of MGNREGA's monitoring system. *Economic and Political Weekly*, *52*(37), p.24
329 Thomas, R. (2017, March 30). Tampered MGNREGA Management Information System causes damage: Activists. *Times of India*. Available at: https://timesofindia.indiatimes.com/india/tampered-mgnrega-management-information-system-causes-damage-activists/articleshow/57922836.cms

and proactive disclosure of information.[330] It aims to provide information of all activities carried out under the Act at the central, state, district, block and panchayat levels, and be accessible to all stakeholders, including workers, citizens, panchayats and state and central ministries.[331] It is available in local languages and in offline mode.

However, reports from the ground have shown that MIS has resulted in centralization, consolidation of administrative control, lack of local accountability, and promotion of a misleading picture of scheme success through false, erroneous or misleading data. A 2013 report of the CAG found that a large amount of data, across all types of records, entered into the MIS by states did not match actual paper records and also found that some states were not doing regular data entry.[332] The report called into question the reliability of the data in the MIS for understanding the number of workers registered or employed, and the extent of progress of work. It identified serious design flaws in the software which allowed for data fudging and manipulation, compounded by the fact that there was no mechanism for identifying who was responsible for incorrect data entry.[333] Even the financial data was considered unreliable due to a lack of clear and coherent accounting logic.[334]

The MIS has led to centralised flow of funds and removed local officials' discretion and control over fund disbursement.[335] Use of MIS has also facilitated centralisation of the process of work planning, to the detriment of the *gram panchayats*' authority under the Act to prepare the list of works.[336]

Linking the operation of the Act to the MIS has led to avoidable disruptions and delays caused due to internet connectivity issues and weaknesses in digital infrastructure.[337] Effective implementation of such a complex technological architecture is also constrained by a lack of capacity of local officials and infrastructure.[338]

Changes and features in the MIS are often introduced without consultation with state governments and workers, and directly impact workers' entitlements and work completion. A respondent interviewee states that the use of MIS has been criticised as creating a "black box" of implementation for workers, which instead of increasing transparency, obscures the accountability of local officials. While the MIS has helped to promote transparency and access to information for bureaucrats and researchers and those with digital literacy, it has not yielded the same benefits for the workers' themselves, who remain constrained in accessing access and using the MIS to collect relevant information. A lack of an effective grievance redressal system has compounded the problem.[339]

330Government of Meghalaya, State Rural Employment Society. (n.d.) Management Information System. Available at: https://megsres.nic.in/management-information-system; Ankita, A. (2017). Tyranny of MGNREGA's monitoring system. *Economic and Political Weekly*, *52*(37), p.24

331 NREGAsoft : Strengthening National Rural Employment Guarantee Scheme (NREGS) implementation. (n.d). Available at:https://nrega.nic.in/netnrega/iceg.pdf

332 Comptroller and Auditor General of India. (2013, April). Performance Audit of Mahatma Gandhi National Rural Employment Guarantee Scheme of Union Government, Ministry of Rural Development. Available at: https://cag.gov.in/en/audit-report/details/704

333 Ibid., p. 119

334 Ibid., p. 123

335 Khera, R. (2016, March 17). MGNREGA: Technology vs Technocracy. *Ideas for India*. Available at: https://www.ideasforindia.in/topics/poverty-inequality/mnrega-technology-vs-technocracy.htm

336 Aggarwal, A. (2017). Tyranny of MGNREGA's monitoring system. *Economic and Political Weekly*, *52*(37), p.25

337 Aggarwal, A. (2017). Tyranny of MGNREGA's monitoring system. *Economic and Political Weekly*, *52*(37), p.24

338 Aggarwal, A. (2017). Ten ways MGNREGA workers do not get paid. *Economic and Political Weekly*, *52*(6), 2349-8846. Available at: https://www.epw.in/journal/2017/6/web-exclusives/ten-ways-mgnrega-workers-do-not-get-paid.html

339 Aggarwal, A. (2017). Ten ways MGNREGA workers do not get paid. *Economic and Political Weekly*, *52*(6), 2349-8846. Available at: https://www.epw.in/journal/2017/6/web-exclusives/ten-ways-mgnrega-workers-do-not-get-paid.html

Aadhaar based Payment Systems (ABPS)
The near ubiquitous and compulsory usage of Aadhaar in welfare schemes can be seen in MGNREGA as well. In 2017, workers enrolled under MGNREGA mandatorily had to provide their Aadhaar numbers for getting their wages through the mechanism of Direct Benefit Transfer (DBT).[340] DBT is used in many welfare schemes for transfer of subsidies and cash benefits directly to the "beneficiaries" through their Aadhaar-seeded bank accounts, with the aim of eliminating leakages, reducing corruption and improving efficiency.[341] It is utilised in several health schemes and programmes, including provision of nutritional support to TB patients, family planning compensation, cash assistance in safe motherhood interventions and payment to ASHAs and contractual staff under the National Health Mission.

Serious problems with the enrolment and receipt of DBT have been documented across welfare schemes. Issues range from creation of bank accounts without the knowledge or consent of DBT recipients, errors or failures in Aadhaar-bank account seeding, incorrect spellings in Aadhaar IDs and duplication of Aadhaar IDs leading to rejected payments, diverted payments, and large scale scams involving siphoning off subsidies and scholarships.[342] In MGNREGA, linking of job cards with incorrect Aadhaar numbers or incorrect bank account details has resulted in reports of non-payment of wages.[343] Moreover, under pressure to meet the 100 percent Aadhaar seeding target, officials seem to have resorted to deletion of genuine job cards, leaving applicants under MGNREGA without work.[344]

Currently, payments to workers can be done through two modes: bank account transfer, and the Aadhaar-based payment system (ABPS). The central government is now pushing for ABPS as the only mode, mandating payment of all wages through the system by 30 June 2023. The ABPS uses the person's Aadhaar number (that is, the Unique Identification Number) as a financial address and allows financial transactions to the last-linked bank account using the Aadhaar authentication infrastructure. The worker's job card and bank account have to be seeded with Aadhaar, and the bank account needs to be mapped to the National Payments Corporation of India (NPCI), with consent required for both steps.[345] Critics have pointed out that the ABPS involves complex and burdensome mapping and seeding procedures and Know Your Customer (KYC) requirements, and errors in any of these steps can lead to misdirected or rejected payments.[346] Concerns about ABPS have also been brought up before

---

340 Government of India, Ministry of Rural Development. (2017, July 1). Notification regarding camps for seeding of Aadhar in the accounts of MGNREGS workers for Direct Benefit Transfer. Available at: https://nrega.nic.in/netnrega/writereaddata/Circulars/2176Aadhar_seeding_letter.pdf
341 See https://dbtbharat.gov.in/scheme/scheme-list for list of schemes using DBT
342 Narayan, A. (2022, July 4). Payment Failures in Direct Benefit Transfers. *Dvara Research.* Available at: https://www.dvara.com/research/blog/2022/07/04/payment-failures-in-direct-benefit-transfers/; Wagner, N. and Dhorajiwala, S. (2019, March 2017). A Bridge to Nowhere. *The Hindu.* Available at: https://www.thehindu.com/opinion/lead/a-bridge-to-nowhere/article62110043.ece; Rethink Aadhaar (2020, November 25). Yet another Aadhaar-enabled scam: When will the Government wake up?. Available at: https://rethinkaadhaar.in/blog/2020/11/25/yet-another-aadhaar-enabled-scam-when-will-the-government-wake-up; Narayanan, R. and Dhorajiwala, S. (2019, December 9). The Namesake: Human Costs of Digital Identities. *Economic and Political Weekly.* Available at: https://www.epw.in/engage/article/namesake-human-costs-digital-identities
343 Sen, J. (2017, July 20). Errors and Exclusion Mark Jharkhand's Aadhaar-MGNREGA Link. *The Wire.* Available at: https://thewire.in/government/aadhaar-card-jharkhand-mgnrega
344 Sen, J. (2017, July 20). Errors and Exclusion Mark Jharkhand's Aadhaar-MGNREGA Link. *The Wire.* Available at https://thewire.in/government/aadhaar-card-jharkhand-mgnrega; Bhaskar, A., Singh, P. (2020, September 18). Plug the gaps: Aadhar and MGNREGA. *The Telegraph.* Available at: https://www.telegraphindia.com/opinion/plug-the-gaps-aadhar-and-mgnrega/cid/1792297
345 Dreze, J. (2023, February 16). Making Aadhaar-Based Payments Compulsory for NREGA Wages Is a Recipe for Disaster. *The Wire.* Available at: https://thewire.in/rights/aadhaar-payments-compulsory-nrega
346 Narayanan, R. et al. (2021, October 27). Heavy Wait: Wage Payment Delays in NREGA by the Central Government across Caste and Payment Type from April, 2021 to September 2021. *LibTech India,* p. 16. Available at: http://libtech.in/wp-content/uploads/2021/11/Heavy-Wait_LibTech_NREGAPaymentDetailsCastePaymentType_AprilSep2021_FINAL.pdf; Dhorajiwala, S. and Wagner, N. (2019, August 23). Consent to nothing: Aadhaar-based payment systems in welfare. *Ideas for India.* Available at: https://www.ideasforindia.in/topics/governance/consent-to-nothing-aadhaar-based-payment-systems-in-

the Supreme Court in an ongoing petition filed by Swaraj Abhiyan challenging pending wage payments, where the cumbersome nature of Aadhaar mapping for ABPS and the fact that a large number of workers did not have Aadhaar-linked bank accounts was highlighted.[347]

A study in Jharkhand which interviewed rural bank officials found that the rushed and forced implementation of ABPS and pressure to meet seeding and mapping targets led to confusion amongst bank officials and frequent flouting of consent norms. The pressure to implement the system also left officials grappling with an inadequate information technology (IT) system that was unable to weed out human errors in data entry, with serious consequences for recipients of welfare benefits.[348] Payment failures through ABPS, involving NCPI software mapping problems or misdirected payments, are notoriously difficult to resolve at the local level, with no grievance redressal mechanism set up under the Unique Identification Authority of India (UIDAI), the body responsible for implementing Aadhaar.[349] Payment failures are discouraging workers from applying for work under the Act.[350] The government's claims of ABPS reducing wage payment delays or increasing savings have been shown to be unsupported by evidence, leading to questions on the need for it being mandated for payment of MGNREGA wages.[351] Mandatory use of the ABPS is also concerning in light of reported cases across India of financial fraud involving cloning of Aadhaar biometric data, which points to inherent vulnerabilities in the payment infrastructure and the real possibility of workers losing their wages to errors or fraud.[352] Data from the beginning of 2023 also shows that 57 percent of workers were ineligible for ABPS raising further questions around the compulsory and exclusive nature of this mode of payment.[353]

National Mobile Monitoring Software (NMMS)

In May 2022, the Ministry of Rural Development mandated the use of a mobile application called National Mobile Monitoring Software (NMMS) for capturing the attendance of workers at worksites with 20 or more workers. This was extended to all works except individual beneficiary works in January 2023.[354] The app has to be used by mates (worksite supervisors). Geotagged and time stamped photos of workers at the worksite have to be uploaded twice a day, once in the morning and once in the evening. It was launched with the belief that the app will ensure more transparency in the implementation of the Act, increase citizen oversight and potentially make payment processing faster.[355] But it has been pointed out that there is no mechanism in the app to authenticate and verify that the photographs taken match those of registered workers, raising questions about the app's

welfare.html; Khera, R. (2019, April 6). Aadhaar Failures: A Tragedy of Errors. *Economic and Political Weekly (Engage).* Available at: https://www.epw.in/sites/default/files/engage_pdf/2019/04/05/154121.pdf

[347] LiveLaw News Network. (2023, April 19). 'Let Governments And Politics Be Out Of It': SC Seeks Centre's Response On Plea For Pending Wages of MNREGA Workers. Available at: https://www.livelaw.in/top-stories/supreme-court-pending-payment-of-mnrega-workers-bank-accounts-linking-with-adhaar-central-government-swaraj-abhiyan-226691

[348] Dhorajiwala, S. and Wagner, N. (2019, August 23). Consent to nothing: Aadhaar-based payment systems in welfare. *Ideas for India.* Available at: https://www.ideasforindia.in/topics/governance/consent-to-nothing-aadhaar-based-payment-systems-in-welfare.html

[349] Narayanan, R. (2021, December 30). The Efficiency Myth of Aadhaar Linking. *The Hindu.* Available at: https://www.thehindu.com/opinion/op-ed/the-efficiency-myth-of-aadhaar-linking/article38067084.ece

[350] Sen, J. (2017, July 20). Errors and Exclusion Mark Jharkhand's Aadhaar-MGNREGA Link. *The Wire.* Available at: https://thewire.in/government/aadhaar-card-jharkhand-mgnrega

[351] Narayanan, R. (2021, December 30). The Efficiency Myth of Aadhaar Linking. *The Hindu.* Available at: https://www.thehindu.com/opinion/op-ed/the-efficiency-myth-of-aadhaar-linking/article38067084.ece

[352] Das, M. (2023, March 4). Cybercriminals 'cloning' Aadhaar biometric data to commit fraud: MHA nodal agency to states. *The Print.* Available at: https://theprint.in/india/governance/cybercriminals-cloning-aadhaar-biometric-data-to-commit-fraud-mha-nodal-agency-to-states/1415112/

[353] Counterview. (2023, February 17). Aadhaar, app-based payments order to deprive 57% rural workers of NREGA wages. Available at: https://www.counterview.net/2023/02/aadhaar-app-based-payments-order-to.html

[354] Ministry of Rural Development. (2023, March 21). National Mobile Monitoring System (NMMS) App for MGNREGS. Available at: https://rural.nic.in/en/press-release/national-mobile-monitoring-system-nmms-app-mgnregs

[355] Ministry of Rural Development. (2022, May 13). Notification regarding mandatory attendance through NMMS app, Available at: https://nrega.nic.in/netnrega/writereaddata/Circulars/2451Mandatory_attendance_through_NMMSapp.pdf

ability to check fake attendance.[356] Workers are also facing loss of wages due to the app malfunctioning, lack of sophisticated mobile handsets that can support the app, and network connectivity gaps which have resulted in workers' attendance not being marked.[357] Some mates even had to take loans to buy smartphones to use the app.[358] Another design flaw that has resulted in the app undermining its own objectives is that the language of the app is English, thus rendering it unintelligible for most of its intended users.[359] The mandatory use of the app was imposed without any independent evaluation of the technology, and there is no publicly available information on whether the app went through any standardisation and quality testing processes.[360]

The three tools examined above suggest that technological fixes are seldom evaluated before being put to use and more often than not are brought in at a large scale while the system, infrastructure and bureaucracy are ill-prepared for the deployment of the technology. It's the workers who bear the brunt of this. Technological design has facilitated opaqueness, centralization and weakening of local institutions. Errors, such as incorrect Aadhaar numbers or bank account numbers in the MIS database or deleted job cards, are very difficult to identify and even more difficult to rectify. What earlier could have been remedied at the local official level now may need the intervention of a block-level or state-level official.[361] Due to pressure to meet certain targets such as 100 percent Aadhaar seeding or 100 percent DBTs, officials are enabled by technological design to side-step their duties and deprive workers of their entitlements by manipulating data or simply deleting their job cards. Lack of an effective and accessible grievance redressal system further complicates the problem of lack of accountability.

6.1.6 Key Issue: Social audit

MGNREGA was the first legislation to mandate social audits of works carried out under the law. The process of social audits fosters community awareness, participation in and monitoring of MGNREGA. It functions as an important tool for transparency and accountability by making the implementers directly answerable to the workers. A respondent interviewee states that social audits are "*one of the vital arms*" of rights-based legislations, and "*a step from transparency to accountability*."

As per section 17 of MGNREGA, the *gram sabha* is responsible for conducting regular social audits of all projects taken up by the *gram panchayat*, and the latter has to make available all relevant

---

356 Narayanan, R. (2023, April 29). Technocratic subversion of MGNREGA. *Economic and Political Weekly*. Available at: https://www.epw.in/system/files/pdf/2023_58/17/ED_LVIII_17_290423_Technocratic%20Subversion%20of%20MGNREGA.pdf

357 Kaman, P. (2022, May 28). Faulty NMMS app affecting monitoring of MGNREGA works. *The Arunachal Times*,. Available at: https://arunachaltimes.in/index.php/2022/05/28/faulty-nmms-app-affecting-monitoring-of-mgnrega-works/; Zee News Rajasthan. (2022, June 21). In MNREGA the new version NMMS became a dilemma. (Trans.). Available at: https://zeenews-india-com.translate.goog/hindi/india/rajasthan/bhilwara/new-version-nmms-in-mnrega-has-become-a-dilemma-instead-of-convenience-for-workers-does-not-seem-to-be-present/1227610?_x_tr_sl=hi&_x_tr_tl=en&_x_tr_hl=en&_x_tr_pto=sc, Ali, A. (2022, August 3). A mobile app is costing India's poorest workers their wages. *Coda Story.* Available at: https://www.codastory.com/authoritarian-tech/app-watches-indias-workers/

358 The Times of India. (2022, August 3). *Delhi: Guaranteed work, but not pay? NREGA workers rue 'endless wait.* Available at: https://timesofindia.indiatimes.com/city/delhi/delhi-guaranteed-work-but-not-pay-nrega-workers-rue-endless-wait/articleshow/93307456.cms

359 Newsclick. (2022, June 21). Use of App to Record MGNREGA Attendance 'Violation' of Worker Rights, Act. Available at: https://www.newsclick.in/use-app-record-MGNREGA-attendance-violation-worker-rights-act

360 Gaur, N. (2023, February 23). Why is the App-based Attendance System Agitating MGNREGA Workers?. *Newsclick.* Available at: https://www.newsclick.in/why-app-based-attendance-system-agitating-mgnrega-workers; IANS (2023, March 28). From people's scheme to tech quagmire: How digital 'surgical strike' hits MGNREGA workers. *The Economic Times*. Available at: https://economictimes.indiatimes.com/tech/technology/from-peoples-scheme-to-tech-quagmire-how-digital-surgical-strike-hits-mgnrega-workers/articleshow/99053951.cms

361 Aggarwal, A. (2017). Ten ways MGNREGA workers do not get paid. *Economic and Political Weekly*, *52*(6), 2349-8846. Available at: https://www.epw.in/journal/2017/6/web-exclusives/ten-ways-mgnrega-workers-do-not-get-paid.htmll

documents for this purpose. It involves a review of expenditures, implementation of all conditions for guaranteed rural employment, provision of minimum entitlements to workers and status of works. The *MGNREG Audit of Schemes Rules, 2011* (Social Audit Rules) further elaborates on the social audit process. Independent social audits of works, facilitated by the state government through Social Audit Units (SAUs), have to be conducted in every *gram panchayat* at least once in six months. The Rules lay down the roles of the SAU, which include building capacities of *gram sabha*s to conduct social audits, and making labourers aware of their rights and entitlements. The resource persons involved in auditing the works in a *panchayat* cannot be residents of the same *panchayat*. Findings of the verification exercise are discussed at the *gram sabha* level, attended by relevant functionaries under the Act. The social audit reports are to be prepared in local language by the SAU and publicly disseminated. The District Programme Coordinator is responsible for ensuring that corrective action is taken on the social audit report, amounts embezzled or misappropriated are recovered, and that action is taken against persons responsible for embezzling or mis-utilizing funds. Social audit reports ultimately have to reach the central government, which has to lay the audit reports before each house of Parliament.

While one respondent interviewee was of the view that institutionalisation of social audits (as compared to civil society led audits) has led to watering down of the potential of social audits, another respondent interviewee was of the view that social audits have to be facilitated by the government. Nevertheless, social audits have been found to be useful in the implementation of MGNREGA. According to a respondent interviewee, social audits help citizens access "*hidden information*" that they would otherwise not be privy to, such as funds spent on materials and wages. They have exposed corruption and irregularities in implementation. For example, in Jharkhand, social audits revealed issues related to fake muster rolls, use of machinery in works, delayed payments, expenditures made for work that had not started, non-inclusion of workers names in muster rolls and other instances of financial forgery.[362] A respondent interviewee observed that even if these findings were not followed up by the administration, it led to public condemnation and pressure, and thus improved implementation.

Social audits have also been found to provide an effective platform for citizens to engage with local officials and empower them to make claims on the State, along with reducing wage-related corruption.[363] In many situations, social audits have taken on the function of grievance redressal of individual wage workers' complaints, though they were not meant to take on that role.[364]

However, effectiveness of social audits has been hampered by slow or no enforcement of audit findings, government apathy towards setting up and making operational SAUs, and lack of support from senior officials.[365] Reporting and management structures which hinder the ability of the Department of Rural Development to take disciplinary action against erring officials hamper enforcement, as does bureaucratic suspicion of the technical capacity of auditors.[366] Excessive bureaucratisation of social audits in Andhra Pradesh, which places accountability for implementation on bureaucrats and not politicians, has also been found to contribute to weak effectiveness of audits. The political system has been found to be linked to corruption in MGNREGA, and by not bearing the

[362]Mukesh, A. (2022, January 18). Irregularities found in implementation of MNREGA in state, claims social audit. *Times of India*. Available at: https://timesofindia.indiatimes.com/city/ranchi/irregularities-found-in-implementation-of-mnrega-in-state-claims-social-audit/articleshow/88961559.cms

[363] Aiyar, Y., and Mehta, S. K. (2015). Spectators or participants? Effects of social audits in Andhra Pradesh. *Economic and Political Weekly*, 66-71, *p. 67, 69*

[364]Pande, S., and Dubbudu, R. (2018, May 10). Improving Social Audits,. *The Hindu*. Available at: https://www.thehindu.com/opinion/op-ed/improving-social-audits/article23828790.ece

[365] Ibid.

[366] Y Aiyar, Y., and Mehta, S. K. (2015). Spectators or participants? Effects of social audits in Andhra Pradesh. *Economic and Political Weekly*, 66-71, *p. 68*

responsibility for delivering on MGNREGA through *panchayat*s, effective containment of corruption is hindered.[367]

In Karnataka, the capacity of *gram panchayat*s to conduct impartial social audits was hampered by capture of the process by influential people in the village, such as landowners or large farmers who had conflicting interests with agricultural labourers.[368] There was inadequate participation of women and SC/ST members in social audits, no gender-sensitive design features which promote women's participation, and no robust mechanism for capacity-building of workers. Participation of workers was further hampered as social audits were held at a time when they would be at work.[369]

This review of MGNREGA and its implementation sheds light on the importance of social audits towards community mobilisation, following a bottom-up approach and involving communities, generating political will, the pitfalls of over-reliance on technology and the significance of a law towards the realisation of the right to employment.

6.2 Right of Children to Free and Compulsory Education Act 2009 (RTE Act)

6.2.1 Overview

The longstanding demand of ensuring primary education for all children, most prominently reflected in Article 21A[370] and Article 45[371] of the Constitution of India, culminated in the passage of the *Right of Children to Free and Compulsory Education Act 2009 (RTE Act)*. Accordingly, the RTE Act guarantees free and compulsory education for all children between 6 and 14 years. It imposes positive obligations on (a) the State, including ensuring the availability of a school in every neighbourhood (Section 6), regulating the quality of elementary education as per prescribed norms and standards (Sections 18-20), and ensuring rational deployment of teachers (Sections 23-28); (b) private schools, including reserving 25 percent of the total number of seats in entry level classes for economically weaker and disadvantaged groups (Section 12) and complying with all the norms and standards of education as set out under the law (Sections 18-22); and, (c) teachers, including being regular and punctual in attending schools and completing the curriculum as prescribed by law (Section 24). In addition to this, the RTE Act expressly prohibits certain activities that may act as barriers to education, including prohibition of capitation fees, screening procedure for admission, proof of age for admission, denial of admission, unrestricted holding back or expulsions, physical and mental harassment (Sections 13-17).

The RTE Act, however, has not been without controversy. Right from its inception, various provisions of the law have been subject to litigation before the Supreme Court and various High Courts. The most publicised of these cases related to the application of the RTE Act to private schools, particularly Section 12 related to 25 percent reservation for economically weaker and disadvantaged groups. In *Society for Unaided Private Schools of Rajasthan vs Union of India*,[372] the petitioners argued that the RTE Act is an unreasonable restriction on the fundamental right to carry on trade and business under Article 19(1)(g) of the Constitution of India. The Supreme Court rejected the argument on two grounds. First, the right to education, by virtue of Articles 21A and 51A(k), places a positive obligation on all

---

367 Ibid*, pp. 69 to 71*

368Rajasekhar, D., *et al* (2013). How Effective are Social Audits under MGNREGS? Lessons from Karnataka*. Sociological Bulletin.* September – December 2013, Vol. 62, No. 3*,* p. 449

369 Kumar, S., and Madheswaran, S. (2019). Social audit of MGNREGA-A panacea or a placebo? Issues and ways forward in Karnataka. *The Institute for Social and Economic Change, Bangalore*. No. 457. 2019, p.27

370 Article 21A states: "The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine."

371 Article 45 states: "The State shall endeavour to provide, within a period of ten years from the commencement of this Constitution, for free and compulsory education for all children until they complete the age of fourteen years."

372 *Society for Unaided Private Schools of Rajasthan v Union of India* 2012 6 SCC 1, para 10, Available at: https://indiankanoon.org/doc/154958944/

stakeholders including the State, private companies, parents and civil society. Second, the fundamental right to run an educational institution does not include the right to ask for recognition, and the State can impose permissible limits on the exercise of this right. This includes the condition to provide 25 percent reservation to economically weaker and disadvantaged groups under Section 12. While upholding the constitutional validity of the RTE Act, the court exempted private unaided minority educational institutions from complying with the 25 percent reservation criteria.[373] The exemption was extended to private aided minority education institutions in *Pramati Education and Cultural Trust v Union of India*.[374]

In effect, the RTE Act seeks to provide a framework for the realisation of the fundamental right to education by removing financial, social and other barriers to access to public and private educational institutions (other than minority institutions). Successful implementation of the law entails setting up a robust administrative machinery including community engagement and grievance redress mechanisms, strengthening public educational institutions by mobilising adequate resources, engaging and regulating the private sector, and the identification of economically weaker and disadvantaged groups. These factors have also underpinned the implementation of existing government health insurance schemes, including the Government of India's AB-PMJAY. Hence, examining implementation of these aspects of the RTE Act, the challenges faced and the lessons learnt, can help inform the systems and processes for effective UHC delivery in India.

This review of the RTE Act is divided into five categories, i.e., resource availability (with a specific focus on physical and human resources), administrative machinery, transparency and accountability mechanisms, the use of technology and the regulation of the private sector which is a unique feature of the Act.

6.2.2 Availability of Resources

The quality of public educational institutions is impeded by inadequate availability of financial, physical and human resources. In order to address this, the RTE Act obligates the State to ensure availability of a school in every neighbourhood, as well as adequate resources to run these schools (Sections 6-9).

A respondent interviewee stated that many government schools were already set up as part of the *Sarva Shiksha Abhiyan*, a government programme aimed at the universalisation of elementary education, prior to the enactment of the RTE Act.[375] However, these schools faced several shortages, particularly related to adequate availability of infrastructure and human resources. Although it was expected that the RTE Act would address these issues, this did not happen due to poor planning and implementation on the ground. One of the primary reasons for this is successive governments have failed to prioritise education as part of their agenda, due to poor articulation of the demand for education by communities and lack of a long-term vision. That being said, some states like Assam and Delhi have earmarked 20 percent of their budget on education, mostly due to widespread social mobilisation and pressure from civil society organisations. Another respondent interviewee expressed disappointment with the manner in which states have discharged their obligation, especially in the last few years where several government schools in tribal areas have closed down because they cater to a small number of students.

Several public interest litigations before the Supreme Court and High Courts have prayed for the State to discharge its obligation in a satisfactory manner. The Supreme Court, in 2012, directed all state governments to ensure availability of adequate toilet facilities for boys and girls, drinking water

---

[373] Ibid, para 19
[374] 2014 8 SCC 1, para 46. Available at: https://indiankanoon.org/doc/32468867/
[375] The *Sarva Shiksha Abhiyan*, along with *Rashtriya Madhyamik Shiksha Abhiyan* and *Teacher Education*, was subsumed under the *Samagra Shiksha Abhiyan* in 2018.

facilities, sufficient class rooms, appointment of teaching and non-teaching staff etc., within six months.[376] In the same year, the Delhi High Court directed the Delhi administration to appoint special educators and ensure barrier-free movement and access to school premises for children with disabilities.[377] In 2016, the Uttarakhand High Court prohibited the state practice of hiring teachers without clearing the mandatory teacher evaluation test.[378] However, court orders seem to have limited effect on the ground. In 2014, the National Coalition for Education filed a writ petition before the Supreme Court of India for effective implementation of the RTE Act, including mandating the central and state governments to upgrade facilities and infrastructure in deficient schools and training teachers to meet the prescribed pupil-teacher ratios. The petition was dismissed in 2015 with liberty to the petitioner to approach the High Courts.[379] Some argue that the process of using litigation can only be successful when litigation is supported continuously by a strong and organised social movement, like in the case of the right to information campaign and the right to food movement.[380] A respondent interviewee recommended that courts could appoint commissioners to monitor the implementation of the RTE Act, as was done in the case of the right to food case. That being said, approaching courts is an expensive and lengthy affair in India. Hence, there may be a need for structural mechanisms, like social audits, for monitoring implementation of the RTE Act.

Existing literature on resource requirements for education provide key insights on the extent and nature of the problem, and the resulting policy implications. In general, the Education Finance Watch 2021 noted that government spending on education in low- and middle-income countries is insufficient for achieving sustainable development goals.[381] In India, the total expenditure on education as a percentage of GDP, including the central and state governments, increased from about 4 percent in 2010-11 to 4.64 percent in 2020-21.[382] While the central government's share increased from 1.11 percent to 1.13 percent in the same period, the state governments' share increased from about 3 percent to 3.52 percent.[383] More than half of the total expenditure focusses on elementary education and the least amount of emphasis is on secondary education.[384] A 2017 study finds that compared to the total requirement of public expenditure, actual expenditure is very low especially in most backward states, such as Bihar, Jharkhand and Odisha.[385] They highlight several deficiencies in the education policy space, including a declining trend in allocations towards *Sarva Shiksha Abhiyan*, decelerating growth rate of expenditure on elementary education by states to comply with fiscal rules, and greater burden of spending on the poor performing states as the central government treats all states equally. They recommend the need for careful strategic planning to prioritise expenditure on elementary education, due consideration to equalisation of funds and regular consultations between the central and state governments to address genuine concerns on matters of equity and autonomy. A respondent interviewee criticised the centralised manner in which public expenditure on education

---

376 Order dated 3 October 2012, in *Environment and Consumer Protection Foundation vs Delhi Administration*, Supreme Court Writ Petition (Civil) No. 631 of 2004, para 9. Available at: https://main.sci.gov.in/jonew/judis/39616.pdf

377 Order dated 5 September 2012, in *Social Jurist vs Government of NCT of Delhi*, Delhi High Court Writ Petition (Civil) No. 4618 of 2011, para 22. Available at: https://indiankanoon.org/doc/127208626/

378 Order dated 16 November 2016, in *Lalit Kumar vs State of Uttarakhand*, Uttarakhand High Court Writ Petition (Civil) No. 1576 of 2016. Available at: https://indiankanoon.org/doc/113304533/

379 Order dated 4 September 2015, in *National Coalition for Education vs Union of India*, Supreme Court Writ Petition (Civil) No. 267 of 2014. Available at: https://main.sci.gov.in/jonew/ropor/rop/all/351759.pdf

380 Rosser A., & Joshi, A. (2018). *Using Courts to Realise Education Rights: Reflections from India and Indonesia*. Policy Research Working Paper 8448. World Bank Group, p. 24.

381 Al-Sammarai, S. et al. (2021). *Education Finance Watch 2021 (English)*. World Bank Group, pp. 4-5. Available at: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/226481614027788096/education-finance-watch-2021

382 Government of India (2022). *Analysis of budgeted expenditure on education: 2018-19 to 2020-21.* Department of Higher Education, Ministry of Education, Government of India, pp. 7-8. Available at: https://www.education.gov.in/sites/upload_files/mhrd/files/statistics-new/budget_exp.pdf

383 Ibid.

384 Ibid.

385 Bose, S. et al (2017). *Resource requirements for Right to Education (RTE): Normative and the Real*. Working Paper No. 201 of 2017. National Institute of Public Finance and Policy, pp. 36-40. Available at: https://www.nipfp.org.in/media/medialibrary/2017/12/WP_2017_201.pdf

is determined, and recommended that funding should be determined according to the needs of every district.

With the onset of COVID-19 in 2020, education budgets declined in 65 percent of low- and middle-income countries including India.[386] In 2021, the central government budgetary allocation on key government programmes to promote school education, including the *Samgra Shiksha Abhiyan*, *Mid-day Meals Scheme* and *the National Education Mission*, further declined.[387] Since then, there has been an increase in the budgetary allocation for education to overcome learning losses due to COVID-19.[388] In spite of the increments, the government is far from achieving the target set out under the *National Education Policy 2020* and a large portion of the allocations are towards *Pradhan Mantri Schools for Rising India*, a centrally-sponsored scheme for development of existing schools.[389]

Some researchers have examined the issue of teacher availability, the most expensive resource in education, in public elementary schools in India.[390] They find that the net deficit in teachers is only about a quarter of the official estimate of one million teachers. A state-wise analysis shows that the majority of teacher vacancies exist in five states, being Bihar, Uttar Pradesh, Jharkhand, Madhya Pradesh and Karnataka; fourteen states have a net teacher surplus. They recommend that the central government provide states with a common methodology for estimating teacher vacancies, state governments should provide data on actual enrollment so that teacher allocation is not based on fake enrollment data from schools' self-reported numbers, and the need for making teacher allocation rules more evidence-based.

A respondent interviewee observed that there is both a shortage of teachers in absolute numbers, as well as a skewed distribution of available teachers. Karnataka has sought to address this issue through a computerised system for teacher recruitments, and giving teachers a say in their placements. Another respondent interviewee recommended that teacher recruitments should take place at the panchayat level, as is the case in Kerala. Apart from this, the central and state governments have not invested in teacher education and training. As a result, the quality of teacher education is sub-standard, as noted by the 2012 Justice Verma Commission report.[391] In 2022, the pupil-teacher ratio under the RTE Act was amended to ensure one special education teacher for every ten pupils with disabilities at the primary level and one special education teacher for every fifteen pupils with disabilities at the upper-primary level.[392]

---

386 Al-Sammarai, S. et al. (2021). *Education Finance Watch 2021 (English)*. World Bank Group, pp. 8-9. Available at: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/226481614027788096/education-finance-watch-2021

387 Bhatty, K. (2021). Budget 2021 utterly disregards the education catastrophe inflicted by COVID-19. The Wire. Available at: https://thewire.in/education/union-budget-education

388 Iftikhar, F. (2023). *Budget 2023: Education gets highest ever allocation to overcome learning losses*. Hindustan Times. Available at: https://www.hindustantimes.com/india-news/union-budget-2023-education-sector-gets-highest-ever-allocation-centre-plans-digital-library-to-overcome-learning-loss-during-covid19-101675258693213.html; Iftikhar, F. (2022). *Union Budget 2022 gives fillip to Covid-hit education sector*. Hindustan Times. Available at: https://www.hindustantimes.com/india-news/union-budget-2022-gives-fillip-to-covid-hit-education-sector-101643741866571.html

389 Kundu, P. and Patil, R. (2023). *Does Budget 2023 combat the digital divide in schools?*. Centre for Budget and Governance Accountability. Available at: https://www.cbgaindia.org/blog/does-budget-2023-combat-the-digital-divide-in-schools/

390 Datta, S. & Kingdon, G (2021). *The Myth and Reality of Teacher Shortage in India: An Investigation Using 2019-20 Data*. Rise Working Paper Series 21/072, pp. 3-17. Available at: https://riseprogramme.org/sites/default/files/2021-05/Myth_of_Teacher_Shortage_in_India.pdf

391 Government of India (2012). *Vision of Teacher Education in India Quality and Regulatory Perspective: Report of the High-Powered Commission on Teacher Education Constituted by the Hon'ble Supreme Court of India*. Volume I. Department of School Education and Literacy, Ministry of Human Resource Development, Government of India (pp. 10-37). Available at: https://www.education.gov.in/sites/upload_files/mhrd/files/document-reports/JVC%20Vol%201.pdf

392 Ministry of Education (2022). *Year End Review: Ministry of Education*. Press Information Bureau. Available at: https://pib.gov.in/PressReleasePage.aspx?PRID=1887647

With the COVID-19 pandemic, schools across the country shifted to an internet-based model of schooling. Due to low levels of internet penetration and digital literacy in the country, the shift had a devastating impact on elementary education with many children either facing long gaps in education or dropping out altogether. In addition, due to the loss of breadwinners in many households, surviving members faced hardships in paying the school fees of children. This again highlighted the failure of the central and state governments to provide free and compulsory education as mandated under Section 6 of the RTE Act. In 2021, the Supreme Court of India took *suo moto* cognizance of the situation. In August 2021, the central and state governments submitted information about various schemes to provide support to distressed children. The Supreme Court directed state governments to negotiate with private schools to waive the fees of distressed children, and bear the burden of the fees if the schools are unwilling to grant a waiver.[393] In May 2022, the court emphasised the obligation of state governments to ensure education is not disrupted and to take corrective steps in case of any disruption. It directed the National Commission for Protection of Child Rights (NCPCR) to set up a web portal on which the information relating to the action taken by the state governments for continuance of education of children is updated.[394]

However, implementing these orders has been difficult. In October 2022, the Supreme Court had to direct the Delhi government to ensure waiver of school fees of a student of Ryan International school and refund the amount to the school.[395] In January 2023, the court issued a notice to the Delhi government for not implementing the order and directed the NCPCR to collect and analyse data in respect of fee waivers for distressed children in private schools from at least six states.[396] While budgetary allocation on education increased in 2023, the government was criticised for making little investment into building digital infrastructure in schools and providing incentives to ensure children remain in school.[397]

6.2.3 Administrative machinery

The regulatory and administrative machinery set out under the RTE Act includes the National and State Commissions for the Protection of Child Rights, National and State Advisory Councils and grievance redress systems with the local authority (Sections 31-34). The implementation of these provisions has been tardy. In April 2012, the Supreme Court of India directed central and state governments to frame rules under the law within six months, constitute State Advisory Councils within three months and set up a proper regulatory authority for supervision and effective functioning of the law.[398] In October 2012, the Supreme Court of India directed all state governments to constitute State Commissions for the Protection of Child Rights.[399] A 2017 CAG Report noted that the National Advisory Council had not existed since 2014, 7 out of 35 states/UTs had not constituted State Advisory Councils, 13 states/UTs appointed State Advisory Councils only after three years of implementation, and 17 states/UTs did not hold periodic meetings with the State Advisory Councils.[400] In 2021, the Ministry for Women and Child

---

[393] Order dated 26 August 2021, in *In re: Children in Street Situations, Suo Moto Writ Petition (Civil) No. 6 of 2021*. Available at: https://main.sci.gov.in/supremecourt/2020/10820/10820_2020_35_1_29612_Order_26-Aug-2021.pdf
[394] Order dated 9 May 2022, in *In re: Children in Street Situations Children, Suo Moto Writ Petition (Civil) No. 6 of 2021*. Available at: https://main.sci.gov.in/supremecourt/2021/28793/28793_2021_5_32_35647_Order_09-May-2022.pdf
[395] Order dated 18 October 2022, in *In re: Children in Street Situations, Suo Moto Writ Petition (Civil) No. 6 of 2021*. Available at: https://main.sci.gov.in/supremecourt/2021/28793/28793_2021_8_46_39077_Order_18-Oct-2022.pdf
[396] Order dated 6 January 2023, in In re: Children in Street Situations, Suo Moto Writ Petition (Civil) No. 6 of 2021. Available at: https://main.sci.gov.in/supremecourt/2021/28793/28793_2021_8_42_40752_Order_06-Jan-2023.pdf
[397] Id. at 388.
[398] *Society for Unaided Private Schools of Rajasthan v Union of India* 2012 6 SCC 1, para 147-149
[399] *Environment and Consumer Protection Foundation v Delhi Administration*, Writ Petition (Civil) No. 631 of 2004, para 8. Available at: https://indiankanoon.org/doc/174516822/
[400] Comptroller and Auditor General of India (2017). *Report of the Comptroller and Auditor General of India on Implementation of Right of Children to Free and Compulsory Education Act, 2009*. Report No. 23 of 2017. Ministry of Human Resource Development, Union Government (paras 4.2 and 4.3). Available at: https://www.cag.gov.in/uploads/download_audit_report/2017/Report_No.23_of_2017_%E2%80%93_Compliance_audit_Union_Government_Implementation_of_Right_of_Children_to_Free_and_Compulsory_Education_Act,_2009.pdf

Development reported that State Commissions for the Protection of Child Rights had been set up in all states/UTs other than Jammu and Kashmir and Ladakh.[401]

The quality of regulation and oversight is also a key issue in the implementation of the Act. Gorur and Arnold note that the NCPCR has struggled to perform its duties under the RTE Act because it mostly relies on short term contractual staff and has a complicated approval process for the exercise of any powers.[402] A respondent interviewee observed that the NCPCR and various state commissions monitor schools only when petitions are filed. There is no system to monitor schools on a regular basis. Another respondent interviewee emphasised the need for an independent regulator to oversee the implementation of the RTE Act.

A 2019 case study argues that the mere act of enacting the RTE Act does not guarantee the provision of primary education, and implementation requires an enabling environment. Through the examples of Kerala and Bihar, the study shows that the relative success of Kerala in the implementation of the RTE Act can be attributed to the long-standing history of education reforms, greater role of Panchayati Raj Institutions, space for citizen participation, political will and the decline of the traditional hegemonic order.[403]

6.2.4 Accountability and Transparency

The RTE Act seeks to provide accountability through a grievance redress mechanism and school management committees. All respondent interviewees observed that these tools are very weak and have not been adequately institutionalised.

In case of any grievance related to the rights of a child, any individual can make written complaints before the designated local authority (Section 32).[404] The literature examining the design and performance of the grievance redress system reveals that it is far from being implemented in a manner that ensures legal accountability of the regulator(s) and the regulated entities. A 2018 study notes that bodies responsible for grievance redress under the RTE Act had been set up in only 14 states till 2012, and were seriously understaffed.[405] This has contributed to the increased number of cases before courts at various levels. Although the implementation status has improved considerably since then, human resource constraints continue to plague the system. Two other studies provide a more in-depth account of the RTE grievance redress system in the state of Karnataka. They note several discrepancies, including the appointment of multiple local authorities with overlapping jurisdictions for grievance redress, severe conflict of interest as authorities responsible for implementing the RTE Act are also running the grievance redress system, limited time for grievance redress as the authorities are saddled with other functions unrelated to education, no systems for monitoring the pendency of

---

[401] Ministry for Women and Child Development, Government of India (July 2021). *State Commission for Protection of Child Rights*. Press Information Bureau. Available at: https://www.pib.gov.in/PressReleasePage.aspx?PRID=1737767

[402] Gorur, R. and Arnold, B. (2022). *Regulating private sector schooling in the global south: the case of India*. Compare: A Journal of Comparative and International Education, *52*(3), pp. 9-10. Available at: https://www.tandfonline.com/doi/abs/10.1080/03057925.2020.1766947

[403] Ray, S. and Saini, S. (2015). *Efficacy of rights-based approach to education: A comparative study of two states of India*. Policy Futures in Education, *14*(2), pp. 280-282. Available at: https://journals.sagepub.com/doi/full/10.1177/1478210315618543

[404] Under Section 2(h) of the RTE Act, 'local authority' refers to the Municipal Corporation or Municipal Council or Zila Parishad or Nagar Panchayat or Panchayat, and includes any other authority that has administrative control over the school or empowered to function as a local authority of any city, town or village.

[405] Rosser A., and Joshi, A. (2018). *Using Courts to Realise Education Rights: Reflections from India and Indonesia*. Policy Research Working Paper 8448. World Bank Group (pp. 19-20). Available at: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/430461526912602601/using-courts-to-realize-education-rights-reflections-from-india-and-indonesia

complaints, an ineffective appellate authority, lack of specificity of remedies, and lack of awareness about the grievance redress system especially in rural areas.[406]

Apart from this, parents can also question the functioning of schools through school management committees. Under the RTE Act, schools are required to set up school management committees to monitor their functioning, and must include representation from the local authority, parents and teachers (Section 22). A respondent interviewee noted that governments have not invested in institutionalising school management committees. Moreover, access to these committees has been difficult. A respondent interviewee stated that most parents, particularly first-generation parents, lack capacity to participate in committee meetings. Moreover, the committees themselves generally discourage any questions on the functioning of the school, and do not send out proper invitations regarding committee meetings.

6.2.5 Use of technology

The COVID-19 pandemic and lockdowns disrupted access to education in India. It led to the closure of 1.5 million schools in 2020 and impacted 247 million students enrolled in elementary and secondary education.[407] In April 2020, the Ministry of Education announced guidelines for an Alternative Academic Calendar on continuing formal education online.[408] Digital education platforms such as Digital Infrastructure for Knowledge Sharing (DIKSHA), e-Pathshala, National Repository of Open Educational Resources (NROER) and National Digital Library came to be used to assist teachers and students in remote learning.

However, problems with internet connectivity, lack of digital infrastructure in schools and low levels of digital literacy meant that the transition was not easy for many students and teachers. A 2020 survey covering Odisha, Bihar, Jharkhand, Chhattisgarh and Uttar Pradesh highlights that 80 percent of parents of children in government schools reported that education was not delivered during the lockdown and 84 percent of teachers in government schools struggled with teaching using digital mediums.[409] Only 41 percent of parents in private schools reported that education was delivered during the lockdown and 82 percent of parents faced challenges in supporting children to access digital education due to poor internet connectivity.[410] A 2021 case study to identify gaps and challenges in the use of education technology in Chennai, Tamil Nadu finds that one in five children were enrolled in schools that did not offer any remote instruction during school closures, and even in schools where remote instruction was available, little more than half the students attended all the classes.[411] A 2022 study finds that digital education deployment in India has been poor mainly due to poor school infrastructure, limited pedagogical capabilities and modest students' skills, socio-demographic differences among students and the digital divide in rural and urban areas.[412]

---

406 Bhattacharjee, M. and Mysoor, D. (2016), *"Unredressed" Grievances under RTE: Navigating the State Labyrinth*. Governance, 29, pp. 4-10, Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/gove.12132; Bhatacharjee, M. et al. (2014). *RTE Grievance Redress in Karnataka.* Economic and Political Weekly, *49*(23), pp. 38-39. Available at: https://www.jstor.org/stable/24479609

407 United Nations Children's Fund (2021). *COVID-19: Schools for more than 168 million children globally have been completely closed for almost a full year, says UNICEF*. UNICEF. Available at: https://www.unicef.org/india/press-releases/covid-19-schools-more-168-million-children-globally-have-been-completely-closed

408 Ministry of Education (2020). *Union HRD Minister releases alternative Academic Calendar of NCERT for schools*. Press Information Bureau. Available at: https://pib.gov.in/PressReleasePage.aspx?PRID=1615009

409 Vyas, A. (2020). *Status Report: Government and private schools during COVID-19*. Oxfam India. Available at: https://www.oxfamindia.org/sites/default/files/2020-09/Status%20report%20Government%20and%20private%20schools%20during%20COVID%20-%2019.pdf

410 Ibid.

411 Vegas, E. et al. (2021). *Ed tech and educational opportunity during the COVID-19 school closures: A case study of Chennai, Tamil Nadu.* Centre for Universal Education at Brookings. Available at: https://www.brookings.edu/wp-content/uploads/2021/08/Ed-tech-and-educational-opportunity-during-COVID-19-school-closures-FINAL-1.pdf

412 Martin, A.V.G. and Ramos, J.M.L (2022). *DEIFDC framework: Evaluation of digital education deployment in India in the midst of the Covid-19 pandemic*. Social Sciences and Humanities Open, Volume 6, Issue 1. Available at: https://doi.org/10.1016/j.ssaho.2022.100281

The Indian government has now introduced a few initiatives to improve digital infrastructure in schools. For example, it has set up information and communication technology (ICT) labs in about 120,000 schools and smart classrooms in about 82,000 schools under the *Samagra Shiksha Abhiyan*, and conducts online teacher training programmes through NISHTHA 4.0 mobile app.[413] However, as noted above, the lack of digital infrastructure was only one of the problems faced by students, parents and teachers in the shift to remote learning.

6.2.6 Key Issue: Regulation of the private sector

Regulation of private schools has been one of the most contentious and debated issues of the RTE Act. The RTE Act obligates private schools to obtain a certificate of recognition and fulfil the prescribed norms and standards (Section 18-22), provide 25 percent reservation in entry-level classes to economically weaker and disadvantaged groups (Section 12), and ensure that no child is denied admission due to capitation fees, screening procedure for admission, lack of proof of age, holding back and expulsion, and mental and physical harassment (Sections 13-17). The constitutional validity of the first two obligations was challenged and upheld by the Supreme Court of India as discussed above.[414] However, its implementation has faced several issues as reflected in existing literature and court judgments.

In general, a respondent interviewee noted that regulation of private schools is weak. As a result, children are not receiving quality education in spite of paying, and many end up dropping out. A review of private schooling in India highlights various causes for the resistance from private schools to apply the prescribed norms and standards of the RTE Act. This includes the non-application of prescribed norms and standards to public schools, the prohibition on private schools to run for private gain or profit, focus on infrastructure and input norms with no proven connection to schooling quality, and delayed and inadequate reimbursement for providing 25 percent reservation to economically weaker and disadvantaged groups.[415] A respondent interviewee disagreed with the argument that input norms don't matter, and felt that the discourse on learning outcomes over-emphasises the importance of testing children. They argue that the school environment should facilitate learning, and input norms should seek to promote such an environment; the fact that the *National Education Policy 2020* seeks to do away with input norms entirely, is damaging to the right to education. Some also noted recent attempts to water down the aforesaid provisions regulating the private sector to empower them and provide greater autonomy to innovate and improve the quality of education.[416]

A respondent interviewee noted that the implementation of the 25 percent reservation mandate has varied from state to state, as well as within states. Some studies highlight some of the common implementation issues, including lack of clarity on the income level for determining economically weaker and disadvantaged groups, lack of awareness amongst parents regarding the admission process to apply for reserved seats, attempts by schools to avoid the obligation by acquiring minority status, delayed and inadequate reimbursements, and the use of e-governance techniques for admissions in the reserved category.[417]

---

[413] Id. at 391.

[414] *Society for Unaided Private Schools of Rajasthan v Union of India*, 2012 6 SCC 1, para 19; *Pramati Education and Cultural Trust v Union of India*, 2014 8 SCC 1, para 46.

[415] Kingdon, G.G. (2017). *The Private Schooling Phenomenon in India: A Review*. IZA DP No. 10612. IZA Institute of Labour Economics, pp. 29-32. Available at: https://docs.iza.org/dp10612.pdf

[416] Gorur, R., & Arnold, B. (2022). *Regulating private sector schooling in the global south: the case of India*. Compare: A Journal of Comparative and International Education, *52*(3), pp. 12-13.

[417]Sarin, A. et al (2017). *State of the Nation: RTE Section 12(1)(c)*. IIM Ahmedabad, Centre Square Foundation and Centre for Policy Research, available at: https://cprindia.org/wp-content/uploads/2021/12/SOTN-Report-2017_FINAL.pdf; Kothari, J. & Ravi, A. (2016). *A battle of rights: the right to education of children versus rights of minority schools*. Oxford University Commonwealth Law Journal, 16:2, pp. 195-218, available at: https://www.tandfonline.com/doi/abs/10.1080/14729342.2017.1285103; Sarin, A. et al (2015). *State of the Nation: RTE Section 12(1)(c)*. IIM Ahmedabad, Centre Square Foundation, Accountability Initiative and Vidhi Centre for Legal

These studies also highlight some success stories.[418] For example, Rajasthan adopted an online admissions system that increased efficiency and provided greater accountability. Maharashtra encouraged active civil society engagement and adopted an online system that provided greater freedom to parents to choose schools. A respondent interviewee pointed out that the Ahmedabad ward councillors took it upon themselves to generate awareness about the 25 percent reservation mandate amongst parents, as a way to give back to their constituencies. In general, areas with better implementation had better community mobilisation and demand.

Apart from implementation issues, the 25 percent reservation mandate has also entailed unintended consequences. Respondent interviewees have emphasised that the mandate is not only about sharing responsibility between the government and the private sector, but also about preventing segregation and creating a more egalitarian education system. Contrary to this intent, a study notes that some schools make RTE students sit separately from fees-paying students, and prevent them from accessing certain facilities and services.[419] However, one respondent interviewee observed that barring anecdotal evidence, the issue of segregation has not been studied systematically.

As far as sharing responsibility between the government and private sector is concerned, a 2016 study finds limited impact of the 25 percent reservation mandate in so far as the majority of the children continue to attend government schools, while a small minority access schools on reserved seats in private schools.[420] Moreover, out of pocket expenditure of reserved category students is about 8 times more than government school students; a substantial proportion of the extra costs is on transportation and expensive uniforms. However, a respondent interviewee felt that these are not relevant criteria for assessing implementation of the 25 percent reservation mandate. Instead, the mandate should be examined on the basis of the criteria such as number of schools fulfilling the mandate and the manner in which governments define eligibility criteria for availing the reservation.

One respondent interviewee noted that the RTE Act is based on the humanist approach. This is reflected in provisions related to prohibition of capitation fees, screening procedure for admission, proof of age for admission, denial of admission, holding back or expulsions, and physical and mental harassment. In spite of these provisions, the interviewee noted with regret that schools have continued to discriminate between children by segregating and labelling them based on their perceived ability.

Notably, the no-detention policy under section 16 of the RTE Act was amended in 2019 allowing state governments to frame rules to re-introduce detention in class V and class VIII.[421] While the rationale offered for the reintroduction of detention is that guaranteed promotions mean that teachers and students don't feel the compulsion to teach and learn, critics noted that the amendment punished children for government failures and highlighted the active lobbying for the amendment by private schools that rely on test results for their branding.[422]

Policy, available at: https://accountabilityindia.in/sites/default/files/state_of_the_nation_-_section_12_1_c_csf_march_2015.pdf

[418] Sarin, A. et al (2015). *State of the Nation: RTE Section 12(1)(c)*. IIM Ahmedabad, Centre Square Foundation, Accountability Initiative and Vidhi Centre for Legal Policy, pp. 134-143.

[419] Gorur, R., & Arnold, B. (2022). *Regulating private sector schooling in the global south: the case of India*. Compare: A Journal of Comparative and International Education, 52(3), p. 9.

[420] Srivastava, P. & Noronha, C. (2016). The myth of free and barrier-free access: India's Right to Education Act—private schooling costs and household experiences in: Non-State Actors in Education in the Global South. Routledge. Available at: https://www.taylorfrancis.com/chapters/edit/10.4324/9780203703281-5/myth-free-barrier-free-access-india-right-education-act%E2%80%94private-schooling-costs-household-experiences-prachi-srivastava-claire-noronha

[421] *The Right of Children to Free and Compulsory Education (Amendment) Act 2019.* Available at: https://dsel.education.gov.in/sites/default/files/rte/rte_2019.pdf

[422] See: Mitra, A. (2022). Assam Government Not to Promote Class 5, 8 Students If They Fail Annual Exams. NDTV. Available at: https://www.ndtv.com/education/assam-government-not-to-promote-class-5-8-students-if-they-fail-

This review of the RTE Act and its implementation sheds light on the importance of institutionalised mechanisms for community mobilisation, decentralised planning and execution, establishing independent regulation, limits of regulating the private sector and challenges in transitioning to a digital education system.

6.3 National Food Security Act 2013 (NFSA)

6.3.1 Overview

The *National Food Security Act 2013* (NFSA) is the result of years of campaigning and persistent pressure from civil society. In April 2001, the People's Union for Civil Liberties filed a public interest litigation (PIL) in the Supreme Court challenging inadequate drought relief measures by the states and central governments. The PIL was filed at a time when India's food stocks soared to unprecedented numbers while hunger in drought-affected areas intensified, suggesting deep-rooted mismanagement and failure of the existing food security machinery.[423] The case, *PUCL v Union of India*, subsequently extended to larger issues of chronic hunger and undernutrition and eventually came to be known simply as "*the right to food case*".[424] The Supreme Court did not pass a final judgment in the case, but issued over forty incisive, comprehensive and enforceable interim orders between 2001 and 2017, affirming the right to food as a part of the right to life under Article 21 of the Indian Constitution. The orders cover a wide range of issues such as the implementation of food-related schemes, urban destitution, the right to work, starvation deaths, and measures of transparency and accountability.[425] An interim order of 28 November 2001, also known as the Basic Entitlements order, gave comprehensive directions on eight food related schemes and has been heavily incorporated in the text of the NFSA.[426]

As an off-shoot of the PIL, a nationwide Right to Food Campaign was launched, demanding equitable and sustainable food systems in India.[427] The campaign gradually built pressure on the government to introduce a rights-based law that guaranteed the right to food. In 2013, the NFSA was passed in the parliament, taking a minimalist approach to food security, while rejecting the inclusion of related issues proposed by civil society, such as agricultural production, access to resources, minimum wages and livelihood.[428]

Food security under NFSA is ensured through four delivery systems: Targeted Public Distribution System (TPDS), nutrition entitlements for lactating mothers and pregnant women, Integrated Child Development Services Scheme (ICDS) and the Mid-day Meal Scheme (MMS). These schemes pre-date

---

annual-exams-3415988; Akhtar, S. (2022). Detention policy back in Delhi schools this year. Hindustan Times. Available at: https://www.hindustantimes.com/cities/delhi-news/delhi-schools-to-enforce-detention-policy-for-classes-5-and-8-from-2023-24-academic-session-students-need-to-secure-minimum-required-marks-and-attendance-101680459404665.html; Mahajan, N. (2022). Haryana scraps 'no detention policy', to conduct Board exam for classes V, VIII. The Pioneer. Available at: https://www.dailypioneer.com/2022/state-editions/haryana-scraps----no-detention-policy-----to-conduct-board-exam-for-classes-v--viii.html; Mody, A. (2019). Scrapping of no-detention policy in schools is an admission of failure by the Modi government. Scroll.in. Available at: https://scroll.in/article/909881/scrapping-of-no-detention-policy-in-schools-is-an-admission-of-failure-by-the-modi-government

[423] Right to Food Campaign. (2005). Supreme Court orders on the Right to Food - a Toolkit for Action, p. 3. Available at: https://www.corteidh.or.cr/tablas/27433.pdf

[424] *PUCL v Union of India and Others*, Writ Petition (Civil) 196 of 2001, Supreme Court of India.

[425] Right to Food Campaign. A list of all Right to Food case orders, 2001-2017. Available at: https://www.righttofoodcampaign.in/legal-action/supreme-court-orders

[426] *Basic Entitlements Order,* dt. 28 Nov 2001, *PUCL v Union of India and Others*, Writ Petition (Civil) 196 of 2001. Available at: https://main.sci.gov.in/jonew/bosir/orderpdfold/33378.pdf

[427] The right to food campaign is an informal network of individuals and organisations committed to the realisation of the right to food in India. Available at: http://www.righttofoodcampaign.in/home

[428] GH Watch. Section 8, The Right to Food Campaign in India, pp. 391-393. Available at: https://www.ghwatch.org/sites/www.ghwatch.org/files/E8.pdf

the NFSA by several decades as independent social security programmes of centre and state governments. Bringing them under one statutory framework, the NFSA has standardised these schemes by setting minimum quality and quantity benchmarks, and making food entitlements legally enforceable. Entitlements under the Act include foodgrains at a predetermined subsidised price under the TPDS (Section 3), supplementary nutrition and IEC for children and pregnant/lactating mothers under the ICDS (Sections 4, 5, 6), and cooked meals for school-going children under MMS (Section 5). These are explored in more detail below.

Integrated Child Development Services Scheme (ICDS) and maternity benefits
Launched by the Government of India in 1975, the ICDS package of services comprises a) Supplementary nutrition (SNP), b) Pre-school, non-formal education, c) Nutrition and Health Education, d) Immunization, e) Health check-up, and f) Referral services. Since 2016-17, the centre has renamed and restructured the ICDS into the "Umbrella ICDS", including within its ambit several other targeted schemes.[429]

Sections 4, 5 and 6 of the NFSA recognize specific legal entitlements of children and women under the Act that are made operational through the abovementioned schemes (in particular, the Anganwadi Services Scheme which carries on core ICDS functions). Section 4 of the NFSA entitles every pregnant woman and lactating mother to free-of-charge meals during pregnancy and six months after childbirth through the local *anganwadi*, and a maternity benefit of not less than rupees six thousand. Section 5 entitles every child between the age of six months to six years to age-appropriate meal free-of-charge through the local *anganwadi* and to children up to the age of fourteen years (or up to class VIII, whichever is applicable) to a mid-day meal free-of-charge in government schools. Section 6 obligates state governments to identify and provide free-of-charge meals to children who suffer from malnutrition through the local *anganwadi*. Schedule II of the Act lists the nutritional standards to be complied with in any scheme that seeks to operationalize these entitlements. There are provisions for take-home rations for children as well as pregnant/nursing women. The Ministry of Women and Child Development frames rules relating to provision of supplementary nutrition under the NFSA.[430]

Mid-day meal scheme (MMS)
The mid-day meal programme, which provides free cooked meals to all students up to class VIII at government-run or aided schools, predates the NSFA by decades and was kickstarted in Tamil Nadu as a dry foodgrain provision scheme to encourage enrolment of children in government schools. The scheme's framework also runs in conjunction with Article 21A (Right to Education) of the Constitution and India's obligations under the Convention on the Rights of the Child. Provision of mid-day meals first found legal backing in the *PUCL interim order of 28 Nov. 2001*[431] wherein the Supreme Court specified a minimum calorie (300cal) and protein (8-12g) requirement to be met by every state, per student per meal, for a minimum 200 out of 365 days. The NFSA further increases the minimum nutritional standards to be met per meal at Schedule II. The PUCL order mandated every school to have facilities for cooking fresh meals, drinking water and sanitation – and centralised kitchens were to be established by the central government where necessary.

The scheme is said to be successful on two parameters: by encouraging enrolment and attendance at school, which supplements the bigger RTE goal, and by improving a child's nutritional intake through the stipulated nutrient benchmarks.[432] Moreover, the PUCL orders coupled with the NFSA provide a

---

[429] Schemes include: Anganwadi Services Scheme, Scheme for Adolescent Girls, Child Protection Services, National Creche Scheme (replacing Rajeev Gandhi National Creche Scheme), POSHAN Abhiyaan (National Nutrition Mission), and Pradhan Mantri Matru Vandana Yojana.
[430] *Supplementary Nutrition (under the Integrated Child Development Services Scheme) Rules, 2017*. Available at: https://hpfoodcommission.nic.in/pdf/Supplementary_Nutrition%20_ICDS_%20Rules_2017.pdf
[431] *Basic Entitlements Order,* dt. 28 Nov 2001, *PUCL v Union of India and Others*, Writ Petition (Civil) 196 of 2001. Available at: https://main.sci.gov.in/jonew/bosir/orderpdfold/33378.pdf (Id. 401).
[432] Chakraborty, T. et al. (2016). *School Feeding and Learning Achievement: Evidence from India's Midday Meal Programme.* IZA Discussion Paper No. 10086. Available at: https://ftp.iza.org/dp10086.pdf

safety-net for children and families even outside of school settings, for instance, by ensuring continuing food entitlements during summer holidays and drought situations.[433]

Targeted Public Distribution System (TPDS)

The TPDS covers the largest percentage of Indian households of the three, including 72.8 crore persons in its ambit as of March 2022.[434] Under the TPDS, each member in an eligible household is entitled to 5 kilogrammes (kgs) of grain per month at INR 2/kg for wheat and INR 3/kg for rice, while *antyodaya* households (the poorest of the poor) get 35 kg/month at the same price, irrespective of family size.[435] Once the NFSA was passed in 2013, it came into effect differently and at different points of time for states across India. Little to no hiccups were noted in the implementation of the ICDS and mid-day meal schemes, as most states had already been operating and updating their programmes for decades. The same was also true for state-level public distribution systems (PDS), but the NFSA brought along substantive changes and benchmarks which required states to revise their schemes.

Since for most states the NFSA had the effect of expanding coverage, the provisions were received positively and implemented within one or two years.[436] The Act prescribes base guidelines for implementation, but states are free to fund and structure the TPDS as they see fit for their population. Field surveys by Khera, Dreze, Somanchi, and Pimenta show that most states have gone beyond the Act and aimed for universal ration coverage, with the exception of Chhattisgarh which focuses on providing more grain to a limited poorer eligible population.[437] In the experience of the abovementioned researchers and a respondent interviewee, "*best performing states*" identified in many TPDS field surveys (on the indicators of indicators of leakages, corruption and diversion) are usually ones expanding their coverage to universality.

With the introduction of NFSA, entitlements under the TPDS became a statutory right through which states could be held accountable. Interviews revealed that corruption and malpractice within Fair Price Shops and other middlemen has reduced drastically since the Act came into effect. Respondent interviewees are unsure whether this can be attributed to the passing of the Act, but the trends since 2015 have been somewhat positive.

This review of NFSA can be divided into six categories, i.e., resource availability (with a specific focus on centre-state roles), administrative machinery, transparency and accountability mechanisms, the use of technology and two issues specific to the implementation of NFSA i.e., determination of eligibility and ensuring the quality of food.

6.3.2 Availability of Resources

Before the NFSA, the Planning Commission was responsible for deciding operational caps for states, including the quantity of ration (previously 10kg) and percentage of population covered, based on the poverty distribution of each state.[438] It accordingly released funds to states, pursuant to the *Public*

---

433 Yadav, M. (2017). *Midday meals scheme: Are corruption claims exaggerated?* Ideas for India. Available at: https://www.ideasforindia.in/topics/governance/midday-meals-scheme-are-corruption-claims-exaggerated.html

434 National Food Security Act Dashboard, Government of India. Available at: https://nfsa.gov.in/public/nfsadashboard/PublicRCDashboard.aspx

435 Section 3, *National Food Security Act, 2013.*

436 Economic Times. (2016). *21 states to implement National Food Security Act by April 1.* Available at: https://economictimes.indiatimes.com/news/politics-and-nation/21-states-to-implement-national-food-security-act-by-april-1/articleshow/51495457.cms; The Hindu. (2015). *Odisha to implement food security act in 14 districts.* Available at: https://www.thehindu.com/news/national/other-states/odisha-to-implement-food-security-act-in-14-districts/article7660587.ece

437 Drèze, J., et al. (2019). *Casting the Net: India's Public Distribution System after the Food Security Act.* Economic and Political Weekly.

438 Planning Commission 1993-94. (1994). *Report of The Expert Group on Estimation of Proportion and Number of Poor*. Available at: https://niti.gov.in/planningcommission.gov.in/docs/reports/publications/pub93_nopoors.pdfPlanning Commission

Distribution System (Control) Order 2001.[439] This Order specified the framework for implementation of TPDS, including methods of eligible household identification and the distribution machinery between centre and states, before the notification of NFSA. Today, it complements the Act in certain administrative capacities. For instance, private Fair Price Shops contracted to deliver grain entitlements under the Act are licensed under the 2001 Order to sell essential commodities at central issue prices. The Order created mechanisms to disburse funds from centre to state as directed by the Planning Commission, but it was then left to states to expand the quantity of foodgrain or coverage with funds out of their own pockets. Once the NFSA was implemented, these numbers increased from the central level and the issue price of grain was reduced to half.[440] This meant that a larger amount of funding reached states, to provide a larger quantity of grain for a cheaper price, to cover a larger population.

However, for states such as Tamil Nadu and Kerala, these numbers were a step back. Both states had developed a system of universal ration coverage before the Act, and now the Act was attempting to reduce coverage (and funding) from the central government. After over two years of negotiations, Tamil Nadu and Kerala became the last states to implement NFSA on the condition that rations above and beyond the statutory entitlements would be funded from the states' own pockets, with small assistance from the central government.[441] This assistance is provided in the form of tide-over grain: small amounts of ration disbursed by the central government to help states retain their "universal" coverage under the TPDS.[442] Section 3 of the Act provides for such tide-over allotment from the central government if the annual allocation of foodgrains to any state "*is less than the average annual offtake of foodgrains for the last three years*" under TPDS. Grain is provided at prices slightly higher than the NFSA rates, as determined by the central government from time to time. Usually, states reserve a small quantity of such grain as "*buffer stock*" (in Meghalaya, for instance, this is five percent of monthly tide-over allotment) for meeting eventualities and natural calamities.[443]

Section 23 of the Act further defines the obligation of the central government to ensure food security through funding and tide-over allocation. It states that in the event of a shortage in the supply of foodgrains from the central pool to a state, the central government must give funds to the concerned state, to the extent of shortage in supply. This is realised through the *Provisioning of Funds to State Governments for Short Supply of Foodgrains Rules 2014* and the *Food Security (Assistance to State Governments) Rules 2015*.[444] The former rules state the manner of allocation and funding of entitled and tide-over grain to states at specified rates i.e., 1.25 times the Minimum Support Price (MSP) of grain) and also obligate the central government to reimburse states when additional grain is purchased at similar rates from the open market.[445] Pursuant to the latter rules, the central

1993-94, Report of The Expert Group on Estimation of Proportion and Number of Poor (1994) https://niti.gov.in/planningcommission.gov.in/docs/reports/publications/pub93_nopoors.pdf.

439 PDS (Control) Order, 2001. Available at: https://dfpd.gov.in/pds-control-order-1.htm. See also the TPDS (Control) Order, 2015, which was notified in supersession of the 2001 Order under Section 3 of the Essential Commodities Act, 1955 and works in conjunction with the NFSA to ensure delivery of TPDS benefits across India. Available at: https://dfpd.gov.in/1sGbO2W68mUlunCgKmpnLF5WHm/file1.pdf

440 Schedule I, *National Food Security Act, 2013.*

441 Thangavelu, D. (2016). *Tamil Nadu to implement National Food Security Act on 1 November.* Livemint. Available at: https://www.livemint.com/Politics/GcSyOFqnaPjvLUxAFzCfVN/Tamil-Nadu-govt-to-implement-National-Food-Security-Act-from.htmlTamil Nadu to implement National Food Security Act on 1 November (2016)

442 Proviso II, Section 3, *National Food Security Act, 2013*; Khera, R., & Somanchi, A. (2020, August 19). A review of the coverage of PDS. Ideas for India. Available at: https://www.ideasforindia.in/topics/environment/a-review-of-the-coverage-of-pds.html.

443 See, Project Management Unit, Directorate of Food Civil Supplies & Consumer Affairs, Government of Meghalaya. Guidelines on implementation of Non-NFSA (Tideover Allocation) for Rice. Available at: https://megfcsca.gov.in/documents/Non-NFSA_Guidelines_v2.2.pdf

444 *Provisioning of Funds to State Governments for Short Supply of Foodgrains Rules, 2014*. Available at: https://epds.co.in/Download/Rules/Short%20Supply%20of%20Foodgrains%20Rules%202014.pdf ; *Food Security (Assistance to State Governments) Rules, 2015*. Available at. https://megsfc.gov.in/acts/Food-Security-Assistance-State-Government-Rules-2015.pdf

445 Section 6, Provisioning Rules.

government is further obligated to meet expenses incurred by states in intra-state movement, handling of foodgrain and margins paid to fair price shops for distribution of grain to entitled households.[446] Payments to Fair Price Shop dealers include an additional margin for purchase, upkeep and running expenses for point-of-sale devices (for Aadhaar-based authentication, discussed below).[447] Such operational financial assistance is provided over and above tide-over allocation. According to sections 10 and 11 of the Assistance Rules, funds are released from the central government to states in two instalments: the first accounts for 75 percent of the estimated annual expenditure of a state, paid at the beginning of the financial year, and the remaining 25 percent is paid in the following financial year. Funding was provided retroactively for the years between the notification of the NFSA and the Assistance rules.

Though many operational expenses and additional grain are disbursed from the central government, as noted above, TPDS takes different shapes and forms in states across India. States like Chhattisgarh and Andhra Pradesh that go beyond central assistance, run an "expanded PDS", which provides more entitlements to more population groups and eligible households, and is funded almost entirely from state finances.[448]

6.3.3 Administrative machinery

The Act provides for a decentralised administrative machinery through the central Ministry of Consumer Affairs, Food and Public Distribution, Department of Food and Public Distribution, Food Corporation of India (FCI), state-level Food Commissions, district-level Vigilance Committees and fair price shops. This is regulated by Grievance Redress Officers at the district level.

The central government provides foodgrain, funds and assistance to states to deliver various entitlements under the Act. The foodgrain quantities specified under NFSA are either provisioned to states directly from the central government, or purchased by states and reimbursed by the latter. Any additional grain (either in quantity or variety) is covered by tide-over funds disbursed by the central government or purchased by states out of their own pockets, as discussed above. Besides grain, financial assistance from the central government also covers other operational or incidental expenses including but not limited to grain transport and storage, and installation and operation of technological tools like ledger systems and point-of-sale machines for Aadhaar authentication at fair price shops.

Foodgrain is delivered to entitled persons and households via Fair Price Shops, which can be government-owned outlets or contracted private dealers. Fair Price Shop dealers authenticate each buyer against their ration card or Aadhaar card and maintain detailed records of every sale, and this information is reported to Vigilance Committees and the State Food Commission.

6.3.4 Accountability and Transparency

Chapter VII and XI of the NFSA detail mechanisms to ensure transparency and accountability for the various programmes it covers. These mechanisms include a grievance redress mechanism, vigilance committees, progressive reform of the TPDS, food security allowances and Aadhaar-based delivery of entitlements. Existing literature suggests that these provisions remain underutilised, or in some cases, have not been put into effect at all.

---

[446] Section 6, Assistance Rules.
[447] Section 7(2), Assistance Rules.
[448] *Chhattisgarh Food and Nutritional Security Act, 2012*

Grievance redress

As per Chapter VII of the Act, every state is tasked with setting up an internal grievance redressal mechanism which may include instituting help lines and call centres, and decentralised grievance redress officers (GROs). Under section 15 of the Act, a complaint may be filed by any individual to their nearest District GRO on grounds of failure of the state to distribute meals or foodgrain ensured under the Act; or generally for enforcement of benefits promised under the Act. The District GRO must redress and resolve complaints in an expedited manner (time limits or other terms of service is specified by the state government) and in case the complainant is unsatisfied with the resolution, they may appeal to the State Food Commission. These Food Commissions are required to be established under section 16 of the Act to monitor its implementation and ensure speedy redressal at a granular level. It must comprise one chairperson and five members, of which two must be women. Functions of the commission include monitoring and evaluating the schemes and provisions of the Act, inquiring into violations of entitlements (either *suo motu* or on receipt of complaint) and hearing appeals against orders of the District GRO.

In a CAG report recording initial state-wise responses to the Act, many states were noted to have implemented toll free numbers and helplines to resolve small grievances within a year of the Act being notified.[449] However, except for Bihar, Maharashtra and Himachal Pradesh, District GROs were not properly installed in many states. In Delhi, a 2017 civil society survey indicated that little to no information was made publicly available on grievance redress systems under the Act – most Fair Price Shops did not display toll free helplines or information on the GRO's office, there were no signs installed to identify a GRO's office or to indicate that the Additional District Magistrate (ADM) acted as District GRO for many districts at the time, and neither the office nor the NFSA Delhi website contained any information on the District GRO's functions, powers and jurisdictions, or the manner of filing complaints before them.[450]

Accountability measures

Section 29 of NFSA establishes state-wise vigilance committees to ensure transparency, proper functioning of the TPDS and accountability of the functionaries within the system. Vigilance Committees pre-date NFSA and were required to be set up as regulators under the *PDS (Control) Order 2001*. Under the Act, the committees may be set up at the state, district, block or Fair Price Shop level to supervise the implementation of all schemes under NFSA, and inform grievance officers of any violations, malpractice, corruption or fraud. Nine states established such committees within a year of the NFSA being enacted, and some more states notified Vigilance Committee Rules within two years.[451] Across states, the rules place an obligation on the state government to annually report on the functioning of vigilance committees to the central government.

Literature suggests that vigilance committees have either not been set up to the extent required by the state rules, or are functioning poorly. In a TPDS survey conducted in Bihar in January 2022, it was found that of the 70 vigilance committees required to be constituted in the 14 survey districts, only

---

449 Comptroller and Auditor General (2015). *CAG Audit on the Preparedness for Implementation of National Food Security Act, 2013 for the year ended March, 2015*. pp. 41-43. Available at: https://cag.gov.in/uploads/download_audit_report/2016/Union_Civil_National_Food_Security_Report_54_of_2015.pdf

450 Delhi Rozi Roti Adhikar Abhiyan, & Satark Nagrik Sangathan (2017). Peoples' Assessment of the Implementation of Transparency, Grievance Redress and Accountability Measures of the National Food Security Act in Delhi, pp. 11-12. Available at: https://snsindia.org/wp-content/uploads/2018/03/Report-13-with-annexures-FINAL.pdf

451 Government of Telangana, (2015, July 16). Order under NFSA no. G.O.MS.No. 9. Available at: http://www.civilsupplies.telangana.gov.in/gopdf/new/GO%20Ms.No.%209.vig%20committes.pdf; Department of Food, Supplies and Consumer Affairs, GNCT of Delhi. The list related to Vigilance Committee Orders. Available at: https://nfs.delhigovt.nic.in/Citizen/ActandRulesandManyMore.aspx?flag=V; Government of Karnataka. (2016). Food, Civil Supplies Consumer Affairs and Legal Metrology Secretariat Notification dt. 30-05-2016. Available at: https://ahara.kar.nic.in/Aharadept/NFSA_DOC/Vigilence%20committee/Vigilance%20Committee%20Gazatte.pdf, Government of Assam, Food, Civil Supplies and Consumer Affairs. Vigilance and Monitoring Committee. Available at: https://fcsca.assam.gov.in/frontimpotentdata/vigilance-and-monitoring-committee

31 were set up. Of these 31, most were not functioning as per state rules.[452] The same year in Delhi NCR, officials cleared the formation of Vigilance Committees at the district level, eight years after the Act was implemented in the state.[453] The CAG audit on the implementation of NFSA, examining states' response to the Act for 2015 (a year after it came into effect across India), also concluded that while grievance redress systems were constituted in most states, they either did not extend to the last tier, or were not found to be fully functional. Monitoring done by the States was also not found to be satisfactory as there were no inspections in the period of 2014-15 and inspections undertaken were far less than what was targeted.[454]

Another salient accountability measure of the Act is the provision of food security allowance.[455] This allowance is a sum of money that may be redeemed against non-delivery of an entitlement under the Act, and is computed at 1.5 times the market price of the non-delivered foodgrain. Governed by the *Food Security Allowance Rules 2015*, the allowance only corresponds to non-delivery of entitled foodgrains under the TPDS.[456] Although a robust accountability and social security measure, section 8 of the NFSA as well as the rules have not been notified yet. They also do not extend to cases of non-delivery of maternal, ICDS, or MMS entitlements.

6.3.5 Use of Technology

Aadhaar-based authentication in TPDS

Section 12 of NFSA places an obligation on state and central governments to progressively undertake necessary reforms in TPDS to realise the objectives of the law. Steps to reform the system include delivery of foodgrains at the doorstep, use of information and communication technology tools to ensure transparency and improve delivery, increased involvement of *panchayats* and self-help groups in the management of Fair Price Shops, diversification of commodities under the TPDS, and introducing schemes of cash transfer or food coupons to enhance delivery in state territories. Since the passage of NFSA, almost all TPDS reforms have been focussed on basing foodgrain delivery in technology.

The most significant TPDS reform, has been the introduction of biometric authentication, specifically Aadhaar-based Biometric Authentication (ABBA). Under section 12, one modality of TPDS reform is leveraging Aadhaar for unique biometric identification of "*entitled beneficiaries*" and proper targeting of benefits. In 2017, the central government issued a notification requiring those entitled to receive benefits or cash transfers under the TPDS to provide proof of possessing an Aadhaar number or to undergo Aadhaar authentication.[457] This was done with the motive of reducing corruption and duplication of ration cards.

Literature on Aadhaar-enabled TPDS echoes a common concern that so far Aadhaar linking has not only failed at tackling systemic corruption in the ration system, but may have caused harm. The first step to avail benefits under an Aadhaar enabled-PDS for many is to generate an Aadhaar number.

---

[452] Ghosh, A., and Kumar, R.K. (2022). *Evaluation of the National Food Security Act, 2013 in Bihar: Reflections from the Field Study*. EPW Engage 57(5). Available at: https://www.epw.in/engage/article/evaluation-national-food-security-act-2013-bihar

[453] Express News Service. (2023). *Delhi L-G clears vigilance panels at fair price shops, expresses 'grave concern' over 8-year delay*. Indian Express. Available at: https://indianexpress.com/article/cities/delhi/delhi-l-g-clears-vigilance-panels-at-fair-price-shops-expresses-grave-concern-over-8-year-delay-8538710/

[454] Comptroller and Auditor General (2015). *CAG Audit on the Preparedness for Implementation of National Food Security Act, 2013 for the year ended March, 2015*. Available at: https://cag.gov.in/uploads/download_audit_report/2016/Union_Civil_National_Food_Security_Report_54_of_2015.pdf

[455] Section 8, *National Food Security Act, 2013*

[456] Section 4, *Food Security Allowance Rules, 2015*

[457]Ministry of Consumer Affairs. (2017, February 8). Food and Public Distribution Notification no. SO371E. Available at:https://dfpd.gov.in/fgAvAHcAcgBpAHQAZQByAGUAYQBkAGQAYQB0AGEALwBQAG8AcgB0AGEAbAAvAE0AYQBnAGEAegBpAG4AZQAvAEQAbwBjAHUAbQBlAG4AdAAvAA==/1_232_1_1-aadhaar-notification.pdf

Khera notes that this process itself is riddled with bureaucratic delays.[458] Once an Aadhaar card is lost, it may never be reissued. People applying for an Aadhaar may also never hear back for no particular reason. Once Aadhaar is generated, the linking and authentication processes are similarly inaccessible and concerns continue to be raised that the Aadhaar-TPDS architecture suffers from lack of awareness, lack of access to the internet, administrative apathy and technical errors in authentication systems.

One of the reasons cited to implement Aadhaar-enabled PDS was to regulate the high rates of duplication and identity fraud within the ration delivery mechanism. But in a survey conducted in Jharkhand, the number of incidents of bogus or duplicate ration cards reported over the years was low.[459] The same study reveals that in practice, trivial roadblocks such as wrongly spelt names during authentication or low battery life of point-of-sale (POS) machines routinely halt distribution of grain. Another study in Andhra Pradesh notes that the ABBA system has led to the disenfranchisement of disabled persons and the elderly.[460] Since authentication requires physical presence at Fair Price Shops, transport and logistics hinder the process substantially; even reaching the ration shop is no guarantee of receiving entitlements due to technical issues with fingerprint authentication and POS machines.

In 2021, the Bombay High Court noted that Aadhaar authentication is only "*one of the modes*" to identify persons entitled to receive foodgrains under TPDS, and therefore, the petitioners (in this case, tribal persons), who were accompanied by 85 similarly placed persons, could not be denied foodgrain on grounds of non-possession of Aadhaar.[461] The court stated that it was "*unable to find any logic, reason or rationale for denying the benefits of distribution of foodgrains*" on technical grounds when ration cards were adequately furnished by the petitioners. Aadhaar-enabled TPDS appear to have created new barriers in availing services under the Act, and continues to undermine the promise of efficient, error-free, transparent delivery of rights and entitlements. Researchers, journalists, and an Andhra Pradesh government-commissioned study have documented how introduction of ABBA often disrupts welfare programmes of any kind. Thus, this pattern is not limited to the NFSA.[462] Therefore, Aadhaar-enabled TPDS may not be the '*progressive reform*' envisioned under section 12 of the Act.

Aadhaar-based authentication in midday meal scheme

In February 2017, the Union Ministry of Human Resource Development passed a gazette notification mandating Aadhaar authentication for students availing the midday meal scheme and cook-cum-helpers preparing meals at schools.[463] Those not possessing an Aadhaar card were asked to get

---

[458] Khera, R. (2019, April 6) Aadhaar Failures: A Tragedy of Errors. *Economic and Political Weekly*, 54(14).

[459] Dreze, J., et al. (2017, December 16). Aadhaar and Food Security in Jharkhand: Pain without Gain? *Economic and Political Weekly*, LII(50), p. 51. Available at: https://www.im4change.org/siteadmin/tinymce/uploaded/Aadhaar%20and%20Food%20Security%20in%20Jharkhand%20Pain%20without%20Gain.pdf

[460] Somanchi, A., et al. (2017, February 17). Well Done ABBA? Aadhaar and the Public Distribution System in Hyderabad. *Economic & Political Weekly,* 52(7). Available at: https://www.epw.in/journal/2017/7/web-exclusives/well-done-abba.html

[461] *Ganpat Dharma Mengal & Ors v Tehsildar Office, Murbad & Ors*, WP-7174/21, 29 October 2021, High Court of Bombay

[462] Khera, R. (2017, October 2). Impact of Aadhaar in Welfare Programmes. Economic and Political Weekly; Matharu, S. (2015, September 28). AP Detects Glitches in Aadhaar-linked PDS Distribution. Governance Now. Available at: http://www.governancenow.com/news/regular-story/ap-detects-glitches-aadhaar-linked-pds-distribution; Khera, R. (2017, July 25). On Aadhaar Success, It's All Hype–That Includes the World Bank. NDTV. Available at: https://www.ndtv.com/opinion/yes-aadhaar-is-a-game-changer-in-wrecking-welfare-schemes-1434424; Ramakumar, R. (2016, March 12). All Pervasive Aadhaar Raises Serious Privacy Concerns. Deccan Herald. Available at: https://www.deccanherald.com/content/534198/all-pervasive-aadhaar-raises-serious.html; Yadav, A. (2016, September 25). Government Presses on with Aadhaar In Ration System Despite Glitches, Delayed Food Law. Scroll.in. Available at: https://scroll.in/article/816863/government-presses-on-with-aadhaar-in-ration-system-despite-glitches-delayed-food-law; Dreze, J. (2016, September 10). Dark Clouds Over the PDS. The Hindu. Available at: https://www.thehindu.com/opinion/lead/Dark-clouds-over-the-PDS/article14631030.ece

[463] Ministry of Human Resource Development. (2017). Aadhaar Notification dated 28.02.2017. Available at: https://pmposhan.education.gov.in/Files/Aadhar/Aadhar_mdm.pdf

enrolled by the end of June 2017. Additional guidelines for authentication are being rolled out by states. For instance, starting January 2023, in Maharashtra, students who do not undergo Aadhaar authentication on the state's flagship Systematic Administrative Reforms for Achieving and Learning by Students (SARAL) portal will not be entitled to midday meals guaranteed under the NFSA. In February 2023, the Navodaya Vidyalaya Samiti (NVS), the government-funded chain of residential schools for poor and meritorious rural children, made Aadhaar-authentication of enrollment mandatory from 2023.[464]

As states pass orders pursuant to the central notification, there are concerns that this move will affect the otherwise universal coverage of the midday meal scheme and leave out a large fraction of students who cannot produce Aadhaar cards. In Bihar, databases reflect that the number of class I to VIII students in government and government-aided schools in the state has fallen by 13 lakh, in response to Bihar's move to link Aadhaar biometric authentication system with the midday meal scheme.[465] In Maharashtra, it is estimated that 59 lakh students will be deprived of essential entitlements like mid-day meals, free uniforms and books due to issues related to their Aadhaar data.[466] These factors may disincentivise students from enrolling in school altogether, which runs contrary to the objectives behind the midday meal scheme and the government's constitutional obligations.

6.3.6 Key Issue: Identification of eligible households

In most states, PDS was always a targeted social security scheme that relied on the Planning Commission's identification of socio-economically weak households. It continues to be targeted under NFSA, aiming to cover 75 percent of rural and 50 percent of urban households, but new methodologies to identify those entitled to receive foodgrains, meal or other entitlements have emerged.

Right from its drafting stages, the NFSA has been plagued by logistical difficulties in identifying eligible households for TPDS. In rural and urban settings alike, households are categorised as "priority" including Below Poverty Line (BPL) and Antyodaya Anna Yojana (AAY) households, "*general*" (households that may become eligible through TPDS reforms or state enactments) and "*excluded*" (households which will not receive benefits). This categorisation has, over the years, led to substantial exclusion and inclusion errors with the poorest households often ending up excluded.[467]

These households are identified through BPL census data, which has its own setbacks. The criteria and indicators used in the BPL censuses of 1997, 2002 and 2011 have been arbitrary, unclear and based on an underdeveloped scoring system. Conceptually, it is difficult to establish rigid poverty indicators to confer BPL status as people move in and out of "*poverty*" all the time.[468]

The Socio-Economic and Caste Census (SECC) emerged as an alternative to BPL-based eligibility. This enumeration, started in 2011, covers a large number of socio-economic indicators, unlike the BPL census which was based on a haphazard "*cut-off score*" method.[469] Before passing the NFSA, the central government denounced BPL data as an identification benchmark, said it would employ SECC for a more efficient TPDS delivery, and committed to release the SECC data well within time for the

---

464 Mohanty, B.K. (2023). *Aadhaar cloud on school midday meals.* Telegraph. Available at: https://www.telegraphindia.com/india/aadhaar-cloud-on-school-midday-meals/cid/1918070
465 Kumar, A. (2017). *After midday meal linked to Aadhaar, 13L fewer class 1-8 students in Bihar schools*. Hindustan Times. Available at: https://www.hindustantimes.com/india-news/after-midday-meal-linked-to-aadhaar-13l-fewer-class-1-8-students-in-bihar-schools/story-LibK7yYvKv3oGYJPis1iQJ.html
466 Saraswati, N.T. (2022). *With No Aadhaar Card, More Than 19 Lakh Students May Miss Mid-Day Meals In Maharashtra*. Medianama. Available at: https://www.medianama.com/2022/12/223-no-aadhaar-19-lakhs-students-miss-mid-day-meals-maharashtra/
467 Dreze, J., and Khera, R. (2010). *The BPL Census and a Possible Alternative*. Economic and Political Weekly, XLV(9), p. 57.
468 Khera, R. *One step forward, one step back?* Seminar India. Available at: https://www.india-seminar.com/2012/634/634_reetika_khera.htm
469 Id. at 403, p. 55.

NFSA roll-out.[470] However, reports from the early days of implementation suggest that the central government was "*grossly negligent in releasing this data*".[471] While data was collected from all 640 districts of India in the 2011 enumeration, the final data released in 2015 only reflected 141 districts. Logistical hiccups with the SECC substantially delayed the NFSA rollout in many states.[472]

Once some data was made available, states such as West Bengal, Bihar and Jharkhand undertook pilot SECCs and used them as the baseline for TPDS delivery. In Bihar's experience, as Dreze notes in the study, SECC data can be efficiently used to identify eligible households if based on an "*exclusion approach*".[473] In this approach, the government notifies a list of simple and transparent exclusion criteria, and every rural household is eligible by default unless it meets some of these criteria.[474] The same was tested in Bihar. The eligibility list used in Bihar was transparently linked to the SECC data available online, and the coverage of SECC data in the state was close to universal. There were some inaccuracies, but the errors rarely excluded eligible households. Overall, it was a marginal success.

Like the TPDS, families entitled to healthcare services under the AB-PMJAY are also identified through the 2011 SECC list.[475] Literature suggests that the SECC may be an enhanced method of identification compared to BPL data. However, it is not immune from similar exclusion-inclusion errors. One solution to the identification problem is following in Bihar's footsteps and adopting the exclusion approach, as explained above. Another solution is to minimise the very need to target and identify. A study on the implementation of the NFSA notes that by eliminating the need to categorise and identify eligible households to an extent, and adopting simpler and clearer methods of identification, states have substantially reduced inclusion and exclusion errors.[476] Tamil Nadu has had a universalised PDS since before NFSA, and Chhattisgarh follows a quasi-universal model which covers about 85 percent of the rural population under the *Chhattisgarh Food and Nutritional Security Act, 2012*.[477] Coverage in Himachal Pradesh is also near universal, and although it follows the BPL standard for pricing, the commodities and quantities of entitlements are the same for everyone.[478]

Where universalisation cannot be achieved, efforts can be made to diminish errors. This may be done by maintaining more holistic population databases that do not only record BPL status but also take into account other poverty indicators. For instance, Madhya Pradesh relies on the state-run SAMAGRA portal which collates information on socio-economically weak households, and enlists their AAY, BPL, employment, education and marital status to aid in identification for TPDS as well as adjacent schemes such as MGNREGA.[479] Creating an integrated database of eligible households in Madhya Pradesh has sped up release of entitlements, expanded coverage and simplified the process of editing BPL lists regularly.[480]

---

[470] Planning Commission. (2011, October 3). Joint Statement by Deputy Chairman, Planning Commission and Minister of Rural Development, Government of India. Available at: https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxoYXFyb3ppcm90aXxneDo2NWIyNTRlYmM5YjdjZjQ4.

[471] Puri, R. (2017). *India's National Food Security Act (NFSA): Early Experiences.* Leveraging Agriculture for Nutrition in South Asia (LANSA) Working Paper Series (14). Available at: https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/13040/NFSA-LWP.pdf?sequence=1&isAllowed=y

[472] Sethi, N. (2015). *Delayed implementation of food law challenged in Supreme Court*. Business Standard. Available at: https://www.business-standard.com/article/current-affairs/delayed-implementation-of-foodsecurity-act-through-executive-orders-challenged-in-sc-115052901251_1.html

[473] Dreze, J. (2015). *Food insecurity and statistical fog*. The Hindu. Available at: https://www.thehindu.com/opinion/lead/Food-insecurity-and-statistical-fog/article62119472.ece

[474] Id. at 403, p. 38.

[475] Ministry of Health and Family Welfare. (2019). *Press Release: Beneficiaries of AB-PMJAY*. Available at: https://pib.gov.in/Pressreleaseshare.aspx?PRID=1575549

[476] Id. at 403, pp. 39, 40.

[477] *Chhattisgarh Food and Nutritional Security Act, 2012.*

[478] Department of Food, Civil Supplies and Consumer Affairs. About. Available at: https://food.hp.nic.in/fun11.htm

[479] Samagra. About. Available at: http://samagra.gov.in/Public/StaticPages/AboutSamagraPortal.aspx

[480] Price Waterhouse-Cooper. (2016). *Report on SAMAGRA Portal: An initiative to implement Integrated Social Security Program by creating a common integrated program to facilitate paradigm shift from conventional demand-based model*

Towards Universalisation

Problems surrounding the determination of eligibility disappear once foodgrain is made available to all populations. In special circumstances, eligibility criteria for delivery of entitlements have been waived. In 2015, through its judgement in *Swaraj Abhiyan v. Union of India*, the Supreme Court urged state governments to provide foodgrain to households and persons without ration cards, in light of the prevailing drought-like conditions across India and the slow implementation of the NFSA in several states.[481] A Delhi High Court order in *Delhi Rozi-Roti Adhikar Abhiyan v. Union of India* also extended foodgrain entitlements free of cost to non-PDS and non-Aadhaar card holders in 2017.[482] While identification of eligible households is a problem that plagues the TPDS, such efforts to move towards universalisation are being made, which eliminate the need for complicated identification processes identifying at the first place.

COVID-19

Another unprecedented event that forced central and state governments to waive eligibility criteria was the COVID-19 pandemic. In April 2020, the centre announced the *Pradhan Mantri Garib Kalyan Yojana (PMGKAY)* as part of the Pradhan Mantri Garib Kalyan Yojana, which was eventually extended till December 2022.[483] PMGKAY was a pandemic relief food security scheme that entitled poor families to 5 kg foodgrain each month, in addition to the NFSA entitlement of 5 kg foodgrains already available at subsidised rates. State governments stepped up to further cover households not eligible under the Act. For instance, the Rajasthan government opened up its TPDS to 4.6 million people who did not have ration cards with grain entitlements.[484] Andhra Pradesh announced free rice entitlements, doorstep delivery and stipulated foodgrain for all BPL families, foregoing any identification criteria.[485] Delhi NCR announced free 7.5kg foodgrain to all;[486] Kerala distributed grocery kits and up to 35kgs of rice to all households in the state;[487] Madhya Pradesh[488] and Uttar Pradesh[489] made foodgrain over and above the PMGKAY entitlements available to households free of cost.

In December 2022, the central government announced that it will provide free foodgrains to close to 81.35 crore entitled persons under the NFSA for one year from January 1, 2023.[490] The decision came around the time when PMGKAY was reaching conclusion on 31 December 2022. Under the PMGKAY, ration cardholders were entitled to 5kg of free foodgrain per household over and above the 5kg provided under the NFSA. Though the new central scheme waives off the cost of grain under the NFSA,

---

of governance. Madhya Pradesh, pp. 17, 18. Available at: https://nceg.gov.in/sites/default/files/nceg2016/casestudies/SamagraPortal_CaseStudy.pdf

481 *Swaraj Abhiyan v Union of India*, W.P.(C) NO. 857 OF 2015, Supreme Court of India.

482 *Delhi Rozi-Roti Adhikar Abhiyan v Union of India*, W.P.(C) 2161/2017, Delhi High Court, pp. 8, 9.

483 Ministry of Finance. (2020). *Press Release: Finance Minister announces Rs 1.70 Lakh Crore relief package under Pradhan Mantri Garib Kalyan Yojana for the poor to help them fight the battle against Corona Virus*. Available at: https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1608345

484 See, https://twitter.com/ashokgehlot51/status/1260263793038200832

485 For free ration notification, see Government of Andhra Pradesh. (2020). Order G.O.Rt.No.210 dated 23.03.2023. Available at: https://drive.google.com/file/d/1rz7dgaqUWCEyds3ViOCdWM2XWm8TJ8Lu/view; For doorstep delivery notification, see https://twitter.com/xpressandhra/status/1243176566361739264, For BPL families notification, see https://twitter.com/AndhraPradeshCM/status/1243907796615090177?s=20

486 Special Correspondent. (2020). *Free ration, double pension in Delhi*. The Hindu. Available at: https://www.thehindu.com/news/cities/Delhi/free-ration-double-pension-in-delhi/article31132091.ece

487 Paul, C. (2020). *'Nobody should go hungry': Kerala to start community kitchens in every panchayat*. The Week. Available at: https://www.theweek.in/news/india/2020/03/25/covid-19-lockdown-kerala-to-start-community-kitchens-in-every-panchayat.html

488 Yadav, S. (2020). *Madhya Pradesh govt. to give BPL families free ration for a month*. The Hindu. Available at: https://www.thehindu.com/news/national/other-states/madhya-pradesh-govt-to-give-bpl-families-free-ration-for-a-month/article31168585.ece

489 Government of Uttar Pradesh. (2020). Agriculture Commission Notification. Available at: https://drive.google.com/file/d/1aiZ-1RzpRl7yn-LlDntDCagrEwTYncMC/view

490 Ministry of Consumer Affairs, Food & Public Distribution (2022). *Press Release: Free foodgrains to 81.35 crore beneficiaries under National Food Security Act: Cabinet Decision*. Available at: https://www.pib.gov.in/PressReleasePage.aspx?PRID=1886215

the discontinuation of PMGKAY implies that households will receive half the amount of foodgrain starting January 2023, i.e., 5kg. For households still grappling with financial losses brought on by the pandemic, this does not present as a progressive reform under TPDS. Civil society groups such as the Right to Food Campaign have proclaimed the announcement to be regressive and insensitive, and have called for the PMGKAY to be extended and the roster of foodgrain to be expanded to include a variety of grain such as millets, pulses and oil.[491] Moreover, the NFSA goes beyond TPDS and provides for maternity and child nutrition in a holistic manner through the ICDS, mid-day meal scheme and universal maternity entitlements. Experts, Dreze and Hussain, believe that the free-grain announcement could come at the cost of undermining or side-lining these provisions.[492] Maternity entitlements, for instance, would benefit from the expansion and funding being supplied to the TPDS.

Objections to universalisation

Though PMGKAY and provision of additional free foodgrain was driven by necessity and helped millions stay afloat during a deadly pandemic, concerns were raised about cost implications of universalising the TPDS. In two years of its implementation, PMGKAY was estimated to cost the government ₹3.91 lakh crore.[493] With buffer stocks depleting around May-June 2022, it was argued that the continuation of PMGKAY without changes would have led to an unsustainable depletion of stocks, leading the centre to double down on its procurement from the open market, further destabilising open market prices.[494] However, these arguments do not justify rolling back a significant social security scheme only to replace it with an inadequate one. The centre has made clear its intentions to cut back on food subsidies since PMGKAY. In the latest Union Budget presented on 2 February 2023, there was a deep slash in foodgrain subsidy, with the allotted budget cut down by 63 percent.[495] Reports suggest that the NITI Aayog has made several submissions arguing to pare down TPDS coverage and cut back on food subsidies disbursed from the centre.[496] In *Re Problems and Miseries of Migrants*, the government quoted some of the Niti Aayog's views in its affidavits submitted to the Supreme Court, arguing against expanding food security schemes to those considered ineligible even in light of the pandemic. NITI Aayog had taken a similar stance at the beginning of the pandemic, by making submissions opposing the terms of PMGKAY.[497] This unfortunate stance runs contrary to India's constitutional and international obligations for the progressive realisation of socio-economic rights.

6.3.7 Key Issue: Quality of food

While the NFSA prescribes quantitative standards of foodgrain for distribution under TPDS, deficiencies in quality of the foodgrain began to surface as soon as the Act was implemented, posing vast challenges to the promise of food security. The quality of wheat and rice available through TPDS may not meet quality standards on two counts: in terms of the physical integrity of the grains due to

---

491 Right to Food Campaign. (2022). *Government of India cuts ration entitlements by 50% of 81 crore people.* Countercurrents.. Available at: https://countercurrents.org/2022/12/government-of-india-cuts-ration-entitlements-by-50-of-81-crore-people/

492 Singh, I.S. (2023). *Full Transcript: What Will Free Rations Under NFSA Mean for the Poor, India's Food Stocks?* The Wire. Available at: https://thewire.in/rights/full-transcript-nfsa-free-rations-pmgkay

493 Kishore, R. and Kanagaraj, P. (2022). *Number Theory: Understanding the rejig in India's food security programme.* The Hindu. Available at: https://www.hindustantimes.com/india-news/understanding-the-rejig-in-india-s-food-security-programme-101672251439489.html

494 Drèze, J. (2023). *What free food rations hide: A rollback of social security in India*. Scroll.in. Available at: https://scroll.in/article/1040987/what-free-food-rations-hide-a-rollback-of-social-security-in-india

495 Jalihal, S. (2023). *Documents Reveal NITI Aayog Pushed Govt to Privatise PDS, Slash Free Food Coverage, Subsidies*. The Wire. Available at: https://thewire.in/government/documents-reveal-niti-aayog-pushed-govt-to-privatise-pds-slash-free-food-coverage-subsidies

496 Ibid.

497 Sharma, H. (2021). *To cut subsidy bill, Niti paper says lower coverage of food security law*. Indian Express. Available at: https://indianexpress.com/article/india/to-cut-subsidy-bill-niti-paper-says-lower-coverage-of-food-security-law-7207884/

inappropriate storage conditions and in terms of the nutrition the grains offer to an under-nourished population.

Storage of foodgrain

Before foodgrain is distributed under TPDS, it is stored in massive quantities at localised warehouses and godowns. These facilities hold grain for long periods of time and supply a stipulated amount in end-mile delivery to different pockets of rural or urban India. As of 2022, the FCI leases out 788 lakh metric tonnes (LMT) of grain for storage to central, state and private warehouses.[498] This includes an estimate of grain needed per eligible household (also called "*operational stocks*"), and an additional buffer stock to ensure long-term food security and insulation from grain shortage. However, such large-scale storage has emerged to be a significant encumbrance to TPDS. A study by the National Academy of Agricultural Sciences (NAAS) finds *"that storage is the major cause of post-harvest losses for all kinds of food in India."* [499] In storage, an interplay of several factors of temperature, moisture or hygiene can lead to deterioration in the quality of grain. Traditional methods of storing wheat in jute sacks, still followed in many pockets of rural India, have also been linked to the faster deterioration of grain.[500] For decades, vital TPDS foodgrains have experienced sub-par storage conditions, damage during transportation, and exposure to elements of nature that may render them unfit for consumption.[501]

Indeed, steps have been taken at the central level to regulate and reform storage facilities with the aim of reducing loss of grain. One approach is rooted in policy and regulation, an example of which is the FCI Storage and Contract Manual which sets out conditions of operation for godowns storing operational and buffer grain, regular inspection of facilities, and curative measures for defaulting warehouses.[502] The Food Safety and Standards Authority of India also steps in to ensure quality compliance through registration of private godowns and guidance documents for efficient storage of foodgrain.[503,504] In 2012, godowns were further decentralised and instructed to be built at the fair price shop level, which resulted in better quality control and reduced leakages.[505] Additionally in 2010, through one of the PUCL orders, the Supreme Court found that food grains were rotting in warehouses due to inadequate storage facilities. It directed the central government to adopt long and short-term measures to store and preserve procured food grain to prevent rotting. These measures include a) constructing adequate FCI storage facilities in each state and division, b) expanding foodgrain coverage, c) keeping Fair Price Shops open for all days in the month, and d) distributing food grains to eligible households at lower or no costs.[506]

Another approach has been to rely on technology to compute an optimal environment for foodgrain storage and create infrastructures that lend themselves to the health and longevity of grain. This, for instance in 2005, resulted in a nation-wide shift from traditional jute-sack warehousing of wheat to

---

498 Food Corporation of India. Storage and Contract. Available at: https://fci.gov.in/storages.php

499 National Academy of Agricultural Sciences. (2019). *Saving the Harvest: Reducing the Food Loss and Waste*. p. 5. Available at: http://naas.org.in/documents/Saving%20the%20Harvest.pdf

500 El-Kholy, M.M., and Kamel, R.M. (2021). *Performance Analysis and Quality Evaluation of Wheat Storage in Horizontal Silo Bags.* International Journal of Food Science. doi: 10.1155/2021/1248391.

501 Singh, P.K. (2015). *What is the cause of huge food grain wastage in India?* Business Standard. Available at: https://www.business-standard.com/article/punditry/what-is-the-cause-of-huge-food-grain-wastage-in-india-115081301512_1.html.

502 Food Corporation of India. Storage and Contract Manual, Part 1-3. Available at: https://fci.gov.in/app/webroot/upload/Storage/S_CManualPart1.pdf

503 In case a warehouse also qualifies as a Food Business, the warehouse must be registered as per section 2 of the *Food Safety & Standards (Licensing & Registration of Food Businesses) Regulation, 2011.*

504 Food Safety and Standards Authority of India (FSSAI) Guiding Document on Food Safety Management System (Food Industry Guide to Implement GMP/GHP Requirements), 2017.

505 Mukherjee, S. (2012). *Ration shops in remote areas to have grain storage facilities*. Business Standard. Available at: https://www.business-standard.com/article/economy-policy/ration-shops-in-remote-areas-to-have-grain-storage-facilities-112050502013_1.html

506 *PUCL v Union of India and Others*, Interim order dated August 12, 2010. Supreme Court Writ Petition [Civil] No. 196 of 2001.

silo storage.[507] But the shift to silo storage has been slow and staggered. In 2016, FCI devised an Action Plan to shift 100 LMT worth of grain to newly constructed silos over the next four years.[508] But an FCI status report from May 2022 suggests that this number is a meagre 12.25 LMT today, six years since the implementation of the action plan.[509] On a brighter note, there is renewed interest in increasing these numbers which is being effectuated. In July 2022, the FCI sanctioned its plan to construct 26 steel silos in Punjab for grain storage, a high-produce area for wheat and rice.[510]

Where silos cannot be constructed in the near future, the FCI has relied on other forms of technology to increase the shelf life of TPDS grain. In 2021, the central government asked FCI to install a Vehicle Tracking System in its 20 regional offices to track movement of trucks transporting TPDS foodgrain from warehouses to depots to curb illegal diversion.[511] In April 2022, an Online Storage Management (OSM) system was launched to help in route optimisation for distribution of grains and to act as a single source of information on foodgrain stocks held in godowns – classified on the basis of procurement year, quality parameters – and truck wise data about grains in transit.[512] Reports suggest that Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Madhya Pradesh, Odisha, Punjab, Tamil Nadu, Telangana, Tripura, Uttarakhand and West Bengal are presently working to implement the OSM system and other states are expected to follow suit.[513] Climate change, and heat waves specifically, additionally catalyse the deterioration of grains in storage, posing considerable threats to India's long-term food security.[514] As of December 2022, the centre is responding to this concern by developing district level risk and vulnerability assessments of various grain and crops, and implementing climate-resistant technologies to keep stored grain intact for longer.[515]

While the state of foodgrain storage in India is less than ideal, given the vast quantities of operational and buffer stocks the country holds versus the quantities that actually reach TPDS eligible households, renewed policy commitments and utilisation of new technology to prolong the life and quality of foodgrain provide grounds for cautious optimism.

Nutritional quality of foodgrain

TPDS grain entitlements account for 39 percent of an average eligible household's monthly food grain consumption.[516] Of these entitlements, the NFSA only guarantees subsidised wheat and rice, and

---

507 A silo is a structure used for storing bulk grains. It is typically made of steel, implying large manufacturing and operational costs, but also takes up less land space and reduces instances of not only grain deterioration, but also theft or pilferage.

508 Food Corporation of India. (2016). Action Plan for construction of Steel Silos. Available at: https://fci.gov.in/app/webroot/upload/Storage/Revised%20Action%20Plan%20dated%2014.01.2016_1.pdf

509 Food Corporation of India. (2022). Status of Silo Construction. Available at: https://fci.gov.in/app/webroot/upload/Storage/Current%20Status_31.05.2022.pdf

510 Hindustan Times. (2022). *FCI to make steel silos for foodgrain storage at 26 sites in Punjab.* Available at: https://www.hindustantimes.com/cities/chandigarh-news/fci-to-make-steel-silos-for-foodgrain-storage-at-26-sites-in-punjab-101657661571874.html

511 Livemint. (2021). *All FCI regional offices asked to implement vehicle tracking system, says Govt*. Available at: https://www.livemint.com/news/india/all-fci-regional-offices-asked-to-implement-vehicle-tracking-system-says-govt-11615902639664.html; Food Corporation of India, Appointment of Vendors for providing Vehicle Tracking Services (VTS) For Owned / Hired / Rented Vehicles used by FCI Road Transport Contractors during Transportation of Foodgrains by road, Brief description/scope of work/services, p. 7. Available at: https://fci.gov.in/app/webroot/upload/Storage/VTS%20MTF%20Amended%20upto%2022.11.19.pdf

512 Financial Express. (2022). *Online tracking of food grains from April to help cut storage cost*. Available at:https://www.financialexpress.com/industry/online-tracking-of-food-grains-from-april-to-help-cut-storage-cost/2413838/

513 Ibid.

514 Charkrabarty, M. (2016). *Climate change and food security in India.* ORF Online. Available at: https://www.orfonline.org/research/climate-change-and-food-security-in-india/

515 Ministry of Agriculture and Farmers' Welfare, Government of India. (2022). *Foodgrain Crisis due to Climate Change*. Lok Sabha (starred question no. 86). Available at: https://pqals.nic.in/annex/1710/AS86.pdf

516 Department of Food & Public Distribution and Microsave consulting. (2019). *A study to assess the nutritional gaps in PDS households*. pp. 13-14. Available at: https://www.microsave.net/wp-content/uploads/2020/01/190802_Nutrition_PDS.pdf

states are at liberty to provide other grains and nutrition at their own cost.[517] Studies over the years suggest that rural India lives in chronic nutritional deficiency, with diets especially deficit of proteins and micronutrients.[518]

At the central level, the focus with TPDS has always been to deliver adequate quantities, but little attention has been paid to nutritional quality. States' TPDS have, however, attempted to address issues related to nutritional deficiencies. For instance, a simple route taken by states with high incidence of protein deficiencies is to introduce various pulses, a rich source of protein, as part of TPDS benefits, provided free of cost or at subsidised rates. Over the past decade, Andhra Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Punjab, Tamil Nadu, and Telangana have incorporated a variety of pulses in the state TPDS.[519] In Kerala, communities most prone to protein deficiencies are provided pulses through targeted schemes, though the same has not been implemented state-wide.[520]

A survey to assess the nutritional gaps in TPDS households reflects that not only proteins, but also calcium, iron, zinc, thiamine, amino acids and other micronutrients also lack in the Indian diet, which are not made available through government nutritional programmes such as the ICDS.[521] Vitamin B12, a vital micronutrient, is seen to be completely missing. The TPDS cannot be solely blamed for these deficiencies. But as a system, it contributes to a substantial chunk of rural India's diet, and it reaches more households in the country than any other food security programme. Therefore, the TPDS can be used as an effective vehicle to deliver a wider variety of nutrients to the households it covers, and the Act can widen its definition of "entitlements" to include more grains and nutrition than wheat and rice.

Quality of mid-day meals

The *Basic Entitlements* Order,[522] passed as part of the *PUCL Orders*, first set out minimum qualitative and quantitative standards for midday meals served in schools. Each meal prepared must contain 300 calories and 8-12 grams of protein, and be served for a minimum of 200 days in a year. The FCI must routinely ensure that fair average quality (FAQ) grain is being used to prepare the meals, and if regular inspections show the foodgrain to be subpar, the FCI must replace the stock. These norms were implemented nationwide, yet issues around the quality of meals served would often surface. In 2015, the CAG published a Performance Audit of Midday Meal Scheme assessing state-wise performance of the scheme on the parameters of implementation, coverage, efficacy, quality, and so on.[523] It was noted that regular inspections on the quality of the foodgrain and the hot meals served to students were not carried out. Where they were, numerous instances of food being prepared in open and unhygienic conditions were reported, which exposed millions of children to health hazards.[524] While inspecting schools in Goa, Madhya Pradesh, Uttar Pradesh, Lakshadweep and Delhi NCR to ensure

---

[517] Section 3, *National Food Security Act, 2013.*

[518] Chand, R. and Jumrani, J. (2013). *Food security and undernourishment in India: Assessment of alternative norms and the income effect*. Indian Journal of Agriculture and Economics, pp. 39–53; Harishankar, Dwivedi S., et al. (2004). *Nutritional status of children under 6 years of age*. Indian Journal of Prev Soc Med. 35(156), p. 62; Cohen M., et al. (2008). *World Food Insecurity and Malnutrition: Scope, Trends, Causes and Consequences*. Rome: International Food Policy Research Institute (IFPRI), Food and Agriculture Organization of the United Nations (FAO).

[519] Puri, R. (2017). India's *National Food Security Act (NFSA): Early Experiences.* Leveraging Agriculture for Nutrition in South Asia (LANSA) Working Paper Series, pp. 26-27. Available at: https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/13040/NFSA-LWP.pdf?sequence=1&isAllowed=y

[520] On Manorama. (2021, December 6). *UDF proposes 'protein ration' for Attappady's Adivasis to bring down infant deaths.* Available at: https://www.onmanorama.com/news/kerala/2021/12/06/udf-vd-satheesan-attappady-adivasis-infant-deaths-prot.html

[521] Id. at 435.

[522] *Basic Entitlements Order,* dt. 28 Nov 2001, *PUCL v Union of India and Others*, Writ Petition (Civil) 196 of 2001.

[523] Comptroller and Auditor General of India (2015). *Performance Audit of Midday Meal Scheme*. Report No. 36 of 2015. Ministry of Human Resource Development, Union Government. Available at: https://cag.gov.in/uploads/download_audit_report/2015/Union_Performance_Civil_Mid_Day_Meal_Report_36_2015_2.pdf

[524] Ibid, pp. 35-38.

FAQ foodgrain were being used to cook meals, the grain was found to be of inferior quality, in one case even infested with larvae.[525]

Implementation of the NFSA shortly thereafter also did not offer much relief. From 2016 to 2019 alone, over 900 students reportedly fell sick across the country from unhygienic and substandard midday meals.[526] Incidents of contaminated food making students grievously ill have emanated from Karnataka,[527] Maharashtra,[528] West Bengal,[529] Uttar Pradesh[530] and many other states. In response, the Union Ministry of Education notified the *Pradhan Mantri POSHAN (midday meal) Guidelines in December 2022*, which comprise specific Guidelines on Quality and Safety Aspects.[531] The guidelines obligate the FCI to supply schools with ingredients that pass the FAQ mark, conduct regular grain inspections and store samples for verification in case complaints arise on the quality of grain. The guidelines provide that the cooking of meals should be assigned to Cook-Cum-Helpers, Local women's/mothers' Self-Help Groups, Local Youth Clubs affiliated to the Nehru Yuvak Kendras or a voluntary organization i.e., Civil Society Organisation (CSO) or Non-Governmental Organisation (NGO) and provide detailed guidance to ensure the quality of cooked meals.[532]. Meals must be prepared as per prescribed food and nutrition norms issued at the state level and where meals are cooked by third parties, such private providers are required to sign a contract or memorandum of understanding (MoU) with the state government, outlining liabilities and the consequences of non-performance on their parts. In Delhi NCR, midday meals are almost exclusively provisioned through private service providers,[533] that are selected through tenders which clearly list out nutritional norms, kitchen hygiene requirements, and even set menus which must be adhered to[534] and the hiring an independent agency to test raw and cooked food samples from time to time is also being considered.[535]

The review of the NFSA for this paper sheds light on the importance of progressing towards universalisation of food security and at a minimum to urgently address exclusion errors in the provision of foodgrains, meals or other entitlements, setting standards and regulating the quality of services keeping in mind the end outcomes and concerns around the use of technology.

---

525 Ibid.

526 Correspondent. (2019). *Midday meals left 900 children ill*. The Hindu. Available at: https://www.thehindu.com/news/national/midday-meals-left-900-children-ill/article28430756.ece

527 Correspondent. (2021). *Karnataka: Around 80 students fall sick after consuming mid-day meal with dead lizard.* Midday. Available at: https://www.mid-day.com/news/india-news/article/karnataka-around-80-students-fall-sick-after-consuming-mid-day-meal-with-dead-lizard-23207145

528 Rao, Y. and Debroy, S. (2017). *In 5 years, 470 kids fell ill after eating midday meals in Maharashtra. Times of India*. Available at: https://timesofindia.indiatimes.com/city/mumbai/in-5-years-470-kids-fell-ill-after-eating-midday-meals-in-maharashtra/articleshow/60432565.cms

529 Press Trust of India. (2023). *Several Children Fall Sick After Consuming Mid-Day Meal In West Bengal's Birbhum*. NDTV. Available at: https://www.ndtv.com/education/several-children-fall-sick-after-consuming-mid-day-meal-in-west-bengals-birbhum-3678819

530 Raju, S. and Mullick, R. (2019). *Dead rat found in midday meal, nine students take ill*. Hindustan Times. Available at: https://www.hindustantimes.com/india-news/dead-rat-found-in-midday-meal-nine-students-take-ill/story-EQOk3apWT0QBeHsvPzVK7M.html

531 Pradhan Mantri Poshan Shakti Nirman (PM POSHAN) Scheme Guidelines, 2022. Available at: https://pmposhan.education.gov.in/Files/Guidelines/2023/Guidelines%20on%20PM%20POSHAN%20SCHEME.pdf

532 Id. pp. 23-30.

533 EduDel Factsheet. (2019). Information Related to MDM Scheme in DOE Schools (as on 30-04-2019) (As per Hon'ble Supreme Court Order in W.P.C No. 618/2013). Available at: https://www.edudel.nic.in//mis/Finance/SchoolFinance/frmMDMSchemeSupremeCourtDistrictLevelReport4.aspx?schid=1821005&schname=Samalka,%20No.1-%20GBSSS

534 See, sample tender. Government of NCT. (2022). e-Procurement Tender Notice. Available at: https://www.edudel.nic.in/tenders_new/tender_mdm_dt_21092022.PDF

535 Mathur, A. (2022). *Delhi government to hire agency to check quality of midday meals in schools.* Times of India. Available at: http://timesofindia.indiatimes.com/articleshow/92113680.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

6.4 Implications for UHC

The review of social sector legislations highlights key factors influencing implementation of all three laws in a meaningful manner.

First is the need for institutional mechanisms that facilitate mobilisation of communities, and articulation of demands in a clear and persistent manner. Pressure from communities is a significant factor in forcing the political class and bureaucracy to implement laws. In most cases, individuals without any community support are reluctant to challenge or question the system. Our review shows that states and districts with mobilised communities saw better implementation of MGNREGA, RTE Act and NFSA, compared to those states and districts with little to no mobilisation. At the least, this entails concerted efforts towards generating awareness about the law among different stakeholders. For example, states where the 25 percent reservation mandate under the RTE Act was relatively functional, invested resources in generating awareness about the provision amongst economically weaker and disadvantaged communities. Similarly, social audit reports on MGNREGA played a key role in making communities aware about different aspects of the law, as well as their implementation status. Another essential aspect of community mobilisation is fostering methods, processes and tools that facilitate community participation in the decision-making and implementation of social policies. As discussed in greater detail in Section 5, participatory health governance is considered essential to the success of any UHC programme. The lessons highlighted above from these three laws in this respect offer critical insights for the implementation of UHC in India.

Second is the need for decentralised planning and implementation. A bottom-up approach is essential for sustaining reasonably effective ways of service delivery. It entails empowering communities, PRIs, and district-level bureaucracy. For example, one of the factors attributed to the relative success of Kerala in the implementation of the RTE Act is the empowerment of PRIs. In other areas, the implementation of the RTE Act has been criticised for the centralised manner in which funds are allocated and teachers are recruited, rather than being based on the needs of each state or even districts. In the case of MGNREGA, which does envisage a role for PRIs, the need for building capacity of these institutions for effective decision-making and planning has been identified. In the health context as well, a more decentralised system is seen to improve human welfare. The examples of Kerala and Karnataka demonstrate that greater decentralisation led to greater presence of health infrastructure in rural areas.[536] However, the nature of decentralisation depends on the kind of healthcare system adopted by states and the stage of 'health transition'.[537] It entails streamlining health financing, and building decision-making and fiscal capacities of states, including at the PRI level.

Third is the universalisation of social sector programmes. For one, identification of eligible households in programmes that target specific populations tend to suffer from exclusion errors, leaving out households that are in need of these services. The implementation of the TPDS under the NFSA has been riddled with these exclusions, whether relying on BPL or SECC based classification. Alternatively, Bihar adopted an exclusion approach, under which everyone is eligible to claim TPDS entitlements except those who are specifically not, ensuring wider coverage and lower instances of error. Nevertheless, it is only with universalisation that exclusion errors can be entirely eliminated. The HLEG Report on Universal Coverage in India also recommends that a system for UHC must cover all socio-

---

[536] Pahwa, D.H., and Beland, D. (2013). Federalism, decentralisation, and health care policy reform in India. Public Administration Research, 2(1), 1.

[537] 'Health transition' encompasses demographic transition (from high to low mortality and fertility), epidemiological transition (from malnutrition and communicable diseases to chronic diseases), social transition (from low to high expectation from the health system) and technological developments in diagnostics and therapeutics. States in early stages should focus more attention and resources on completing the unfinished agenda. States which are further along in health transition should focus on developing programmes to address their dominant health risks, and less risky health financing systems. All states must develop strategies to address inequities in rural and urban, and tribal and non-tribal settings. *See*, Peters, D. H. et al (2003). *Lumping and splitting: the health policy agenda in India*. Health Policy and Planning, *18*(3), p. 249-260.

economic classes and sections of the Indian population.[538] Specifically, including the relatively better off will ensure their interest in building and benefitting from an efficient and equitable health system, which in turn will facilitate the creation of a robust and sustainable system of UHC.

Fourth is the rational use of technology for implementation. Moving towards a tech-enabled system is not, in and of itself, problematic. Issues emerge when complex and underdeveloped systems are brought into the picture without a holistic understanding of how it would affect service delivery, especially in rural and hard-to-reach areas as well as populations with low levels of digital literacy. For instance, the use of MIS for the implementation of MGNREGA has led to centralization, consolidation of administrative control, lack of local accountability, and promotion of a distorted picture of scheme success through false or misleading data. The use of ABBA for delivery of TPDS entitlements under NFSA has led to disenfranchisement of poor and marginalised sections of society. In contrast, adoption of accessible and easy-to-use technological solutions, such as digitised records, SMS services, live tracking of food grain delivery and comparative ledgers, have aided in reforming the TPDS. *While Working Paper 4 in this series examines key issues and concerns related to digital health technologies and UHC, it is worth noting that across the three laws examined in this section of the paper, technology while helpful has not been able to provide a one-stop solution to the myriad implementation issues plaguing these sectors.*

Fifth is establishing an independent grievance redress system. The MGNREGA and RTE Act have been criticised for leaving grievance redress mechanisms in the hands of government authorities and officials responsible for implementation of these laws. As a result of this, not only has the quality of grievance redress suffered, but also tends to add to the reluctance of individuals to access these systems.

Sixth is the need to review the mechanism for monitoring the implementation of these laws and policies. The need for this particularly stood out in reviewing the administrative machinery governing the RTE Act, including the National and State Commissions for the Protection of Child Rights. Existing literature shows that the quality of monitoring has suffered because these authorities are saddled with multiple responsibilities apart from the RTE Act, struggle with inadequate financial and human resources, and are limited by complicated processes for the exercise of powers.

[538] HLEG. (2011). *High Level Expert Group Report for Universal Health Coverage in India*. Planning Commission of India, p. 5.

7. CONCLUSION AND KEY MESSAGES

The enactment of rights-based legislations were watershed moments in long standing social movements on the rights to work, education, food and health. While their implementation has not been without difficulties, narratives that suggest that rights-based laws and policies are not implementable are over-simplistic and deflect attention from the real barriers to fulfilling the obligations of the government under the Constitution and under international law. It is of note that MGNREGA and NFSA became literal lifelines for millions at the height of the COVID-19 pandemic.

In many ways the rights enshrined in these social sector legislations mitigated the effects of the draconian measures taken by the government under the *Epidemic Diseases Act, 1897* and the *Disaster Management Act, 2005*. Regrettably, rights-based approaches that have populated the health sector for decades now and the philosophy that protection of rights is intrinsic to the prevention and control of epidemics enshrined in the *HIV Act* did little to inform the approach of the government during the pandemic. There is considerable hope that the lessons from the handling of the pandemic will inform the debates and discussions around UHC in India and lay the foundation for a rights-based approach to public health. Indeed, the Supreme Court has called on state governments to consider adopting or updating their public health laws based on the right to health framework in the National Health Bill, 2009. Most recently, the Rajasthan government has manifested a rights-based approach to health through its *Right to Health Act, 2023*.

What is evident from this paper as well is that the right to health, whether enshrined in laws, policies or programmes must be fulfilled as per the ***legal standards and norms*** established in domestic (Article 21 of the Constitution) and international law (AAAQ, ICESCR). Indeed, the right to health includes access to social determinants of health; the interplay of the social sector legislations during the pandemic is noted above. Of note is a provision in the *Assam Public Health Act* that requires the health department to coordinate with non-health departments (water, food, sanitation, housing, social welfare). Free access to health services and treatments in the *HIV Act* and the *Mental Healthcare Act* are intrinsically linked to the prohibition of discrimination, the right to consent and confidentiality and several other determinants of health. Ironically the hurdles faced in implementing these provisions reveal their importance as they directly impact whether and how people access healthcare or not.

The review of laws and policies in this paper have highlighted the fact that implementation has varied across different aspects of the laws, as well as from state to state and within states. The quality of implementation has depended on a host of factors, such as the will of the political class, availability of resources, state capacity and community mobilisation. The issue of ***political will*** plagues implementation in myriad ways. In the case of the *HIV Act*, the non-notification of Rules in some states delayed implementation significantly. In other states, the lack of political will has taken the form of half-hearted attempts to appoint implementation mechanisms like the ombudsman. Similar half-hearted attempts are visible in the constitution of Mental Health Review Boards, the grievance redress systems of the National Health Mission or in the desire to sustain or build on community-based monitoring beyond the pilot phase. Political will is particularly critical where the private sector plays a key role in the fulfilment of rights; the experience of the RTE Act in regulating private schools indicates how challenging the task would be for a UHC roadmap that relies on the private health sector.

Budgetary allocations and availability of resources are most obviously and directly impacted by the lack of political will as seen in the implementation of NFSA, MGNREGA and RTE. This issue of ***financing*** goes to the heart of implementation. Thus, poor implementation caused due to irrational (tertiary), unstable (fluctuating yearly) allocation of funds can be seen in the case of the *Mental Healthcare Act* while the National Health Mission suffers from the lack of timely distribution of funds.

Implementation is also heavily dependent on ***capacities*** of all kinds. The capacity of healthcare workers is intrinsic to the delivery of the right to health. In the case of the *Mental Healthcare Act*, the

current approach to training of healthcare workers based on a bio-medical approach is considered inappropriate. In the case of the *HIV Act*, the capacity of healthcare workers is linked not only to their training which is necessary to counter, inter alia, misinformation related to HIV that fuels stigma, discrimination and rights violations under the Act, but is also linked to occupational health and safety guarantees for healthcare workers. The *Assam Public Health Act* provides for special measures to make available trained human resources for rural health programmes and for all public healthcare institutions to adhere to Indian Public Health Standards but there is little to indicate how these provisions are being implemented. The issue of capacities also arises at governance levels. For instance, the implementation of the *Mental Healthcare Act* has been stymied by the lack of initiative and knowledge to prepare budgets in several states as well as the ability to assess data being collected under the Act to respond to needs based on trends being captured. An overlooked issue of capacity crucial to the effective implementation of a law or policy is educating stakeholders about it, resulting in weak implementation and persistent violations, including against the most vulnerable and marginalised populations. The lack of awareness of the provisions of the *HIV Act* and the *Mental Healthcare Act* appears to be a critical factor in the lack of use or reliance on these laws by affected communities.

An interesting and positive finding emerging from this review is the incorporation of multiple mechanisms for ***transparency and accountability***. While this is expected in the case of laws and policies emerging from peoples' movements, it has been interesting to note their incorporation across key health policies and programmes. This is not to say that implementation issues do not plague these mechanisms. The review of grievance redress mechanisms in particular have highlighted issues of the lack of independence and neutrality, opaqueness in appointments and functioning, and overlapping, conflicting roles that are at once administrative and adjudicatory, going against principles of natural justice. In terms of mechanisms of participation, there have been challenges in the constitution of committees, issues of conflict of interest, accountability and capacity issues in understanding roles and responsibilities. One particular mechanism that did stand out in this review was that of social audits which could be considered for the health sector as well. The difficulty in getting information and data for the purposes of this paper has also underscored the importance of rights-based indicators described in Working Paper 1 in this series for assessing the implementation of laws and policies as providing not just quantitative but also qualitative data on the fulfilment of the right to health.

A key response to issues of capacity, transparency and accountability is the increasing reliance on ***technology*** by the government as seen in the implementation of MGNREGA, the RTE Act and NFSA. A common thread that emerges across the experience of the three laws is that hurried, obligatory, and sweeping technological fixes are often met by an ill-prepared and ill-trained bureaucracy and fragile local infrastructure that are unable to cope with the scale and depth of change. Technological tools are often not evaluated independently before being put to use. The continued insistence on using Aadhaar and Aadhaar-based systems for welfare schemes has led to large scale exclusions, fraud and suffering, calling into question the appropriateness of its compulsory use for the fulfilment of rights. This holds important lessons for any UHC rollout in India. Considering the government's emphasis on using technology and digital systems for health delivery, the observed flaws in the use of technology across all three laws hold cautionary lessons for designing a nimble digital health ecosystem that is responsive to the needs of people and most importantly, one that does not end up denying healthcare.

Perhaps the most important finding emerging from this paper is the affirmation that the direct participation of affected communities in planning and implementation of laws, policies and programmes, now recognised as a cornerstone of UHC, is essential for strengthening governance systems across social sectors. Community participation mechanisms need to be supported with adequate funding and capacity-building efforts. While several studies and expert groups recommend that community participation mechanisms should be supported by way of a statute, irrespective of legal backing, these mechanisms require sustained funding and capacity-building. Timely disbursal of funds, periodic capacity-building of community members on areas such as fund utilisation, better

linkages with PRIs, more people-centric focus and adequate funding are significant focus areas across the board which need improvement to realize the right to health mandate of ***peoples' participation***.

Most importantly, there is a need for long-term commitment to community participation. Such participation is often practiced as a singular event without long-term commitment by political representatives, availability of financial resources and technical guidance. For community participation to impact transformation of the public healthcare system, undertake decentralized health planning and seek greater accountability from healthcare providers, governments must undertake sustained efforts to invest financial resources, offer technical guidance and promote active leadership from political representatives. For better accountability, community-based monitoring such as social audits and *jan sunwai*s, needs to be adopted at scale. A crucial aspect that must be taken into consideration in ensuring peoples participation is also accounting for how discrimination, marginalisation, stigmatisation and criminalisation due to gender, caste, class, health status, sexual orientation, gender identity, citizenship and other grounds for exclusion can hamper real participation. Creative, sensitive and empathetic approaches are required to ensure peoples' participation.

It is noteworthy after this extensive review, that despite the problems plaguing the implementation of rights-based laws and policies, nearly all respondent interviewees stressed on the importance of a rights-based framework for the delivery of services. That said, effective implementation is equally important, and entails an enabling environment. Various factors that facilitate or hinder the creation of such an enabling requirement are highlighted in this paper and must be accounted for in envisaging a roadmap towards UHC in India. *In this regard, a strong recommendation is that a consultation of key experts, community groups and patient-led organisations will enrich the understanding, findings and possible recommendations of the governance workstream of the Commission, just as it has provided critical insights in the research of this paper.*

Annexure: List of Experts Interviewed

1. Abhijit Nadkarni, MBBS, DPM, MRCPsych, MSc, PhD, Associate Professor, Centre for Global Mental Health (CGMH), Department of Population Health, London School of Hygiene & Tropical Medicine, UK and Co-Director, Addictions & Related Research Group (ARG), Sangath, Goa
2. Ajit Kumar Singh, State representative PATH, Bihar
3. Amiti Varma, Research Associate, Keshav Desiraju India Mental Health Observatory, Centre for Mental Health Law and Policy, Indian Law Society, Pune
4. Amritananda Chakravorty, Advocate, Delhi
5. Ankur Sarin, Faculty Member, Indian Institute of Management Ahmedabad (IIM)
6. Anmol Somanchi, graduate student, Paris School of Economics
7. Anuradha Talwar, State Committee member, Paschim Banga Khet Mazdoor Samity
8. Ashish Ranjan, Jan Jagran Shakti Sangathan, Bihar
9. Biraj Patnaik
10. Dr Soumitra Pathare, MD DPM MRCPsych PhD, Director, Centre for Mental Health Law & Policy, Indian Law Society, Pune
11. Dr. Antony Kollannur, Independent Monitor, National Health Mission, India and formerly Health & Nutrition Specialist, UNICEF
12. Ganesh Acharya, HIV/TB Activist
13. Hemraj Patil, Support for Advocacy and Training to Health Initiatives (SATHI)
14. Kajal Bhardwaj, Legal Researcher
15. Lalduhawma Chawngthu (LD), HIV & PUD Activist, Founder - Mizoram Drug Users Forum (MDUF) and Founding Member - Indian Drug Users Forum (IDUF)
16. Manisha Shastri, Research Associate, Keshav Desiraju India Mental Health Observatory, Centre for Mental Health Law and Policy, Indian Law Society, Pune
17. Meena Saraswathi Seshu. General Secretary Sampada Grameen Mahila Sanstha (SANGRAM)
18. Mihir Samson, Advocate, Delhi
19. Nikhil Dey, Founder Member of Mazdoor Kisan Shakti Sangathan (MKSS) & National Campaign For Peoples' Right to Information (NCPRI)
20. R. Venkat Reddy, National Convener, M.V. Foundation
21. Santosh Karambe, Community Healthcare Worker
22. Siraj Dutta
23. Tanya Fernandes, Research Associate, Keshav Desiraju India Mental Health Observatory, Centre for Mental Health Law and Policy, Indian Law Society, Pune
24. Trupti Malati, Support for Advocacy and Training to Health Initiatives (SATHI)

C-HELP | CENTRE FOR HEALTH EQUITY, LAW & POLICY

Indian Law Society
Law College Road
Pune 411004
Maharashtra, India
www.c-help.org
contact@c-help.org