Fact Finding Report of Maternal Death

Name of the Woman: Smt. Laxmi Meena

Date of Death: 01/06/2019

Date of Fact Finding: 12/06/2019

(Village-Bhuri Talai, Block-Pratapgarh, District-Pratapgarh, State-Rajasthan)

Deceased Smt. Laxmi Meena

Fact Finding Report by Prayas

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Acronyms

ANC	Antenatal Check-up
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda Unani Siddha Homoeopath
BMO	Block Medical Officer
CHC	Community Health Centre
DoHFW	Department of Health and Family Welfare
DWCD	Department of Women and Child Development
GoI	Government of India
HPS	High Performing State
HSC	Health Sub-Centre
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LPS	Low Performing State
MDSR	Maternal Death Surveillance and Response
MC	Medical College
MMR	Maternal Mortality Ratio
NFHS	National Family Health Survey
NHM	National Health Mission
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PMSMA	Pradhan Mantri Surakshit Matritiva Abhiyaan
VHND	Village Health & Nutrition Day

Introduction

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM), launched in 2005 with the objective of reducing maternal and neonatal mortality. It is a centrally sponsored scheme, which integrates cash assistance with delivery and post-delivery care. JSY promotes institutional delivery especially among women belonging to weak socio-economic status i.e. women from Scheduled Castes, Scheduled Tribes and BPL households. The scheme particularly focuses on States with low institutional delivery rates namely Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir, which are also referred to as the low performing states (LPS). Women of all ages and with any number of children are entitled to JSY benefit. The scheme enables the States/UTs to hire the services of a private specialist to conduct caesarean section or for the management of obstetric complications in the public health facilities, where government specialists are not in place. States are encouraged to accredit private health facilities for increasing the choice of delivery care institutions. In LPS, including Rajasthan, all pregnant women delivering in government health facilities and BPL/SC/ST women delivering in accredited private health facilities are entitled to JSY benefits. In the rural areas a woman gets Rs. 1400 per delivery and in urban areas she gets Rs. 1000 per delivery as incentive for delivering in a health facility.[1 2]

A study commissioned by the Ministry of Health and Family Welfare, GoI and conducted in three districts in each of the eight EAG (Empowered Action Group) states including Rajasthan found that after the launch of JSY, over 50% of women who had their previous delivery at home opted for institutional delivery. NFHS-4 also shows the rise in institutional delivery from 29.6% in 2005-06 (NFHS-3) to 84% in 2015-16 in Rajasthan. The above study found that despite the fact that out-of-pocket expenditure exceeded the cash transfer, women preferred institutional delivery for health and safety reasons. It supported the contention that JSY has resulted in an increase in institutional deliveries, and that it has enabled and empowered poor women to access public health facilities.[3] The institutional births in public facilities increased from 19% in 2005-06 (NFHS-3) to 63.5% in 2015-16 (NFHS-4) in Rajasthan.

Despite the reduction in MMR from 301 maternal deaths per 100,000 live births in 2001–03 (Registrar General of India, Sample Registration System, RGI, SRS) to 130 maternal deaths per 100,000 live births in 2014–16 (RGI, SRS), in India nearly 32,000 pregnant women still lose their lives every year during pregnancy, childbirth and the postnatal period.[4] The MMR of Rajasthan is amongst the highest in the country at 199 maternal deaths per 100,000 live births (Registrar General of India,

Sample Registration System, RGI, SRS 2014-16). By 2030, with the SDGs the world aims to reduce the global maternal mortality ratio to less than 70 per 100 000 live births and reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.[5]

Objectives and Methodology

The fact finding was conducted on 12/06/2019 by Prayas team members with the following objectives:

1. To review the factors that led to Smt. Laxmi Meena's maternal death, such as gaps in information, service delivery and quality of services, negligence and denial of services.
2. To file a legal petition to secure compensation for poor and irresponsible implementation of maternal health services leading to death, inconvenience and avoidable out of pocket expenditure.

The fact finding team comprised:

- Sh. Jawahar Singh Dagur, Prayas, Pratapgarh

The fact finding team conducted:

- Interviews with family members, neighbours and frontline workers
- Observation of quality of care provided in different facilities
- Site visits to home, AWC and health sub centre

Respondents

- Sh. Mukesh Meena – Laxmi's husband, mobile-8290157437
- Sh. Ramchandra Meena – Laxmi's father-in-law
- Sh. Kalu Meena – Laxmi's neighbor, mobile-6367993202
- Sh. Munshi Meena - Laxmi's brother-in-law
- Smt. Meera Devi – Anganwadi worker (AWW)
- Smt. Guddi Meena – ASHA Sahyogini (Bhopakhera), mobile- 8107826436

Background

The village Bhopa Khera is part of the Gram Panchayat Pal. Gram Panchayat Pal is located inside the Sitamata wildlife sanctuary which is spread across 422.95 sq km in Pratapgarh district. Pal Panchayat comprises 8 revenue villages which have about 24 hamlets. All of these are inside in the Sitamata wildlife sanctuary. 1004 families live in the Pal Panchayat, and the total population of the panchayat is 5622 (2696 men and 2926 women). 90% of the population settled here before 1972, after their villages were submerged by the Mahi and Kadana dams. Earlier it was a territorial forest but later it was declared a wild life sanctuary without taking into account the rights and consent of people already living inside the forest area. Since then the area is under the forest department and has no roads, electricity or facilities for drinking water, education or health care.

There are no means of transport in the area because of several rivers, streams, hills and *kaccha* roads that make the terrain very difficult for motorised vehicles. In the rainy season, it is difficult to move around in the area even on foot as the rivers and streams overflow and hills are mucky. It is therefore very challenging for health workers to visit the area especially during the monsoon season. Most of the AWCs and schools do not have permanent structures of their own and are operational in the open or in someone's *kaccha* hutment.

The government has provided for three sub-centres in the Pal Gram Panchayat considering its geographical location and the demand of the local people. However, two out of the three sub-centres have never been functional while at the third one also there has been no ANM for the last 5-6 years. There is a dispensary in the area which too is shut. A male nurse from Gyaspur PHC used to visit the Pal Gram Panchayat area once or twice a month to provide essential health services but now his services too have been suspended. A compounder had been appointed in the area by the AYUSH department, who retired and since then no new appointment has been made.

The Case

Woman's name and age	Smt. Laxmi Meena, 21 years
Village	Bhopakhera (Hamlet Bhuri Talai)
Anganwadi Centre	Bhopakhera, located 2 km from Laxmi Meena's house
AWW	Smt. Meera Meena
ASHA	Smt. Guddi Meena
HSC	5 km from Laxmi Meena's house
Name of ANM	Post vacant
PHC	Gyaspur, 14 km from Laxmi Meena's house

CHC	Dhariyavad, 28 km from Laxmi Meena’s house
District Hospital	Pratapgarh, 35 km far from Laxmi Meena’s house
Age at marriage	20 years
Education status	12th
Total Children	1
Occupation	Housewife
Date of delivery	12/05/2019
Place of delivery	Home
Date of death	01/06/2019
Place of death	Pacific Institute of Medical Sciences, Udaipur
Husband’s name and age	Mukesh Meena, 22 years
Education status	Literate
Occupation	Farmer and labour

Hills ***Kaccha* Roads**

Smt. Laxmi Meena, w/o Sh. Mukesh Meena, r/o hamlet Bhuri Talai, village Bhopa Khera, panchayat Pal, was first time pregnant. Since there are no health services in the village, Laxmi Meena's husband once took her to PHC Gyaspur for ANC and once to CHC Dhariyavad for HIV test, but she did not get complete ANC. He also took her to a private hospital once and informed the fact finding team that she did not have any illness during pregnancy. Sh. Mukesh Meena could take his wife outside the sanctuary area for check-up because he has a motorcycle. It is much more difficult to access health services for those families living in the sanctuary area who do not own a motorcycle. The staff at PHC Gyaspur is reluctant to provide services to the residents of Pal Panchayat and asks them to get ANM appointed in their area instead of increasing their work load. The residents of Pal Panchayat are provided ANC only on the day of the Pradhan Mantri Surakshit Matritiva Abhiyaan (PMSMA) at the PHC.

Kaccha Roads

Health Sub-Centre, Pal

104 and 108 ambulances do not come inside the sanctuary area. They come only till the *pucca* road and ask people to come there and also drop them at the end of the *pucca* road. Since the *pucca* road is quite a distance from the villages inside the sanctuary, people do not call the ambulance. Families who have a vehicle or who are financially slightly better off, take their women outside the sanctuary area for delivery on their own. However, 90% of the pregnant women do not receive complete ANC and their deliveries happen at home itself. The same happened with Smt. Laxmi Meena also. Her husband and father-in-law informed that by the time they could arrange a vehicle to take her to a hospital, she delivered at home. Laxmi had a normal delivery and gave birth to a baby boy who is still alive.

Mukesh Meena's house

Mukesh Meena and his family

Though the government claims high rate of institutional deliveries but in the absence of the required facilities, 90% deliveries in Pal Panchayat are still home deliveries.

Smt. Laxmi Meena did not go to the Bhopa Khera AWC which is 2km from Bhuri Talai. She did not get the supplementary nutrition either. There is no AWC in Bhuri Talai.

Mukesh's parents and neighbour **Mukesh's younger sister taking care of his newborn child**

Smt. Laxmi Meena started having problem 18 days after the delivery, from 28 May 2019. She had nausea, vommitting and her hands and legs felt very weak. The family took her to a private clinic, Sharma Nursing Home in Badi Sadari by a hired private vehicle. The doctor admitted her, took Rs. 3000 advance, put her on IV drip and started her treatment. After some time, he said that he would not be able to treat her. He returned Rs. 1000 to the family from the advance he had taken and advised the family to either take her home or to a hospital in Udaipur. The family took her to Udaipur the same day by the same private vehicle. The driver of the vehicle told the family that Pacific Hospital in Udaipur is good, so the family took her there. Laxmi was admitted at the hospital and her treatment was started. She was given two units of blood but the family was not told anything about her illness or recovery. They were allowed to meet her briefly only in the mornings and evenings. She was under treatment for three days but did not show any improvement. Eventually she died on 1 June 2019 in the hospital itself. The family spent around Rs. 16000 from the time Laxmi became pregnant till she died. The family brought her dead body home by a private ambulance that cost them Rs. 5000.

Guidelines & Guarantees

The fifth and sixth schedules of the Constitution of India provide protection to the tribal population through separate laws for the scheduled areas. The Panchayats (Extension to Scheduled Areas) Act, PESA 1996 that empowers the gram sabha, provides for the legal and administrative reinforcement of the fifth schedule. In 1999, a separate Ministry of Tribal Affairs (MoTA) was created to ensure the socioeconomic development of scheduled tribes. The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, FRA 2006 was introduced to restore their right to land and forest produce.

As per the current GoI norms (IPHS), tribal and hilly areas should have an HSC for every 3000 population, a PHC for every 20000 population and a CHC for every 80000 population. However

rural health statistics reveal huge gaps in health infrastructure and resources in tribal areas due to serious geographical and socioeconomic challenges. Access to health services becomes difficult due to poor or restricted roads. Poor availability of health personnel, lack of adequate equipment, language and social barriers, distance of health centres and poverty add to problems of access. Various states have tried different measures to overcome the shortage of health personnel but the problem persists. Within the limits of the national guidelines of the Tribal Sub-Plan (TSP) and of the National Health Policy (NHP 2016), it is possible to finance tribal healthcare. As per the TSP guidelines, DWCD and DoHFW are supposed to earmark 7.5 to 8.2% of their plan outlays for the TSP.[6]

Constitutional Guarantees

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The Hon'ble Supreme Court has interpreted Article 21 to include numerous fundamental rights already protected under international law, including a fundamental right to health (both physical and mental)[i]; the right to live with dignity[ii]; and the right to be free from torture and cruel, inhuman, or degrading treatment.

Articles 14, 15, and 38 of the Constitution of India provide additional guarantees. Article 14 guarantees equality before the law, and the Hon'ble Supreme Court has described gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution of India."[iii] Article 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. While the burdens of pregnancy and childbirth are inequitably borne by women, the ability to reproduce should not increase women's chances of death, disability, or illness. Finally, Article 38 guarantees access to medical services regardless of status.

International Conventions

The right to survive pregnancy and childbirth is a basic human right. Under international law, India has a duty to ensure that women and infants do not experience death or morbidity from wholly preventable causes.[iv]This duty arises from multiple international conventions to which India is a

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[i] *Consumer Education and Research Centre v. Union of India,* [1995 SCC (3) 43]

[ii] *Francis Coralie Mullin v. Union Territory of Delhi &Ors.*, [1981 SCR (2) 6]

[iii] *Apparel Export Promotion Council v. Chopra*, [AIR 1999 SC 625].

[iv] *See generally* Center for Reproductive Rights, *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change*, 2008, pp. 9, 27–38, *available at* http:// reproductiverights.org/sites/crr.civicactions.net/files/documents/MM_report_FINAL.pdf; International Initiative on Maternal Mortality and Human Rights, *No More Needless Deaths: A call to action on human*

party, and which establish the right to health, the right to reproductive autonomy, and the right to be free from degrading treatment. Relevant conventions include the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC).[v]

Janani Suraksha Yojana (JSY), a demand promotion scheme was launched in April 2005 with the objective of reducing maternal and neonatal mortality. JSY promotes institutional delivery especially among women belonging to weak socio-economic status i.e. women from Scheduled Castes, Scheduled Tribes and BPL households. It is a centrally sponsored scheme, which integrates cash assistance with delivery and post-delivery care. The scheme particularly focuses on States with low institutional delivery rates namely Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir, which are also referred to as the low performing states (LPS). Women of all ages and with any number of children are now entitled to JSY benefit. The scheme enables the States/UTs to hire the services of a private specialist to conduct caesarean section or for the management of obstetric complications in the public health facilities, where government specialists are not in place. States are encouraged to accredit private health facilities for increasing the choice of delivery care institutions. In LPS, including Rajasthan, all pregnant women delivering in government health facilities and BPL/SC/ST women delivering in accredited private health facilities are entitled to JSY benefits. In the rural areas a woman gets Rs. 1400 per delivery and in urban areas she gets Rs. 1000 per delivery as incentive for delivering in a health facility.[1] [2]

Janani Shishu Suraksha Karyakram (JSSK) launched in 2011 provides service guarantees in the form of entitlements to pregnant women, sick newborns and infants for free delivery including caesarean section and free treatment in public health institutions. This includes free to and fro transport between home and institution, blood transfusion if required, drugs, other consumables, diagnostics and diet for up to 3 days for normal delivery and 7 days for C-section. It also provides free transport between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. The scheme has been expanded to also cover the complications during ANC, PNC and sick infants.[7]

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rights and maternal mortality (2009), *available at* http://righttomaternalhealth.org/resource/no-more-needless-deaths.

v *See especially* ICCPR Art. 6 (right to life); ICESCR Art.12 & CEDAW Art.12 (right to the highest attainable standard of health, including the right to health services that are accessible and of good quality); ICESCR Art. 15 (right to enjoy the benefits of scientific progress, including in obstetrics and pediatrics).

Under NRHM, 30, 50 and 100 bedded state of the art maternal and child health wings have been established in District Hospitals/District Women's Hospitals/Sub-District Hospitals/CHC-FRUs to overcome the constraints of increasing case loads and institutional deliveries at these facilities.[8]

National Quality Assurance Programme: Despite the increase in the number of institutional deliveries since the launch of the NHM, quality of maternal and newborn health services has not shown the desired improvement in the country. Recognising that pregnant women are often meted out rude and uncourteous treatment at the health facilities, GoI has operationalised the National Quality Assurance Programme for improving the quality of care at public health facilities. Quality Assurance Standards for District Hospitals, Community Health Centres, Primary Health Centre and Urban-Primary Health Centres have been drafted using which the states are expected to continue to work towards achieving full NQAS certification of the health facilities.

LaQshya (Labour Room Quality Improvement Initiative): The LaQshya Guidelines are intended for achieving improvements in the labour room and maternity operation theatre during the intra-partum and immediate post-partum period in order to provide respectful and zero defect care to all pregnant women and newborns. The goal is to reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery. The guidelines specify the following level of care for pregnant women and newborns:

- Ensure availability of optimal and skilled human resources as per case-load and prevalent norms through rational deployment and skill upgradation.
- Ensure skill assessment of all staff of labour room and maternal OT as per Dakshata guidelines for delivery of 'zero-defect' quality obstetric and newborn care.
- Sensitise care-providers for delivery of respectful maternity care and close monitoring of language, behaviour and conduct of the labour room, OT and other concerned staff.
- Create an enabling environment for natural birthing process.
- Implement clinical guidelines, labour room clinical pathways, referral protocols, safe birth checklist (in labour room and obstetric OT) and surgical safety check-list.
- Ensure round the clock availability of blood transfusion services, diagnostic services, drugs and consumables.
- Ensure availability of triage area and functional newborn care area.
- Ensure systematic facility-level audit of all cases of maternal/neonatal deaths, stillbirth, and maternal near miss.
- Operationalise C-Section audit and corrective and preventive actions for ensuring that C-Sections are undertaken judiciously in those cases having robust clinical indications.

- Institute an ongoing system of capturing of beneficiaries' independent feedback and take actions to address concerns for continual enhancement in their satisfaction.
- Ensure availability of essential support services such as 24x7 running water, electricity, housekeeping, linen and laundry, security, equipment maintenance, laboratory services, dietary services, biomedical waste management, etc.
- Use of digital technology for record keeping and monitoring for maternity wing (MIS), including use of e-partograph.
- Use aggressive IEC, user friendly training material and IT-enabled tools.
- Use quality tools for prioritisation, and gap closure such as Plan Do Check Act (PDCA), Root Cause Analysis, Run Charts, Pareto chart and Mistake Proofing for achieving desired targets.[9]

Guidelines for midwifery care: Recognizing that midwifery care can serve as cost-effective and efficient model to provide quality maternal and child care, especially considering the lack of specialist doctors, the MoHFW has developed these guidelines for midwifery care in India. These guidelines include the introduction of midwifery model of care for normal births in midwifery-led units of public health facilities. They also include guidance for education and training of midwifery educators and Nurse Practitioners in Midwifery in line with international standards of skills and competencies. They also provide options to integrate this model of care in the current public health system to contribute to achieving the SDGs. The purpose of introducing a trained midwife cadre is to:

- provide access to quality maternal and newborn health services and promote natural birthing by promoting positive child birthing experience
- promote respectful maternity care throughout pregnancy and child birth to identify, manage, stabilize and/or refer as needed, women and their newborns experiencing complications
- decongest higher level of healthcare facilities
- expand access to quality maternal and neonatal services in remote areas including pockets of high home delivery rates and urban slums.

It is critical that strong referral linkages to First Referral Unit (FRU) and Special Newborn Care Units (SNCUs) are established to support Midwifery Care Units. The referral units should be accessible within a short period of time. Pregnant women identified with complications are to be referred to a medical officer or specialists for further management. The midwife will follow the model of continuum of care to provide services to pregnant women ranging from family planning, ANC,

delivery, PNC to safe abortion services. Midwife will promote natural birthing process with Respectful Maternity Care.[4]

Operation Guidelines on Maternal and Newborn Health, were developed by the MoHFW and NRHM in 2010 to help programme managers at district and state levels, to plan, implement and supervise the delivery of services that would guarantee a safe childbirth for every mother. These guidelines direct that:

- All women must have access to a package of antenatal services provided in the community or at the facility by a provider who is skilled and who has the necessary equipment and supplies.
- Every woman must be enabled to have her childbirth with a Skilled Birth Attendant (SBA) (professionally qualified individual who can handle normal pregnancies and deliveries, equipped with skills to provide essential newborn care, identify obstetric and neonatal emergencies, manage complications as per their defined competencies, and undertake timely referral to a higher centre where comprehensive obstetric care can be provided.) competent to provide essential newborn care, in a setting of maximal dignity, comfort, and care.
- Since life threatening complications may arise in any delivery, every effort must be made for all women to deliver in an institution where most complications can be promptly and effectively managed, and with the means to transport a patient safely and quickly to an institution where complications that require surgical care and blood transfusion can also be managed.
- In the anticipation of emergency, every woman should deliver in an institution with access to a referral centre within one hour in case of complications, requiring surgery and blood transfusion. District health plans must conform to a roadmap to reach this ideal, respecting and supporting the wishes of families at every stage.
- Where a delivery is known to have much higher risk of complications even before the onset of labour, e.g. a previous Cesarean, every effort must be made so that the delivery takes place in an institution where surgical care and blood transfusion for managing emergencies is available.
- Every mother must be provided with postnatal care that ensures support to her in this period, identifies complications and arranges for referral when required. This care is preferably institutional in the first 48 hours, with home based follow-up for a 42 day period thereafter.

- Every newborn must be provided with appropriate care and support from the moment of birth. This includes initiation of breastfeeding, keeping the baby warm, identifying illnesses or risk including low birth weight, resuscitation where indicated, access to referral care at an institution, and close follow-up at home for 28 days after birth.
- The public health system must hold itself accountable to provide skilled human resources, infrastructure and equipment, institutional linkages and supervision needed to ensure that these service guarantees for safe maternal and newborn health are realised.
- A grievance redressal mechanism must be in place which should receive reports of any failure to deliver the services that are certified as available in a particular facility and take appropriate action, and provide feedback to the complainant and public.
- Every maternal or newborn death must be accounted for and investigated so as to detect system gaps and to increase accountability.
- The provision of maternal and newborn care should be based on a 'continuum of care' approach that covers the entire period of pregnancy, delivery and postnatal period, and the needs of the newborn, through a seamless transition from home and community to the facility, referral institutional care where needed, and back again to the home.[10]

Indian Public Health Standards (IPHS): The Indian Public Health Standards (IPHS) for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals were published in 2007 and have been used as the reference point for public health care infrastructure planning and up-gradation in the States and UTs. IPHS are a set of uniform standards envisaged to improve the quality of health care delivery in the country. The IPHS documents were revised in 2012 keeping in view the changing protocols of the existing programmes and introduction of new programmes especially for Non-Communicable Diseases. Flexibility is allowed to suit the diverse needs of the States and regions. These IPHS guidelines act as the main driver for continuous improvement in quality and serve as the bench mark for assessing the functional status of health facilities. States and UTs are expected to adopt these IPHS guidelines for strengthening the public health care institutions and put in their best efforts to achieve high quality of health care across the country.[11]

In order to understand and act upon the causes of maternal death, it is important to collect accurate information about how many women died, where they died and why they died. Government of India issued the **maternal death surveillance and response (MDSR) guidelines** in 2017 that spell out a mechanism to collect and ascertain such information and also to take action on findings of the review. MDSR system is a continuous cycle of identification, notification and

review of maternal deaths followed by actions to improve the quality of care and prevent maternal deaths in future.[12]

Recommendations

- An investigation should be initiated and maternal death audit conducted as per the GoI's MDSR guidelines to ascertain the cause of as well as the contributing factors that led to Smt. Laxmi Meena's untimely death.
- DoHFW and DWCD should make necessary arrangements for timely and complete ANC in Pal Panchayat.
- There are three HSCs in the area but none of them has an ANM. DoHFW should be directed to immediately post ANMs at these HSCs.
- Considering the geographical location of Pal Panchayat, DoHFW should develop all the three HSCs as delivery points.
- Smt. Laxmi Meena's family should be given appropriate compensation for the loss of life, and emotional and mental trauma.
- Coordination should be established between the different departments like the Forest department, PWD, MoHFW and roads should be constructed in the area so that ambulance can come to the villages inside the forest.

Conclusion

The Pal Panchayat area is devoid of government's health programmes and schemes. Though the health department has recognised the peculiarity of the area and therefore sanctioned three sub-centres for one Panchayat, yet that has not translated into availability of services for the people living in the forest area. With no services and no means of transport, the people are left to fend for themselves. The area neither has infrastructure nor personnel to provide health and nutrition related services.

There are several women like Smt. Laxmi Meena in the area who do not get the required care. Almost 90% of the deliveries occur at home, which is shocking as the rate of institutional deliveries all across the country as well as in Rajasthan has been increasing over the last few years.

The lack of services puts the pregnant women and their new born children at high risk. The area perhaps requires some atypical solutions since the traditional health delivery model seems to have repeatedly failed in meeting the needs of the people living in the protected area.

Dilapidated School Building, Bhuri Talai **Class in open**

Anganwadi Centre operational in *kaccha* premises

Annexures

S. NO.	DESCRIPTION OF DOCUMENTS WITH DATE	ORIGINAL / COPY	NO.OF PAGES
1.	Laxmi Meena's Adhaar Card	COPY	**1**
2.	Mukesh Meena's Adhaar Card	COPY	**1**
3.	Bhamashah Card	COPY	**1**
4.	Death Certificate of Smt. Laxmi Meena dated 01/06/2019	COPY	**1**
5.	Ration Card of Sh. Ramchandra Meena	COPY	**1**
6.	Laxmi Meena's Mamta Card	COPY	**1**
7.	Fact finding report	COPY	

References

[1] http://pib.nic.in/PressReleaseIframePage.aspx?PRID=1575157

[2] https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3467679/

[4] http://164.100.154.238/images/pdf/programmes/maternal-health/guidelines/Guidelines_on_Midwifery_Services_in_India.pdf

[5] https://www.who.int/sdg/targets/en/
[6]https://mohfw.gov.in/sites/default/files/Tribal%20Health%20Expert%20Committee%20Report_Executive%20Summary.pdf
[7] http://www.nrhmhp.gov.in/sites/default/files/files/Entitlements_JSSK.pdf

[8] https://mohfw.gov.in/sites/default/files/Chapter415.pdf

[9] https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdf

[10] http://nhsrcindia.org/sites/default/files/Operational%20Guidelines%20for%20Maternal%20%20Newborn%20Health.pdf

[11] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=971&lid=154

[12] https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Guideline_for_MDSR.pdf