SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS : REVIEWING EXECUTION OF LAWS POLICIES AND PROGRAMS

Case studies from different states of India

प्रयास Prayas

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प्रयास Prayas

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- Enable poor to have opportunities for their social, economic, physical and cultural growth.
- Create alternative knowledge and mechanisms for community development.
- Advocate for secure social, economic, political and cultural rights for all.
- Respond to contemporary poverty related community needs
- Campaign for gender sensitive conduct and equity

Credits

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Acknowledgement

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We convey our deep admiration for the team of investigators and researchers from Prayas, Human Rights Law Network, volunteers, interns and other collaborating organisations for their amazing efforts, endless hours of hard work and dedication they put in towards conducting and producing these fact findings. The conviction and professionalism with which they strived to get into the depths of the incidents to bring the facts out was exceptional and immensely motivating. We also extend our gratitude to all those who helped us with the documentation, report writing, editing and everything that it took to ensure that the facts and events are conveyed to the readers in the most genuine yet impactful way.

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Case Studies from Different States

1. Closed Health Centre and Delivery in the Ambulance, Madhya Pradesh

INTRODUCTION

Indian health system revitalized with the launch of National Rural Health Mission in 2005 following the leads from major national and international discussions like Alma Ata 1978, Sustainable Development Goals, and recommendations from various committees like Bhore, Srivastav etc. The mission was designed and aimed to focus and improve primary health care and community participation in rural areas. A four tier system of government aided hospitals/facility was created to reach remotest populations and distribute health services evenly. This system consists of a Sub Center as the first unit serving 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. Sub Centers refer patients to the Primary Health Centers (PHCs). The nomenclature of a PHC varies from state to state that include a Block level PHCs (located at block HQ and covering about 100,000 population and with varying number of indoor beds) and additional PHCs/new PHCs covering a population of 20,000-30,000 etc. Regarding the block level PHCs it is expected that they are ultimately going to be upgraded as Community Health Centres with 30 beds for providing specialized services[1].

The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the Sub-district and District Hospitals. The CHCs were designed to provide referral health care for cases from the PHC level and for cases in need of specialist care approaching the centre directly. Usually four PHCs are included under each CHC thus catering to approximately 80,000 populations in tribal/hilly/desert areas and 1,20,000 population for plain areas. CHC is a 30-bedded hospital providing specialist care in Medicine, Obstetrics and Gynaecology, Surgery, Paediatrics, Dental and AYUSH. [2]As of March 2018, there were 158417 sub centres, 25743 primary health centres, 5624

Status of Infrastructure and HR in PHCs, MP. (RHS, 2018)	MP	India
PHCs functioning on 24X7 basis	65.4	36.9
With Labour Room	76.5	67.6
With OT	37.1	36.9
With at least 4 beds	98.5	77
Without Electric Supply	0.0	3.2
Without Regular Water Supply	9.6	5.1
Without All -Weather Motorable Approach Road	4.3	8.9
With Telephone	100	52.3
With Computer	44.1	70.3
Referral Transport	100	64.5
Registered RKS	98.8	85.6
Shortfall of Health assistants (female)	Nil	41.0
Shortfall of Health assistants (male)	53.6	66.0
Shortfall of Doctors at PHC	5.03	14.3

[1] *Indian Public Health Standards Guidelines for Sub center and Primary Health Center, Revised 2012*

[2] *Indian Public Health Standards Guidelines for Community Health Center, Revised 2012*

community health centres, 1130 sub-district health centres, 764 district hospitals and 1741 mobile health clinics in rural India. Despite the robust planning and establishment of health system infrastructures throughout the country, government has not been able to channelize the human resource and essential facilities in these centres specially those at the remote/tribal areas. Another aspect with which government is always found struggling is maintaining quality and assurance of all the entitlements served to beneficiaries. There was shortfall of 18 % sub centers, 22 % PHCs and 30 % CHCs in the country as of 31st March 2018. Moreover, there were only 7 % sub centers, 12 % PHCs and 13 % CHC found to be functioning as per the IPHS norms.[3]

Madhya Pradesh is one of the EAG states with very poor health as well as other development indicators. The state of Madhya Pradesh is home to 5.25 crores of rural population out of which 1.42 crores (27 %) are tribal (Census 2011). As far as the health infrastructure is concerned Madhya Pradesh has 11192 sub centers, 1171 PHCs, 309 CHCs, 66 Sub District Hospitals, 51 District Hospitals and 144 Medical Mobile Vehicles. There was a shortfall of 10 % sub centres, 41 % PHCs and 38 % CHCs in the state as of 31st March 2018. The shortfall of PHC and CHC is much higher as compared the national statistics. Moreover, there was no PHC found to be functioning as per the IPHS norms laid by the Government of India.[4]

Out of 1171 PHCs in the state of Madhya Pradesh, only 65.4% were functional as 24X7 PHCs. Only 37.1% were having an operation theatre for surgery. All the PHCs had electric supply, most of PHCs had regular water supply and connected with all-weather approachable roads. Telephone facility was universally present among all PHCs. However, only 44.1% had computers. Commendably, all the PHCs had referral transport facility which is an integral part of maternal health & new-born care. As far as human resource is concerned, the female health assistant were in surplus while more than half (53.6 %) of the PHCs had shortfall of male health assistant. There was only 5% shortfall of doctors at the PHCs and there were no vacant position of AYUSH doctors.

Moreover, 13% of PHCs were without a doctor and only 13.9% PHCs had a lady doctor. Around 44.8% of PHCs were without a lab technician and about 24% PHCs were without a pharmacist.

Status of Doctors positioned at PHC, MP	MP	India
With 4+ doctors	2.1	4.5
With 3 doctors	6.1	3.7
With 2 doctors	26.4	28.4
With 1 doctor	52.4	57.5
Without doctor	13.0	5.8
Without lab technicians	44.8	34.6
Without pharmacist	24.0	15.6
With lady doctor	13.9	28.1

The data definitely indicates the need of further strengthening of infrastructure and human resource to efficiently operationalize primary health system in the state of Madhya Pradesh.

[3] *Indian Rural Health Statistics, as of March 2018*

[4] *Indian Rural Health Statistics, (RHS, 2018) as of March 2018*

BACKGROUND

Jhamanjhor is predominantly a tribal (Adiwasi) village and falls under Gram Panchayat Mancchguan. The houses of the Pal and Chadhar caste (that fall into the category of backward classes) comprise of one section of the village while the other part is that of tribal communities (adiwasi). The house of Mrs. Dropti Devi was in the tribal locality. Also, one house in the village belonged to a family of Sapera community (snakecharmer) and their main job was to catch snakes. The population of the village at the time of the fact finding was 726, comprising of 389 women and 337 men. Four handpumps were present in the village for drinking water. There was one Anganwadi centre which operated at the premises of the house of ASHA worker, Mrs. Sakuntla Pal, as the hall for the Anganwari centre was non-functional. The anganwari worker, Mrs. Usha Devi Pal, travelled from Village Mancchguan. This village was located approximately 20 kilometres from the Tehsil headquarters and approximately 25 kilometres from the District headquarters, Teekamgarh. A pukka road had been constructed to reach this village, however very few vehicles were available. The village residents used motorcycles to travel to and fro from the village to the district headquarter, Teekamgarh and the tehsil headquarter, Baldevgarh. The first Friday of every month was celebrated as Immunisation Day at the anganwari centre. The Sub Health Centre was built in the village and nurse Mrs. Neelu Pushapakar was posted there, who resided 1.5 kilometres from Jhomanjhor village. She used to visit the sub centre from Teekamgarh only two to three times in a week. The village had a school till 5th class. For higher education, the children from the village travelled 5 kilometres to Sarkanpur. Farming is the only source of income for the villagers. The youth of the village also migrate to Delhi, Jhansi or Gujarat in search of work.

Dropti Devi was married to Halke Ram Deendayal, a tribal resident of village Jhamanjhor, Gram Panchayat Mancchgaaun, District Teekamgarh, in the year 2016, at the age of 18 years. After marriage, Dropti Devi started living with her in-laws along with her husband. She also started working as an agricultural worker. As the agricultural land was less, both husband and wife worked mostly as labourers. In addition to farming, Halke Ram would also travel to Delhi for six months in a year to work as a labourer. As the economic condition was poor, Dropti Devi and Halke Ram could not continue their studies after marriage. According to Dropti, whenever a woman experienced labour pains in the village, she was usually taken to the Primary Health Centre in Sarakpur or District Hospital in Teekamgarh. Also, at the Sub Health Center the nurse was not available daily and therefore even for minor health ailments residents had to travel to PHC Sarakpur.

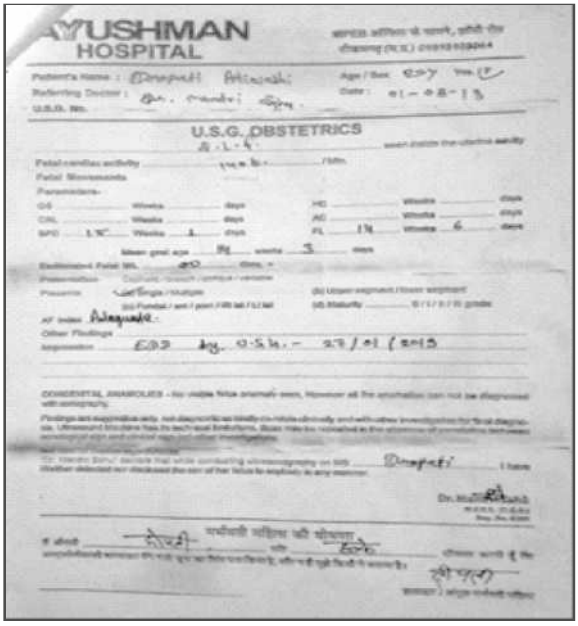
THE CASE

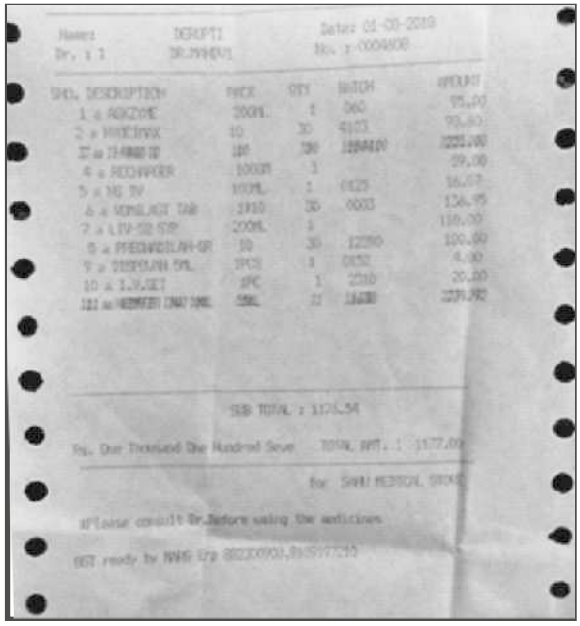
Mrs. Dropti Devi Adiwasi

According to Dropti Devi, when she realised she was pregnant, she went to the ASHA worker, Shakuntla Pal, at the anganwari centre on 10th August 2018 for a health check-up. However, she was told by the ASHA worker to return on the third Monday of the month, the day celebrated as Immunisation Day, when nurse, Neelu Pushpakar, would be available to carry out the necessary health examination. Dropti Devi thus returned to the anganwari centre on the requested day on 20thAugust 2018 during the Village Health & Nutrition Day (VHND). Nurse Neelu Devi carried out the health check-up and it was ascertained that Dropti Devi was 14 weeks pregnant. The first tetanus shot was administered and essential check-up was done, wherein body weight was measured as 46 kilograms, blood pressure was 120/70 mm Hg, haemoglobin was 9 grams etc. On 15thOctober 2018, second antenatal check-up was carried

out, where the second tetanus shot was administered and essential health check-up were done including body weight which was measured as 47 kilograms, blood pressure as 11/80 mm Hg, and haemoglobin at 9 grams etc. The third antenatal check-up was done on 19th November 2018, where body weight was found to be 48 kilograms, blood pressure was 110/90 mm Hg, haemoglobin 9 grams etc. The fourth antenatal check-up was not carried out. During pregnancy, Dropti Devi was not advised by any health worker about dietary intakes, about the haemoglobin levels being low and other precautions. The dietary supplements provisioned by the anganwari centre for pregnant women were also not provided to her regularly. Whenever Dropti Devi would go to the anganwari centre to collect nutritional supplements she was often sent away by the anganwari worker Usha on the pretext of no supplies. Dropti Devi received nutritional supplement packets only once a month.

Dropti Devi further revealed that during pregnancy, she complained regularly of stomach ache, and for which she even visited district hospital. On 1st August 2018, when she visited the district hospital, the doctor told her to get sonography and other examinations from a private hospital (Ayushman Hospital) on account of the machines and diagnostic equipments not being functional in the district hospital. Dropti Devi visited Ayushman hospital on 1st August 2018. There a lady doctor named Dr. Mandvi Sahu got her sonography done which determined the length of pregnancy to be 14 weeks and 3 days. Other tests such as haemoglobin test, blood sugar, VDRL test and blood group determination were also carried out. The doctor further prescribed medicines worth Rs. 1,177. Images of the sonography report and bill of purchase of the medicines are attached.

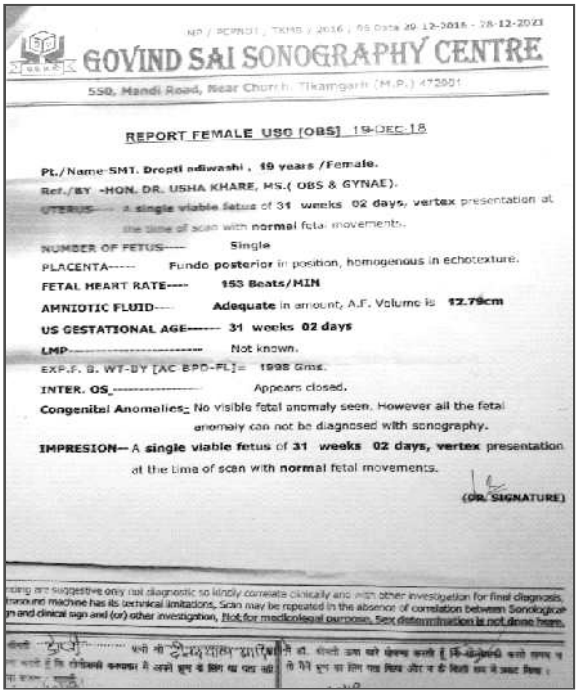

AYUSHMAN
HOSPITAL
U.S.G. OBSTETRICS



Sonography report and medicines prescribed at Ayushman Hospital

According to Dropti Devi, the prescribed medicines did not offer much relief. On 19th December 2018 due to continued stomach ache, Dropti Devi's brother- in- law, Dashrath Adiwasi, sister-in- law, Raja Bai, and husband Halke Ram, together took her by motorcycle to Teekamgarh. Upon reaching there, Dropti Devi's husband was of the opinion that since the doctor from the government hospital would refer her to a private hospital anyway, therefore it was better to go to a private hospital directly. Therefore, they went to a private

hospital called Govind Sai Maternity Home in Teekamgarh and consulted doctor called Dr. Usha Khare. Dr. Usha did a sonography and according to the sonography report, Dropti Devi was pregnant for 31 weeks and 2 days. Other tests were carried out including haemoglobin which was found to be 8 grams, blood sugar 73 and blood group was B+. The total cost for these tests and the sonography came to about Rs. 2000 and further medicines worth Rs. 585 had to be purchased from Deepak Medical store which was just outside the hospital. Images of the sonography report and tests are attached.



GOVIND SAI SONOGRAPHY CENTRE

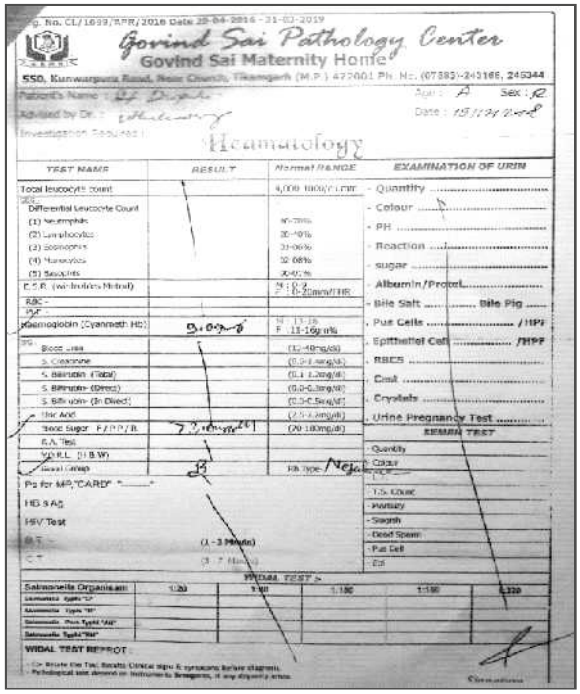
550, Mandi Road, Near Church, Tikamgarh (M.P.) 472001

REPORT FEMALE USG [OBS] 19-DEC-18

Pt./Name-SMT. Dropti ndiwashi , 19 years /Female.
Ref./BY -HON. DR. USHA KHARE, MS.(OBS & GYNAE).
UTERUS---- A single viable fetus of 31 weeks 02 days, vertex presentation at the time of scan with normal fetal movements.
NUMBER OF FETUS---- Single
PLACENTA----- Fundo posterior in position, homogenous in echotexture.
FETAL HEART RATE---- 153 Beats/MIN
AMNIOTIC FLUID---- Adequate in amount, A.F. Volume is 12.79cm
US GESTATIONAL AGE------ 31 weeks 02 days
LMP---------- Not known.
EXP.F. B. WT-BY [AC &PD-FL]= 1998 Gms.
INTER. OS---------- Appears closed.
Congenital Anomalies:- No visible fetal anomaly seen. However all the fetal anomaly can not be diagnosed with sonography.
IMPRESION-- A single viable fetus of 31 weeks 02 days, vertex presentation at the time of scan with normal fetal movements.

(DR. SIGNATURE)

...ings are suggestive only not diagnostic so kindly correlate clinically and with other investigation for final diagnosis. ...rasound machine has its technical limitations. Scan may be repeated in the absence of correlation between Sonological ...n and clinical sign and (or) other investigation. Not for medicolegal purpose. Sex determination is not done here.



Govind Sai Pathology Center
Govind Sai Maternity Home
550, Kunwargunja Road, Near Church, Tikamgarh (M.P.) 472001 Ph. No.: (07683)-243186, 245344

Haematology

TEST NAME	RESULT	Normal RANGE
Total leucocyte count		4,000-11000/c.mm
Differential Leucocyte Count		
(1) Neutrophils		40-75%
(2) Lymphocytes		20-40%
(3) Eosinophils		01-06%
(4) Monocytes		02-08%
(5) Basophils		00-01%
E.S.R. (wintrobe's Method)		M : 0-9 F : 0-20mm/1HR
RBC :		
WBC :		
Haemoglobin (Cyanmeth Hb)	8.0 gm%	M : 13-16 F : 11-16gm%
Blood Urea		(12-45mg/dl)
S. Creatinine		(0.6-1.4mg/dl)
S. Bilirubin (Total)		(0.1-1.2mg/dl)
S. Bilirubin (Direct)		(0.0-0.3mg/dl)
S. Bilirubin (In Direct)		(0.2-0.5mg/dl)
Uric Acid		(2.5-7.0mg/dl)
Blood Sugar F/PP/R	73 mg/dl	(70-180mg/dl)
R.A. Test		
V.D.R.L. (I.B.W)		
Blood Group	B	Rh Type: Nega
Ps for MP "CARD"		
HBsAG		
HIV Test		
B.T.	(1-3 Minute)	
C.T.	(3-7 Minute)	

WIDAL TEST REPORT :

Salmonella Organism	1:20	1:40	1:80	1:160	1:320
Salmonella Typhi "O"					
Salmonella Para Typhi "AH"					
Salmonella Typhi "H"					

EXAMINATION OF URIN
- Quantity
- Colour
- PH
- Reaction
- sugar
- Albumin / Protein
- Bile Salt ..... Bile Pig
- Pus Cells ..... / HPF
- Epithelial Cell ..... / HPF
- RBC'S
- Cast
- Crystals
- Urine Pregnancy Test

FEMALE TEST
- Quantity
- Colour
- T.S. Count
- Pathery
- Saagth
- Dead Sperm
- Pus Cell
- Epi

Sonography report from Govind Sai Hospital

On 9th January 2019, at about 2:30 PM, Dropti Devi felt labour pains and her husband, Halke Ram, went to the ASHA worker, Shakuntla Pal, requesting her to help them in managing Dropti's condition. However, she refused. When Halke Ram returned home he found that Dropti Devi was in severe pain which was only aggravating with time. Halke Ram then went to the ASHA again and requested her to call the Janani ambulance so that Dropti Devi could be taken to the health facility. However, on this she started shouting at Halke Ram and refused to call the ambulance. Halke Ram returned home and called the ambulance on 108 himself. Around 3 PM the ambulance reached Jhamanjhor village and took Dropti to PHC Sarkanpur where they reached around 3:30 PM. On reaching teh PHC it was found that the health facility was locked and the doctor appointed at the facility, Dr S. K. Chilwaar, along with other staff were absent. The ambulance workers and family members called around for the staff and enquired from nearby people, however, they could not determine why the health centre was locked. Apparently, the doctor appointed at Sarkanpur, Dr S. K. Chillwaar, was overloaded with work due to also having the charge of CMO, and only visited the PHC two to three times a week. Due to this other staff was also careless and irregular. Even after waiting for a while when nobody was found at the centre, the ambulance driver, Mohseen Khan, and EMT Vijay, decided to take Dropti to CHC Baldevgarh as her pain was aggravating. However, as the ambulance was midway to the destination, near Sujanpura Dropti Devi began to deliver. Seeing this, EMT Vijay stopped

the ambulance on the roadside and helped with the delivery in the ambulance itself. Dropti Devi delivered a healthy baby girl. As soon as delivery was complete, driver started the ambulance and drove quickly towards the CHC. The staff at the CHC admitted Dropti and the newborn and carried out necessary check-ups. Upon examination it was found that Dropti's health was declining. Two days after admission, Dropti Devi was discharged from the hospital on 11th January 2019 and was transported home by Janani ambulance.

Dropti Devi with newborn after delivering in the ambulance

On 9th January 2019, Dropti Devi had to deliver her baby in the ambulance due to the health centre being locked. When this information reached the reporter of the local newspaper – Teekamgarh Patrika, Sanket Srivastava, he visited the PHC Sarkanpur and reported this incident in the edition of 10th January 2019, in an article titled "Primary Health Centre doors locked, mother delivers child in the Janani Express". Only after the news report was published did the health officials came out in the open and a proper enquiry of the incident was ordered.

टीकमगढ़ पत्रिका

कम नहीं हो रही स्वास्थ्य विभाग की लापरवाही

प्राथमिक स्वास्थ्य केन्द्र में पड़ा था ताला, जननी एक्सप्रेस में हुआ प्रसव

रास्ते हुआ प्रसव

The incident covered in Tikamgarh Patrika

Discussion with the family of Dropti Devi:

During the visit to Dropti's home, she and her sister-in-law, Raja Bai, were present in the house. After introducing themselves, the fact finding team of two asked them about the incident. Initially Dropti Devi seemed a little hesitant to answer questions. However, a little later, once brother- in-law, Dasrath Adiwasi, arrived Dropti and others began to speak comfortably.

Investigators at Dropti Devi's home

CHC Baldevgarh where Dropti Devi was admitted after delivery in the ambulance

Discussion with women from the village:

On 26th February 2019, after collecting information from Dropti Devi and her family, information was sought regarding government schemes and benefits being made available to the women of the village. For this a group discussion with village women was organised.

Discussion with village women

These women were asked to provide information about nutritional supplements from the anganwari centre, information about nurse visits for health check-ups, and other information about health education services available. According to them, the anganwari centre did not provide any nutritional supplements to the women, the food that was provided to the children was not warmed and further the anganwari helper did not even call the tribal children to the anganwari and discriminated with them on the basis of caste. A school up to class fifth was there in the village, however according to the women, the teachers never showed up on time for classes. Sometimes the school even remained closed due to teachers' absenteeism. All the women thus expressed their disappointment with regard to delivery of health, nutrition and education services in the village.

Discussion with the anganwari worker, Jhamanjhor:

The investigating team then visited the anganwari centre Jhamanjhor to seek information regarding the facilities and services provided to Dropti Devi during her pregnancy. Anganwari worker, Usha Pal, was present there. As the hall for the centre was non-functional, the anganwari operated out of the house of Shakuntala Devi Pal, the ASHA worker. Due to a wedding in her family, she was not present at the centre though. Not even a single child was present at the anganwari during the visit and no nutritional supplements were found stocked there. When the team enquired about the health check-ups and nutritional supplements that were received by Dropti Devi and requested for the registers containing this information, the worker told that the registers were at her home. The team then visited the home of the anganwari worker to check the registers. They found that in the registers, no new entries for expectant mothers, children and lactating mothers was made after the year 2014. The attendance register for children attending the anganwari was also blank. When asked about the blank columns, Usha said that she was educated only up till class 6th and was unable to fill the details in the registers. Further when the education status of her husband was asked, he told that he was educated up till class 12th, however Usha never asked him to help her with the registers. Usha refused to share the mobile number of her supervisor. She accepted her mistake and assured the team that she would follow up correctly henceforth. Responding to the complaints of the tribal women about not receiving services from the anganwari centre, she told that the group of people from whom the nutritional supplements were procured for the anganwari were close to the village head (Sarpanch) and he did as he pleased. According to Usha, she herself had requested the sarpanch several times; however she was threatened that she would be removed from the anganwari centre if she intervened further. She did convey this to her supervisor as well.

Discussion with Anganwari Worker

Visit TO PHC Sarkanpur:

Discussion with LHV Mrs. Rampyari Saini at PHC, Sarkanpur

The same day in the afternoon the fact finding team visited PHC Sarkanpur to get into the depths of the incident. The appointed doctor, Dr. S. K. Chilwaar, was absent on the day. The team thus had to interact with Lady Health Worker (LHV), Mrs. Pyaari Saini. According to her the doctor had gone to the CHC in Baldevgarh. On asking about the Dropti Devi incident she told that the centre was locked as very few patients visited the centre and due to the shortage of staff the centre was generally closed by 1:00 PM. According to Pyari Devi, even though the health facility was locked she had the keys with her and had she been informed she would have opened the facility. When asked about routine deliveries and who carried them out, she replied that when she was present, she carried out the deliveries. On an average, 6-8 deliveries were carried out in the PHC every month, however, due to shortage of staff, the number of patients had reduced. As per Pyari Devi, earlier, this centre had staff strength of 7, out of which 3 had been transferred- ward boy Turab Khan, nurse Ramdevi Yadav, and nurse Saroj Vanshkar. Now only Dr S. K. Chilwar, pharmacist Shyam Varan Yadav, nurse Prem Bai Rai and herself were left. According to her, five sub health centres fall under PHC Sarkanpur- Sujanpura, Sijaura, Badkhera, Badthani and Sarkanpur.

GUIDELINES AND GUARANTEES

National Health Mission

The National Rural Health mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. It has been clubbed with National Urban Health Mission and called as National Health Mission. The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indictors.

The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.

Few of the strategies of NHM concerning the primary and secondary health facilities were:

- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels).[5]

Janani Shishu Suraksha Karyakram (JSSK)

Through the NHM, the government also coordinates the JSSK scheme, which the Government launched in June 2011 as a means of eliminating out-of-pocket expenses incurred by pregnant women and sick new-born, which are "without doubt, a major barrier" for pregnant women and children, many of whom "die on account of poor access to health facilities." Therefore, the JSSK scheme provides that pregnant women seeking institutional delivery and sick new-borns until 30 days after birth are entitled to absolutely free care in all government health facilities. JSSK services are available to all women who deliver in government health facilities, regardless of age, number of children, or economic status. These free JSSK services include delivery (including Caesarean section), medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery and 7 days for Caesarean section), free transportation to and from the facility (and between facilities in cases of referral), and exemption from all user charges. The JSSK scheme provides essentially the same free services to sick new-borns that are available to pregnant women.

[5] *NRHM Framework for Implementation, Retrieved from http://www.nhm.gov.in/nhm/nrhm/nrhm-framework-for-implementation.html*

Indian Public Health Standards (IPHS)

Indian Public Health Standards (IPHS) for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals were published in January/ February, 2007 and then revised in year 2012 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 have been revised 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 are supposed to 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 advised 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.[6]

RECOMMENDATIONS

1. Dropti Devi should be paid compensation for the inconvenience occurred during her delivery time. She could not be admitted in a facility as the PHC which was supposed to be open 24X 7 for delivery, was found closed. Due to this, she had to deliver baby in the ambulance while on her way to a higher facility.

2. Sanctioned position of staff including doctors must be filled in the PHC immediately to functionalize the PHC.

3. Government must ensure transport facility in the PHCs where deliveries are being conducted. It is mandatory under JSSK to provide transport to women coming for delivery in a government institute, both from home to hospital and drop back facility.

4. The defaulters must be penalized accordingly and corrective action should be immediately undertaken.

CONCLUSION

Dropti Devi faced the irregularities of health system from the very beginning of her pregnancy. Despite her haemoglobin level being very low she never received any treatment or counselling. She was not provided enough nutrition supplements from the anganwari centre. Despite her frequent illness and stomach aches, none of the health worker or government hospital staff took the matter seriously. She and her husband were treated badly and many times returned with offensive behaviour by anganwari worker and ASHA worker. Even when Dropti Devi was in labour the ASHA worker did not call the Janani Express.

Apart from all other irregularities, the PHC which was supposed to be open 24X7 for deliveries was found closed when Dropti Devi reached there in labour. This forced her to give birth to her baby on the way. Dropti Devi gave birth to a healthy baby girl, however, given the circumstances, it was a big risk for Dropti and her child and anything could have happened. The carelessness of health department and staff had to be taken seriously. Dropti Devi must be paid compensation for risking her and newborn's life due to department's failure.

[6] *IPHS revised Guidelines, retrieved from http://www.nhm.gov.in/nhm/nrhm/guidelines/indian-public-health-standards.html*

2. Death Due to Negligence during Sterilization Operation, Rajasthan

INTRODUCTION

The meaning of family planning services can be explained as the temporary or permanent method for providing gaps between pregnancies and control of fertility through sterilization respectively. Female sterilisation is a permanent means of contraception for women. Before going through this process women must receive careful counselling to make sure that she understands the non-reversible nature of this procedure. After analysing all the techniques for female sterilisation, it is safe to describe it as 99 percent effective procedure and it should be done post-partum (along with C-Section), or when the women is non-pregnant (Termed Interval Sterilisation).Basically there two broad methods to carry out this procedure and they are as follow:

- Tubal Ligation – This procedure also known as 'having your tube tied', as part of the procedure the fallopian tubes are cut, sealed, clipped or tied. This method involves very tiny cut made on the woman's abdomen or belly. It prevents pregnancy instantly or immediately.
- Tubal Implant–This process involves insertion of very tiny spring like coils into the fallopian tube. These coils cause scar tissues to form in the fallopian tube which ultimately blocks it and prevent sperms to meet or fertilise with an egg. This procedure does not involves making cut on the abdomen of the women instead it involves insertion of thin tube to thread small coils through vagina and uterus into the fallopian tube, these coils then placed there. It requires about 3 months for scar tissue to completely block fallopian tube, therefore it is advised to use back-up type of birth control for initial 3 months and after that the healthcare provider will carry out x-ray test to confirm that the coil is in right place and scar tissues have completely blocked the fallopian tube.

They both work by creating a blockage in the fallopian tubes (tubes that connects woman's ovaries to the uterus or womb) so that the sperms cannot be able to fertilise an egg because it never meets one.

In India there were only 53.5% of currently married women ages 15-49 years using any method of family planning. Less than 50% (47.8 %) of women use any modern method of family planning. There were only 36.5% of women opting for female sterilization, while the situation of male sterilization was as lesser as 0.3%. Among the methods adopted only 1.5% women chose IUD/PPIUD, 4.1% used pills and 5.6% used condom as method of family planning. (NFHS 4)

Despite India being the first country to launch a national level population control program in 1954 and having a robust population policy in year 2000, the family planning statistics at national and state level does not show very satisfactory results. As per NFHS 4 results, the total unmet need was 12.9% and unmet need for spacing was 5.7%. Only 17.7% of the health workers reported to have ever talked to female non users about family planning. Also, 46.5% of the current users were ever told about the side effects of current method. Though nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.8: NFHS-4) and the general awareness of contraception is almost universal (98.6% among women and 98.6% among men: NFHS-4), accessibility and quality of family planning methods has always been questioned. The issues like burden of sterilization carried by women, failed sterilization, quality of sterilization camps etc. have been raised time and again by media and activists. Hence the government of India launched Family Planning Indemnity Scheme and very recently Mission ParivarVikas to overcome the barriers and compensate the victims.

The Government of India introduced the "National Family Planning Insurance Scheme" since 25th November 2005 which has now been modified into "Family Planning Indemnity Scheme (FPIS)" with effect from 1st April 2013. The objective of the FPIS is to indemnify all beneficiaries of sterilization, doctors and health facilities (public and accredited private/NGO) conducting sterilization operation in the unlikely event of death/ failure/complication following sterilization operation. Mission ParivarVikas (2016) was introduced to support 145 high fertility districts over seven high focus states whose TFR was 3 and above. A five pronged strategy was developed to substantially increase the use of contraceptives and family planning services in these districts which included delivery of assured services, building additional capacity for enhanced service delivery, ensuring commodity security, Implementation of new promotional schemes and creation of enabling environment.

In such scenario, it becomes very critical to improve the quality of service and information disseminated to people about not only the importance of the family planning but also regarding the side effects/ long term effects of the methods available. It is a basic right of the couple opting for any method especially sterilization to be informed regarding chances of failure, alternatives and available schemes providing compensation for any such events.

The state of Rajasthan is one of the Empowered Action Group (EAG) states of the National Health Mission (NHM). These states have struggled to contain population growth at manageable levels and have poorer quality of life indicators than other states. The central government has released significant funds to address issues such as human resources, social challenges, and family planning for these states. Though Rajasthan too has lowered its MMR from 388/1 lakh live births in 2004-05 to 199 in 2014-16, it is still below the national average of 130 in 2014-16 and far below well performing states such as Kerala (46), Tamil Nadu (66) and Andhra Pradesh (71) for the same period[1].

Results for Rajasthan from the Annual Health Survey 2012-13 show how lightly the health department takes its responsibility of ANC. While some ANC is provided to most women, it is not consistent and continuous – factors that are important for timely detection of complications. The following data are clear evidence of the government's lack of consistency in providing good health services.

88% of all mothers receive some ANC (87% in rural and 95% in urban). However, percentage of mothers who had ANC check-up in first trimester is only 62.8 (59.6% in rural and 74.8% in urban areas). Mothers who had full course of ANC check-up further drops to just 9.5% (6.7% in rural and 19.4% in urban areas).

Poor as the services are even in urban areas, there is nevertheless a wide gap between service delivery in rural and urban areas. The service that exists is neither adequate nor of good quality. The data seems to point to the fact that the health of women is quite low on the government's list of priorities.

Late Smt. Bhavna Devi

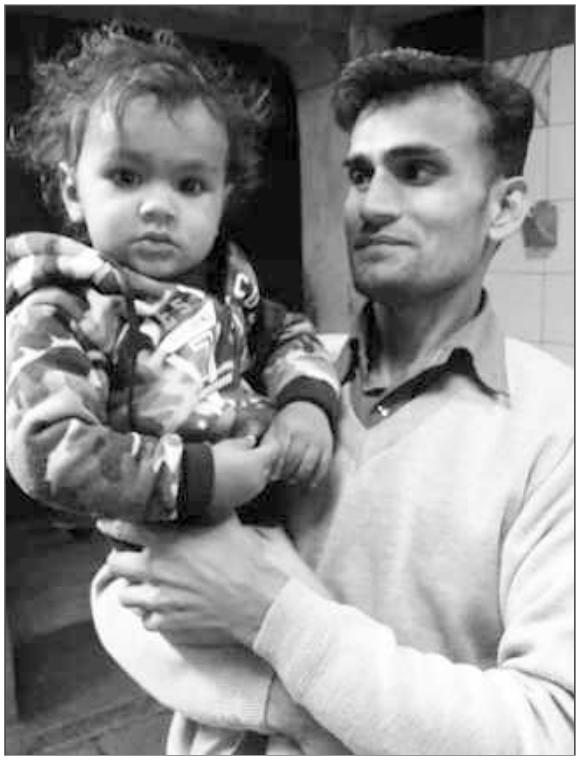
BACKGROUND

Mr. Dinesh Chandra Suthar, son of Mr. Bholi Ram Suthar residing near Mahadev temple, Bansi, tehsil Badi Sadri, District Chittorgarh got married to Smt. Bhavna Devi in the year 2015. At the time of marriage the age of Dinesh Chandra Suthar

[1] *http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012-13/FACTSHEET- Rajasthan.pdf*
https://www.researchgate.net/publication/249008760_Maternal_Mortality_in_India_Problems_and_Strategies
https://niti.gov.in/content/maternal-mortality-ratio-mmr-100000-live-births
http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012-13/FACTSHEET- Rajasthan.pdf

and Bhavna Devi was 28 years and 21 years respectively. Instead of helping his family in their family business, Dinesh Chandra Suthar started teaching in a private school of Badval village which was 6 kms away from village Bansi as he had done B.ED. Bhavna Devi was educated till 10th class and was a house wife. The family of Dinesh Suthar belonged to lower-middle class. Previously, the family used to live in a mud house but now they lived in a concrete building which was still under construction. After marriage the couple was blessed with their first child named Chirag on 15th July 2018 who was born in CHC Bari Sadari.

Mr. Dinesh Chandra Suthar's mother and his Son



Mr. Dinesh Chandra Suthar and his son (Chirag)

CASE

Description of second Pregnancy and Delivery:

This was the second pregnancy of Bhavna Devi. At the time of her delivery Bhavna was 24 years old. She got registered in the anganwari when she was in her 4th month of pregnancy. She received all the ANCs and all her reports were normal. She had a normal delivery on 25th June 2019 at CHC Bari Sadari and gave birth to a healthy boy later named Devansh. Bhavna was discharged from the hospital three days after the delivery.

Description of sterilization operation:

ASHA worker of village Bansi, Rukmani Devi, took care of Bhavna's health before and after her delivery and made frequent visits to check on her. During one of those visits, about 20 days after Bhavna's second delivery, Rukmani Devi asked Bhavna to visit CHC Bari Sadari and get a health check up done including some blood tests. Following her advice, Bhavna along with her mother Smt. Parvati Devi went to the CHC

and got the suggested tests done. The results of all her tests were found to be normal and there was nothing to worry about. Soon after the tests, ASHA worker, Rukmani Devi, and on duty doctor began to insist Bhavna to go for sterilisation operation. The doctor and ASHA worker also suggested that Bhavna undergoes sterilisation the same day as there was already a sterilisation camp going on in the CHC. They further stated that since Bhavna was already on postnatal rest if she had the sterilisation done immediately she would not have to take rest again. All of this convinced Bhavna and her mother to agree for sterilisation and they immediately informed Dinesh about it over the phone.

Dinesh informed the fact finding team that he got the phone call only around 2 PM and that's when he got to know that Bhavna was about to undergo sterilisation operation. He told that ASHA worker, Rukmani Devi, did not discuss anything about sterilisation with him when she had come to their home to take Bhavna to the CHC. It took Dinesh about two hours to reach the CHC after he received the call as he was in Badval village taking a class. Around 4 PM when he reached the CHC he met the doctor who told him that his wife was completely fine and that it was perfectly okay for her to go through sterilisation.

Description of Sterilisation Operation:

On 16th July 2019, Dr. Rajeev Mangal performed five sterilisation operations in the CHC, including that of Bhavna. Bhavna was the first among the five to be operated at around 5 PM. While other women were discharged about two hours after their operations, Bhavna remained unconscious for about three hours following the surgery and after she gained back consciousness she felt extreme pain in the abdomen. When Dinesh informed the doctor about her pain the doctor administered an injection on Bhavna and told that she will have to stay in the hospital for a day as her blood pressure was found to be quite high. The next day, i.e., 17th July 2019, Bhavna was discharged from the hospital at around 2:00 PM, however, she was still experiencing pain in the abdomen. When the family consulted the doctor about it he ruthlessly replied that she had had an operation and that some pain was obvious and that they should not make it a big deal. Dinesh then brought Bhavna home by a vehicle provided by the hospital.

After reaching home Bhavna had some biscuits and a cup of tea. Later in the night her stomach began to swell up and the pain aggravated. However, since the health facility was far off from their home the family waited till the morning to take her to the hospital. On the morning of 18th July 2019, at 8:00 AM, Bhavna was taken to PHC Bansi by a private vehicle. Taking into account the condition of Bhavna, the doctor on duty immediately administered an injection and a bottle of IV fluid on her. The doctor also referred her to CHC Badi Sadari. Soon they left for the CHC by a government ambulance and as soon as they reached there Bhavna was taken through several investigations including X-Ray and sonography. At around 5 PM, the doctor analysed the reports and suggested that Bhavna be admitted for further treatment.

After admission, Bhavna was administered six bottles of IV fluid everyday for three consecutive days. For the first two days she was not fed any food which reduced the abdominal swelling, however, on the third day of her stay in the hospital, the swelling recurred and her health began to deteriorate quickly.

Description of referring to other hospital:

On 21st July 2019, at 10:00 PM, Dr. Rajeev Mangal suggested that Bhavna be referred to city hospital in Udaipur as her condition was critical. The doctor called a private vehicle on rent and also sent along a compounder from the CHC to accompany Bhavna and her family to Udaipur hospital. Dinesh paid a sum of Rs. 1500 for the rented car. They reached the general emergency ward of the Maharana Bhupal City Hospital in Udaipur at 2:00 AM where Bhavna was admitted and put on a drip instantly after undergoing X-Ray.

After admission, at around 9:00 AM on 22nd July 2019, Bhavna was referred to women and children ward of the hospital. However, when they reached there the on duty doctors denied catering to Bhavna stating that they are not accountable for the mistakes made by other hospitals. Though after tons of requests by Dinesh and other family members, doctors agreed to examine Bhavna and asked them to get a sonography done and admitted her in the ward. Soon after taking a look at the sonography report the doctors informed Dinesh that Bhavna will have to undergo two operations. The first operation was performed at 2:00PM and the second at around 4:00 PM and soon after Bhavna was shifted to ICU ward. Doctors informed Dinesh that the next 48 hours post the operations were going to be critical for Bhavna. The doctors also explained that how during sterilisation procedure Bhavna's intestine apparently got punctured by the doctor and that's why faeces were spreading out and infecting other parts of her body. They admitted that Bhavna's condition was very serious.

From 22nd July 2019 to 24th July 2019 Bhavna was kept under medical observation but there was no improvement in her health. Eventually on 24th July 2019, at 7:15 PM Bhavna passed away. Dinesh stayed in the hospital with deceased Bhavna for about 23 hours waiting for the post mortem. Next day at around 6 PM post-mortem was conducted and then the body was handed over to the family. However, they were neither provided the post mortem report nor the death certificate. Dinesh had to arrange a private vehicle to take his wife's body home. They reached home around 11 PM and had to pay Rs. 2000/- for the hired vehicle. Bhavna was cremated the next day.

On 2nd August 2019 Dinesh went back to Udaipur to collect the death certificate and the post-mortem report. However, while he was given the death certificate, he was still denied the post-mortem report by hospital staff. He received the report later on 8th August 2019 after he officially appealed the Superintendent of Maharana Bhupal Hospital for the same. The post mortem report number was 751/19.

Primary Health Centre Bansi

बड़ीसादड़ी चिकित्सक के खिलाफ मामला दर्ज

बड़ीसादड़ी. पुलिस ने शुक्रवार को नगर के चिकित्सक डॉ. राजीव मंगल के खिलाफ उपचार में लापरवाही का मामला दर्ज किया। बारसी निवासी दिनेश पुत्र भोलीराम सुथार ने जिला पुलिस अधीक्षक के समक्ष गुरुवार को परिवाद पेश कर बताया कि उसकी पत्नी भावना के परिवार नियोजन के ऑपरेशन में लापरवाही बरती इससे उसकी पत्नी की उदयपुर में उपचार के दौरान मौत हो गई। परिवाद में बताया गया कि 25 जून को नगर के राजकीय अस्पताल में डॉ. राजीव मंगल ने ही उसके दूसरे पुत्र की डिलिवरी करवाई और 16 जुलाई को वह नसबंदी ऑपरेशन के लिए बड़ीसादड़ी लेकर आया। यहा डॉ. मंगल ने ऑपरेशन किया व 17 जुलाई को छुट्टी दे दी। 18 जुलाई को तबीयत बिगड़ने पर उसे पुनः बड़ीसादड़ी लेकर आया और भर्ती कर उपचार शुरू किया। तीन दिन बाद सुधार नहीं होने पर डाक्टर ने उदयपुर रैफर कर दिया। उदयपुर में 24 जुलाई को उपचार के दौरान उसकी मौत हो गई। सहायक उपनिरीक्षक भारत सिंह ने उदयपुर जाकर मेडिकल बोर्ड से पोस्टमार्टम के बाद शव परिजनों को सौंप दिया। गुरुवार को पुलिस अधीक्षक कार्यालय में परिवाद पेश किया इस पर बड़ीसादड़ी पुलिस ने प्रकरण दर्ज कर जांच शुरू कर दी है।

News paper cutting of the stated case

Home of Late Smt. Bhavna Devi

KEY CASES

- In Francis Coralie Mullin v. Union Territory of Delhi &Ors., [1981 SCR (2) 6], the Supreme Court held that the right to live with dignity and protection against torture and cruel, inhuman or degrading treatment are implicit in Article 21 of the Indian Constitution.
- In Pt. Parmanand Katara v. Union of India &Ors., [1989 SCR (3) 997], the Supreme Court held that Article 21 of the Constitution casts the obligation on the state to preserve life.
- In Consumer Education and Research Centre v. Union of India, [1995 SCC (3) 43], the Supreme Court held that Article 21 of the Constitution of India includes a fundamental right to health, and that this right is a "most imperative constitutional goal."
- In PaschimBangaKhetMazdoorSamity v. State of West Bengal, [1996 SCC (4) 37], the Supreme Court affirmed that providing "adequate medical facilities for the people is an essential part" of the government's obligation to "safeguard the right to life of every person."
- In PUCL v. Union of India,[1996 SCC], the Supreme Court held that all pregnant women should be paid Rs. 500 under NMBS at 8–12 weeks prior to delivery for their first two births, irrespective of the place of delivery and age.
- In Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors., [W.P. (C) 8853/2008], the Delhi High Court held that an inalienable component of the right to life is "the right to health, which would include the right to access government health facilities and receive a minimum standard of care. In particular this would include the enforcement of the reproductive rights of the mother."
- In Sandesh Bansal vs. Union of India &Ors.,[W.P. (C) 9061/2008], the Indore High Court concluded that timely health care is of the essence for pregnant women to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India.

GUIDELINES & GUARANTEES

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[2]); the right to live with dignity[3]; 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 Honourable Supreme Court has described gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution of India."[4] 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.[5] This duty arises from multiple international conventions to which India is a 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).

Standards for female and male sterilization services

These standards are by the Ministry of Health and Family Welfare. The state should constitute a district-wise panel of doctors for performing sterilization operations in government institutions and accredited private/NGO centres based on the above criteria. Only those doctors whose names appear on the panel should be entitled to carry out sterilization operations in the government and/or government-accredited institutions. The panel should be updated quarterly.

Eligibility of Providers for Performing Female Sterilization

Service Basic Qualification	Requirement of Provider
Minilap services	Trained MBBS doctor
Laparoscopic sterilization	DGO MD (Obstetric & Gynaecologist) MS (Surgery) *trained in laparoscopic sterilization

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

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

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

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

Clinical Processes- Preparation for surgery includes counselling, preoperative assessment, preoperative instructions, review of the surgical procedure, and post-operative care. It is essential to ensure that the consent for surgery is voluntary and well informed, and that the client is physically fit for the surgery. Preoperative assessments also provide an opportunity for overall health screening and treatment of RTIs/STIs.

Counselling- Counselling is the process of helping clients make informed and voluntary decisions about fertility. General counselling should be done whenever a client has a doubt or is unable to take a decision regarding the type of contraceptive method to be used. However, in all cases, method-specific counselling must be done.

The following steps must be taken before clients sign the consent form:

- Clients must be informed of all the available methods of family planning and should be made aware that for all practical purposes this operation is a permanent one.
- Clients must make an informed decision for sterilization voluntarily.
- Clients must be counselled whenever required in the language that they understand.
- Clients should be made to understand what will happen before, during, and after the surgery, its side effects, and potential complications.
- The following features of the sterilization procedure must be explained to the client
    a. It is a permanent procedure for preventing future pregnancies.
    b. It is a surgical procedure that has a possibility of complications, including failure, requiring further management.
    c. It does not affect sexual pleasure, ability, or performance.
    d. It will not affect the client's strength or her ability to perform normal day-to-day functions.
    e. Sterilization does not protect against RTIs, STIs, or HIV/AIDS.
    f. Clients must be told that a reversal of this surgery is possible, but that the reversal involves major surgery and that its success cannot be guaranteed.

Clinical Assessment and Screening of Clients- Prior to the surgery, compilation of the client's medical history, physical examination, and laboratory investigations as specified below need to be done in order to ensure the eligibility of the client for surgery.

Demographic information- The following information is required: age, marital status, occupation, religion, educational status, number of living children, and age of the youngest child.

Medical history- History of illness to screen for the diseases mentioned under the medical eligibility criteria Immunization status of women for tetanus Current medications ,Last contraceptive used and when Menstrual history: Date of last menstrual period and current pregnancy status Obstetrics history

Physical examination- Pulse, blood pressure, respiratory rate, temperature, body weight, general condition and pallor, auscultation of heart and lungs, examination of abdomen, pelvic examination, and other examinations as indicated by the client's medical history or general physical examination.

Laboratory examinations- Blood test for haemoglobin, urine analysis for sugar and albumin, and other laboratory examinations as indicated.

Family Planning Services:

All the spacing methods, viz. IUCDs, OCPs and condoms are available at the public health facilities beginning from the Sub-Centre level. Additionally, OCPs condoms, and emergency contraceptive pills (since are not skill based services) are available at the village level also through trained ASHAs. Permanent methods are generally available at Primary Health Centre level or above. They are provided by MBBS doctors who have been trained to provide these services. Laparoscopic sterilization is being offered at CHCs and above level by a specialist gynaecologist/surgeon only.

The public sector provides the following contraceptive methods at various levels of health system:

Spacing Methods	Limiting Methods
IUCD 380 A and Cu IUCD 375	**Female Sterilization:**
Injectable Contraceptive MPA (Antara Programme)	Laparoscopic
Combined Oral Contraceptive (Mala-N)	Minilap
Centchroman (Chhaya)	**Male Sterilization:**
Progesterone-Only Pill (POP)	No Scalpel Vasectomy
Condoms (Nirodh)	Conventional Vasectomy
EMERGENCY CONTRACEPTION	
Emergency Contraceptive pills (Ezy pills)	

Above services are provided at various levels of public sector facilities; following table provides details of the same:

Family Planning Method	Service Provider	Service Location
SPACING METHODS		
IUCD 380 A, IUCD 375	Trained & certified ANMs, LHVs, SNs and doctors	Sub centre & higher levels
Injectable Contraceptive MPA (Antara Programme)	Trained ANMs, SNs and doctors	Sub centre & higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels

EMERGENCY CONTRACEPTION		
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels
LIMITING METHODS		
Minilap	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Laparoscopic Sterilization	Trained & certified MBBS doctors & Specialist Doctors	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels

Note: Contraceptives like OCPs, Condoms are also provided through Social Marketing Organizations.

Family Planning Indemnity Scheme:

Family Planning Indemnity Scheme indemnifies all clients of sterilization as also doctors/ health facilities conducting sterilization operation in both public and accredited private/NGO sector health facilities for unlikely events of complications/failures/deaths attributable to sterilization operations. The available benefits under the Family Planning Indemnity Scheme are as under:

Section	Coverage	Limits
SECTION I (A-D) : For Beneficiaries		
IA	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
IB	Death following sterilization within 8 -30 days from the date of discharge from the hospital	Rs. 50,000/-
IC	Failure of sterilization	Rs 30,000/-
ID	Cost of treatment in hospital and upto 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/
SECTION II: Empanelled Doctors under Public and accredited Private/Ngo Sector and Health Facilities under Public and accredited Private/Ngo Sector		
II	Indemnity coverage up to 4 cases of litigations per doctor and per health facility in a year	per health facility in a year Upto Rs. 2 Lakh per case of litigation

Salient Features of the Scheme:

1. The Family Planning Indemnity Scheme has all India coverage.
2. All persons undergoing/undergone sterilization operations in public health facility or private/NGO facilities accredited by SQAC/DQAC for sterilization services are covered under Section- I–A, I-B, I-C and I-D of the scheme.
3. The Consent Form duly filled in by the beneficiary at the time of enrolling himself/herself for sterilization operation duly countersigned at the medical facility shall be a proof of coverage under the scheme.
4. The medical records and checklist for female/male sterilization should also be duly filled in by the Doctors/Health Facilities.
5. All the doctors/health facilities in public sector and private/NGO facilities empanelled/ accredited with SQAC/DQACs conducting such operations are covered under Section-II of the scheme. There is a stipulated criterion for empanelment of doctors/accreditations of health facilities for sterilization which can be referred from "Standard and Quality Assurance in sterilization services, Nov 2014"
6. All claims arising under Section I and Section II shall be admissible from 1st April 2013, under the scheme.
7. Claims arising out of cases of sterilization operations which were detected and reported after 1st April, 2013, will come under the purview of State Programme Implementation Plans (PIPs). Claims arising out of cases of sterilization operations detected and reported before 1st April, 2013, will not come under the purview of State Programme Implementation Plans (PIPs). Such claims would be covered and processed as per the respective guidelines of expired policies from 29th November 2005 to 31st March, 2013 and the convener of DISC (CMO or Equivalent) designated for this purpose at district level would be responsible for unpaid/time barred claims above. No provision will be made for unpaid claims in the State PIPs.
8. The claims will fall within the "Family Planning Indemnity Scheme" only if the beneficiary files the claim with the DISC within 90 days from the occurrence of the event of death/ failure/complication.
9. Every claim, writ and summons related to the event of death/failure/complication should be forwarded to SISC/DISC by the doctors/health facilities under Section II.

Violation of Rights:

- As per the Family Planning Indemnity Scheme -2013, on death of a woman after tubal ligation operation, woman must be compensated with a sum of Rs.2 lakhs.
- Death of Bhavna after sterilization is a clear indication of a violation of the 'Standards of Male and Female Sterilization, 2006' laid down by the Guidelines of the Ministry of Health and Family Welfare.
- Quality and safe sterilization was not provided to Bhavna which was laid down in 'Quality Assurance Manual for Sterilization Services, 2006'
- They were not provided any counselling prior to sterilization about potential risks or post-surgical care. This is in violation of Standards of Male and Female Sterilization, 2006.
- Her Right to Information had been violated; the Anganwari/ASHA workers are mandated to "Provide

information on where, when and how to access other methods (sterilization, Intra Uterine Contraceptive Device (IUCD), starting the use of OCP) and provide information on compensation for sterilization and IUCD services and family planning indemnity scheme. They were not provided any such information after sterilization and nor did the health workers help her claim compensation.

Findings:

- During the permanent sterilization operation of Bhavna Devi, the doctor accidently cut off the wrong intestine due to which Bhavna Devi died.
- After 20 days of the second delivery of Late Smt. Bhavna Devi, ASHA worker Smt. Rukamani lured her and took her to the community health care centre in Badi Sadri for conducting her tests but instead Smt. Rukamni forced her to have permanent sterilisation operation.
- Mr Dinesh Chandra and his family did not receive any prior information about the sterilisation operation of Late Smt. Bhavna Devi.
- Even after the sterilisation operation, when Late Smt. Bhavna Devi was getting discharged then also the doctors from community health care centre in Badi Sadri did not tell the family about their mistake. Doctors in Community health care centre just ignored their mistake and did not take any action to rectify it.
- After 2 days of the sterilisation operation when Late Smt. Bhavna Devi was again admitted into the same community health care centre of Badi Sadri, then also the doctors did not tell them about how they accidently punctured her intestine with the surgical blade. If they would have told the family about their mistake by the right time and had taken corrective measures then who knows the life of Smt. Bhavna Devi could be saved.
- But eventually on 24th July 2019, at 7:15 PM Smt. Bhavna Devi died in the women and child ward of Maharana Bhupal city hospital, Udaipur.

RECOMMENDATIONS

1. Mr. Dinesh Chandra, husband of Late Bhavna Devi, should be provided the claimed compensation for which he and his family are rightfully entitled under Family Planning Indemnity Scheme for unplanned pregnancy due to death after sterilisation operation.
2. The government must make counselling mandatory for couples wanting to limit their family. The miss/lack of information can cause long term implications on not only the family planning program but on people's lives too and sometimes this could lead to the death of the patient.
3. ASHA worker, ANM, Anganwari worker and PHC/CHC staff must be responsible and trained to give counselling to couples, explaining the side effects or precautions after adopting any family planning method.
4. The weak implementation of the Family Planning Indemnity Scheme cause delay in payment of compensation of failed sterilization to needful beneficiaries. Government must provide the compensation timely to the victims of irregularities of doctors/health system.
5. The quality of sterilization camps must be improved to give satisfactory service to beneficiaries.

6. The defaulters must be penalized accordingly and corrective action should be immediately undertaken.

CONCLUSION

Late Smt. Bhavna Devi suffered from traumatic sterilisation failure death due to the lack of care and negligence of the hospital staff. The hospital staff did not inform the family about the real condition of Late Smt. Bhavna Devi and showed no care. Oblivious to the consequences, Late Smt. Bhavna Devi found herself in immense pain. Mr. Dinesh Chandra Suthar and his family were not informed about any compensation they would receive due the death following sterilisation.

The plight of Mr Dinesh Chandra Suthar shows the irresponsibility and carelessness of the health department towards fair implementation of quality service and care. The government must provide compensation to the family of victim immediately and take corrective actions in the system so that no other person is forced to go through a similar situation.

3. Death of Children in Muzaffarpur, Bihar

INTRODUCTION

Acute encephalitis syndrome (AES) is a serious public health problem in India. It is characterized as acute-onset of fever and a change in mental status (mental confusion, disorientation, delirium, or coma) and/or new-onset of seizures in a person of any age at any time of the year. The disease most commonly affects children and young adults and can lead to morbidity and mortality. Viruses are the main causative agents in AES cases, although other sources such as bacteria, fungi, parasites, spirochetes, chemicals, toxins and non-infectious agents have also been reported over the past few decades. Between 2008 and 2014, there have been more than 44,000 cases and nearly 6000 deaths due to encephalitis in India.

Characterized by high case-fatality rate (CFR), the disease occurs in seasonal outbreaks every year, taking a heavy toll of life, especially of children below 15 years of age. The patients often present with acute onset of fever and altered consciousness, with a rapidly deteriorating clinical course, leading to death within hours. Many of those who survive may have residual disability impacting on long-term quality of life. While Japanese encephalitis virus (JEV) is the leading diagnosed cause of acute encephalitis, other causes include enteroviruses, scrub typhus, measles and other viruses circulating in the local area. In many cases, however, no etiological agent is determined, and such cases are categorized broadly as acute encephalitis syndrome (AES).

AES due to JEV was clinically diagnosed in India for the first time in 1955 in the southern State of Madras, now Tamil Nadu. During 2018, 10485 AES cases and 632 deaths were reported from 17 states to the National Vector Borne Diseases Control Programme (NVBDCP) in India, with a case fatality rate around 6 per cent. AES cases were reported mainly from Assam, Bihar, Jharkhand, Karnataka, Manipur, Meghalaya, Tripura, Tamil Nadu, Uttar Pradesh.

In the year 2013, starting from the monsoon months till the end of November, 2,205 people were reported to be affected by JE, and the death toll due to JE rose up to 590 (Indian Express, November 26, 2013). Many cases of AES were reported in 2014 from the states of UP (3,329 cases, 627 deaths), Assam (2,194 cases, 360 deaths), West Bengal (2,381 cases, 169 deaths), and Bihar (1,385 cases, 355 deaths) (Indian Express, September 22, 2015). JE was the major cause of these deaths, albeit virologists identified another causal agent in the form of 'toxin-mediated illness'. Investigators hypothesized the causal agent as a toxin prevalent in the litchi fruit (Indian Express, October 14, 2014). In these cases, although encephalitis was not confirmed, pathogenesis leads to encephalopathy with hypoglycaemia. Sixty-three percent of 390 patients suffered from hypoglycaemia with low blood glucose levels, and it was observed that only treatment for hypoglycaemia reduced the number of deaths from 44% in 2013 to 26% in 2014. The toxin was identified as methylene cyclopropyl glycine and was found to rise in litchi seed. Later, though not confirmed, the rise in the toxin in litchi seeds was implied to the use of alpha cypermethrin above the minimum safety levels (Indian Express, July 23, 2014).[1]

Photograph of a child suffering from malnutrition in Muzaffarpur

BACKGROUND

In 2012 reportedly 120 children died due to AES and as per the available data the number of dead children in 2014 was 90. In 2015 the Health Department of the Government of Bihar adopted a Standard Operating Procedure or SOP in collaboration and cooperation of UNICEF. As a result of following the SOP, the number of deaths decreased. In 2018 only 11 deaths were reported while this year in 2019 more than 175 deaths have been reported. However, it was expected that the number of causalities will be low this year as the government issued a revised Standard Operating Procedure for the treatment of AES cases in 2018, but unexpectedly, due to negligence on the part of government machineries there has been massive deaths of children due to AES in the district of Muzaffarpur.

A data of the deaths due to AES in the district of Muzaffarpur is provided below:

Year	Number of deaths
2012	120
2013	39
2014	86
2015	11(SOP followed for the first time)
2016	04
2017	04
2018	11 (SOP lastly followed)
2019	175+*

** The data provided is as per various news reports published by the local and national newspapers.*

[1] *Acute Encephalitis Syndrome in India: The Changing Scenario, SourishGhosh and AnirbanBasu, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5043220/*

According to a report by the Ministry of Health and Family Welfare (published in 2015)[2], AES/ Japanese Encephalitis situation in the country in the years 2012, 2013 and 2014 was as below:

AES/ Japanese Encephalitis Situation in the Country							
Sl. No.	Affected States/UTs	2012		2013		2014(P)	
		Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Andhra Pradesh	64	0	345	3	31	0
2	Arunachal Pradesh	0	0	0	0	88	9
3	Assam	1343	229	1388	272	2194	360
4	Bihar	745	275	417	143	1358	355
5	Delhi	0	0	0	0	0	0
6	Goa	84	0	48	1	17	0
7	Haryana	5	0	2	0	6	1
8	Jharkhand	16	0	270	5	288	2
9	Karnataka	189	1	162	0	75	0
10	Kerala	29	6	53	6	6	2
11	Meghalaya	0	0	0	0	212	3
12	Maharashtra	37	20	0	0	0	0
13	Manipur	2	0	1	0	1	0
14	Nagaland	21	2	20	0	20	1
15	Punjab	0	0	0	0	2	0
16	Tripura	0	0	211	0	323	0
17	Telangana					155	5
18	Tamil Nadu	935	64	77	8	346	4
19	Uttar Pradesh	3484	557	3096	609	3329	627
20	Uttarakhand	174	2	0	0	2	0
21	West Bengal	1216	100	1735	226	2381	347
Total		8344	1256	7825	1273	10834	1716
P= Provisional							

[2] *Funds allocated for the Prevention of Communicable Diseases, Ministry of Health and Family welfare, Union of India on 05-May-2015.*

METHODOLOGY

A team of social activist and lawyers visited Muzaffarpur on a fact finding mission relating to the deaths of children due to Acute Encephalitis Syndrome. The team visited villages Ali Neura, Mustafapur, Kanti Block's Primary Health Centre and Sri Krishna Medical College and Hospital (SKMCH) in Muzaffarpur to collect the testimonies of various stakeholders including aggrieved families. The team adopted random sampling method to interact with the various stakeholders. i.e health care providers at Sri Krishna Medical College and Hospital, PHCs, ASHA workers, ANM, Anganwadi workers and with parents of the children affected with Acute Encephalitis Syndrome.

People waiting outside a PHC for ORS distribution in Muzaffarpur

OBJECTIVE OF THE FACT FINDING MISSION

The fact finding was conducted on 20th of June, 2019 with the following objectives:

1. To analyse all the possible factors that played an important role in the outbreak of Acute Encephalitis Syndrome.
2. To analyse the lacuna in implementation of the revised Standard Operating Procedure for the treatment of AES cases in Bihar, 2018.
3. To identify the role of various stakeholders responsible for the ongoing issue of AES.
4. To assess the availability and accessibility of Anganwari services and health services at PHCs.
5. To assess the implementation of the ICDS scheme.

The malnourished children of Mustafapur, Muzaffarpur.

THE CASES

When the team reached Muzaffarpur, it came to know about Ali Neura village where four cases of AES had been found. The team decided to talk to its Mukhiya (Village Head) Mr.Ramprit Ram, aged 39 years. Ramprit was elected as the Mukhiya in the year 2016. In this village most of the families were from Dalit community.

Case Study - 1: Ramprit Ram- Mukhiya (Village Headman), Village: Ali Neura, Muzaffarpur

"I am Ramprit Ram - Mukhiya of the Village Ali Neura, Muzaffarpur aged 39 years. As the mukhiya, I witness everyday villagers facing enormous issues with respect to awareness, monitoring, and management of AES. The situation hasn't been the same as was in 2018. ASHA workers are not visiting my village regularly and there is no proper awareness being generated among the people about the AES. Since, there are no PHCs functioning in or near our village anymore, the role of the ANM is largely restricted and we have now lost a significant portion of health-care services because of that. Previously, even the Anganwadi workers used to make people aware about the AES and its impact, but it is simply not happening anymore. I have noticed that even the distribution of life saving drugs and medicines like ORS has gone down in the village.

"I have made umpteen complaints about the situation to the authorities, but no grievance redressal has been undertaken so as to rectify the situation. In addition to no PHC functioning in the village anymore, no ambulance has ever made it to the village which practically forces the people to arrange their own mode of transportation through private vehicles in case of a medical emergency.

"I have also noticed the mid-day meal scheme getting worse gradually. The quality of food, as I have noticed, is utterly bad and is of no nutritional value. After I was elected Mukhiya in 2016, I have even raised the issue of BPL cards not being issued by the government thus actually depriving us of much needed benefits of the economic schemes."

A volunteer cleaning the area outside a PHC in Muzzafarpur.

Case Study - 2: Phoolwati, mother of an ailing girl child Village: Ali Neura, Muzaffarpur

"I am Phoolwati, mother of a 10 year old daughter. I have been struggling with health-care services since 16.06.2019. Before introducing my case, I just want to lay out the fact that I come from a family with limited means. I come from the Dalit community and my husband works as a daily wage labourer, our family income is only about Rs. 7000. We have been going through poverty for a long time. Because of being economically backward, we were issued a BPL card, so we get ration from the PDS system albeit inconsistently. Sometimes we get ration after 5 months, sometimes after just 2 months, the pattern of which is purely random. Moreover, the quality of food that we get is not satisfactory at all. Regarding the quality of food, even the food provided through the mid-day meal scheme is pathetic in its quality. The food prepared is so bad that most of the village residents, including myself don't allow our children to consume that food.

"On 16.06.2019, my daughter felt ill all of a sudden, she vomited, felt severely dehydrated. The previous day, she was very normal, ate dinner and slept. There was no litchi in her diet over the past few days but on the 16th, her eyes started to swell and these symptoms came along. I was dishevelled in this situation and sought out help from my neighbours. The residents of the village called an ambulance for my daughter, but it was made clear to us that there was no chance of an ambulance coming to our village. Hence, one of the residents and my husband left on a motorcycle with the ill child to the SKMCH for treatment. In SKMCH, she was admitted and emergency services were given to her. Two days later, she was discharged without even a receipt or a discharge letter.

"We didn't have any alternate means besides going to the SKMCH, as the PHC has stopped functioning. In addition to that, the Anganwadi Sevika - Gayatri Devi or any Anganwadi worker for that matter don't visit our village anymore. Even the ASHA/ANM workers have stopped visiting, and hence even the necessary supplies like ORS weren't distributed in the village."

An aggrieved mother waiting for the doctor in SKMCH, Muzaffarpur

Case Study - 3: Md. Jahur, father of a 5 year old girl who lost her life due to AES, Village : Pokhripar, Mustafapur

"I am Md. Jahur, living in Pokhripar area of Mustafapur in Muzaffarnagar district of Bihar. I am a poor landless labourer, who earns around Rs. 4000 per month. I do get PDS system benefits but, in all honesty, it is quite impractical. Even if a healthy adult consumes that food, chances are he/she may fall ill.

"On the midnight of 5-6 June, 2019, my 5-year old daughter felt ill. She went through sudden stroke of severe fever and loose motions dehydrated her body badly. She didn't eat any litchi before that incident. Around 7 AM, on the morning of the 6th, we were in a panic and our neighbours called for an ambulance. They tried calling the ambulance 3-4 times but nobody picked the call from the other side. As a last resort, we had to take the ill girl by bike.

"When we reached SKMCH, there was no doctor on call, no nurse present to attend to my struggling daughter. Even the emergency services were denied to us, and after around half an hour of our misery, at around 8:30 AM, she was finally admitted to ICU. On 10th June, 2019, she succumbed to death in the ICU.

My mother was there with her at the time. After her death, she was naturally broken to see her little granddaughter struggle to death. In spite of all of this, the hospital forced her grandmother to take away her body without any receipt or document. They literally forced my mother out of the hospital without any death summary, without any conveyance/vehicle to bring the dead body of my daughter back home. It still makes me cry to think about it that my mother walked 7 Kms from the SKMCH to our home with her five year old granddaughter's dead body in her hands. No relief of any kind has been given to our family and all we are left with is the agony and memories of our daughter.

"It enrages me to think that there was no help given to us from Anganwadi workers or ASHA or ANM who, by my limited understanding, were designed to help us in these scenarios. No sevika or attendant is ever present in the village. Since there is nobody to distribute ORS, we don't get proper needful supplies like those as well."

Case Study - 4: Krishan Prasad, father of a 10 years old child who died due to AES, Village : Mustafapur

"I am the father of a 10 year old son, who died due to AES. I do farming for a living and live with my family as a resident of Mustafapur. I am originally from backward class and due to that I face various issues in the society. I earn around Rs. 12,000 per month. My family has been recognised as BPL, and we get ration through the PDS system. The quality that we get in the food supplied through the PDS system is not good at all.

"We are not receiving any healthcare help, be it from Anganwadi Workers, ASHA for any health issues. Children get sick all the time and there is no respite for the residents in Mustafapur. The PHC in the village is not functional anymore, which has multiplied the problems faced such as the distribution of basic medications such as Paracetamol and rehydration liquids.

"My own 10 year old son died due to the circumstances present. On 09.06.2019, after having dinner just like any other night, he slept. There was no litchi which was present in the meal or the meals preluding the dinner. On the morning of 10.06.2019, he woke up with extremely high fever. The residents of the village got alert and our neighbours accompanied us to rush to the hospital SKMCH. He was referred to ICU there and was declared dead. We did not get any kind of death summary. Also, no compensatory relief was granted to us."

Case Study - 5: Bhola Ram, father of a 3 year old girl who died due to AES, Village : Sonbarsa

"I am Bhola Ram from the village Sonbarsa. My monthly income is around Rs. 5000 per month and I belong to the Mahadalit community in Bihar.

"I am going through deep remorse after my 3-year old daughter passed away on 10.06.2019. On the morning of that sad day, at around 7 AM, she made several complaints about feeling uneasy. She was crying, shouting and whimpering in pain. The residents of the village arranged a private vehicle and accompanied us to the Kejriwal Hospital where she was declared dead at around 3:30 PM. I was not even issued any death summary on the terrible ordeal of my daughter.

"There was no other alternative other than taking her to the hospital because there were no healthcare facilities available in or around our village. Even the PHCs we had do not function anymore making the lives of the residents extremely difficult with healthcare access."

Case Study - 6: Alauddin, father of an ailing child, Village: Basant, Muzaffarpur

"My name is Alauddin. I am a seasonal farm labourer working in my village Basant in Muzaffarpur district. Since there was no PHC functional in my village, I had to take my two year old daughter to the SKMCH in the morning on 20.06.2019, after she vomited in the morning and started crying. She is still suffering from pain in the hospital. There was even a time when she was shivering in fever but no one paid heed to her. I am in deep concern because no doctor or nurse has attended to my daughter."

Case Study - 7: Dinesh, father of an ailing child, Village: Pahadchak, Muzaffarpur

"I am Dinesh, father of a 3 month old child admitted in SKMCH, resident of Pahadchuk village in District Muzaffarapur. My child has been here in the hospital for more than 24 hours and still no doctor has come around to attend him. I have been looking for a doctor for a long time just so I could bring my child to the doctor's attention. My child has been repeatedly crying due to severe discomfort.

"I tried to take him to the PHC first, but was told by the staff to bring the child here immediately. No health assistance has been made available to our village like the Anganwadi worker, ASHA and ANM. The PHC exists in our village but it is only very rarely open and health troubles have increased in the village because of this fact."

Case Study - 8: Priyanka Kumari, mother of an ailing child, Village: Saraiyan, Muzaffarpur

"My name is Priyanka and I am from Saraiyan Village of Muzaffarpur. My husband is a labourer who works in a city. We are from BPL category. My 2 years old daughter was admitted to the SKMCH due to AES this morning but no doctor has attended her so far. No assistance of any kind has been provided by ANM, ASHA or Anganwadi Workers. No ORS packets are even available to us, which we sorely need.

"My daughter had high fever and loose motions. At first, I tried to treat her at home but when nothing worked I finally brought her to the SKMCH on 20.06.2019 in the morning."

A photograph of volunteers interacting with the aggrieved families in Muzaffarpur.

Case Study - 9: Arvind Kumar, father of an ailing child, Village: Tejpur, Sheohar District

"I am Arvind Kumar, father of a 3 year old boy admitted in SKMCH and a resident of Tejpur village in Shehohar District. My 3 year old son was admitted in SKMCH due to the symptoms of AES on 19.06.2019. It has been more than a day and still no doctor has attended him. No ORS or any medicine has been provided to him for relief. I first got my son admitted to the PHC but considering the deteriorating health conditions of my child, I moved to SKMCH where I am in hope to get my son's treatment done. I sincerely hope that my child gets well soon and we all get away from this terrible misery we have been facing."

Case Study - 10: Satyam Kumar, father of an ailing child, Village : Bhatnaha Thana, Muzaffarpur

"I am Satyam Kumar, father of an ailing child in the SKMCH waiting for my son to get his treatment started. I am from Bhatnaha Thana, Muzaffarpur. My 7 year old disabled child was admitted to SKMCH for treatment of AES this morning. Till now no progress has been made as to the treatment of my son. My entire family is waiting with the hope that a doctor may visit us soon. There has been absolutely no healthcare benefit provided to us. Even no primary treatment was available to us in the village's PHC."

Case Study - 11: Chanda Devi, Mother of an ailing child, Village : Runnisaidpur, Sitamarhi

"I am Chanda Devi sitting on the hospital floor with my two and a half year old daughter who has been struggling with her health for more than a day. I am extremely concerned because no one from the medical unit has attended her yet - neither a doctor nor a nurse. I had to come to Muzaffarpur district as there is no health facility available in my district Sitamarhi and the PHC there is not functional. I had to bring my daughter all the way from there for her treatment. There is no ASHA/ANM or Anganwadi Worker who has helped me and they rarely visit our village. My husband is a landless farmer and we are below the poverty line. My husband earns about Rs. 7000 per month. I do not get any benefit from the PDS system as I have been told I should. Even after travelling such a long way for treatment of my daughter, no one from the medical unit has attended her yet- neither a doctor nor a nurse."

Patients and their families waiting for the doctors

Case Study - 12: Ashok Kumar, father of two ailing children, Village : Harivanshpur, Vaishali

"My name is Ashok Kumar, I am a father of two ailing children admitted to the SKMCH. I am from Harivanshpur, Vaishali. My two sons were first admitted in the PHC of our village and were referred to the SKMCH after considering the symptoms. No Anganwadi worker has been working in our village for quite some time now. However, I have been facing problems in the SKMCH as no doctor is available to attend my ill sons. I work in an unorganised employment sector for an independent contractor and hence I am not well-off financially. I hold a BPL card and get the PDS benefits, but these benefits don't make any sense to us as the food quality is significantly poor."

Case Study - 13: Mundrika Sahni, father of an ailing child, Village : Saraiyan, Muzaffarpur

"My name is Mundrika Sahni, father of an ailing child, resident of village Saraiyan in the district Muzaffarpur. My five year old daughter was admitted to the SKMCH this morning. I am a carpenter and work in the nearby city for employment. I make about Rs. 10000 per month. I do not get any food from the PDS. No medical staff has attended him yet. No ORS supplies have been made available for immediate relief. There have been absolutely no visits from ANM, ASHA and Anganwadi workers."

Case Study - 14: Mukesh Sahni, father of an ailing child, Village: Ghunsaut, Muzaffarpur

"My name is Mukesh Saini, father of a 10-year old ailing child admitted on 20.06.2019, resident of Ghunsaut village in Muzaffarpur. I have been here lying on the floor with my wife and my ill son. I am a seasonal farm labour and hence do not have much financial means. My village PHC had absolutely no facility for admitting the child so we had to rush to SKMCH. There was no other health facility available closer to our village."

Photographs of the SKMCH, Muzaffarpur (as on 20.06.2019)

A photograph of the SKMCH, Muzaffarpur where the patients had to lie down on the floors of the ward due to lack of beds.

Photograph of a family waiting for the Doctors in SKMCH

Photgraph of a team of volunteers cleaning the inner campus of SKMCH, Muzaffarpur.

OBSERVATIONS AND RECOMMENDATIONS

Pathetic, inhuman and unhygienic condition of Sri Krishna Medical College and Hospital (SKMCH):

SKMCH is the only government medical hospital treating the children affected with AES but its condition is so unhealthy and unhygienic that a normal human being can easily catch up any disease in the hospital. The families whose children were affected to AES were lying down on the floors of the wards due to insufficient number of beds, the doctors were not attending the patients, there was no arrangement of Air Conditioners and power back up even for the ICU wards. The oxygen cylinders get switched off whenever the power is cut. It takes at least five minutes to switch on the generator, and those five minutes are very crucial for a child who has been diagnosed with AES.

Condition of health services in the villages of Muzaffarpur:

During the field visit many villagers were asked about the whole issue of AES outbreak in Muzaffarpur. The common questions asked were about the condition of health services in the district. A few common responses of the villagers were:

- In most of the villages PHCs are not functional.
- In most of the villages the PHCs are out of reach of the villagers. In many villages ANMs, ASHAs and Anganwari workers are not regular in their work. People are not aware about the work responsibilities of village health workers.
- The anganwari centres of the villages are not functional and are open only in the morning, that too rarely.

The condition of PDS and mid day meal in Muzaffarpur:

One of the major issues which came to light has been the issue of malnourishment among children. From the above mentioned case studies, it can be inferred that the majority of children affected with AES belonged to the low income group families. They were not getting proper meals. The government operated PDS shops are not functional. The poor people are either not getting food through the PDS, or the quality of food which the people are getting through PDS is not edible. PDS is not reaching people in need.

Functions of ASHA, Anganwadi Worker(AWW) and ANM - Analysis of their performance :

ASHA workers

ASHAs have a vital role in promoting access to healthcare and health education in the community. Every village is assigned an ASHA worker which works as the first port of call for health related demands at community level. She is also responsible for promoting institutional deliveries, universal immunization and other public health initiatives, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.

As has been noticed in the case studies, the ASHA workers have not only failed in performing their roles and functions but were not even aware of the ongoing events of their villages. They didn't visit the households in most of the cases. In some cases, they didn't address the problems faced by the residents of the village appropriately and the overall healthcare standards of the villages went down even after there is an ASHA worker.

Anganwari Workers

Anganwari Worker (AWW) performs activities such as organising Health Day once/twice a month at Anganwari Centre and orienting women on health related issues such as the importance of nutritious food, personal hygiene, care during pregnancy, importance of immunisation etc. She is also responsible for providing nutrition supplements to pregnant women and children below the age of six.

In the case studies, it has been pointed out that people did not have access to basic medical and nutrition supplements. As the Anganwari worker is a depot holder for drug kits, it should have been the responsibility of the Anganwari workers to ensure that proper distribution of ORS was carried out. In addition to it, proper awareness must be created regarding the importance of nutritious food which was clearly not present among the residents of the village.

ANM

ANMs provide mentoring and support for the ASHAs linked to their Sub Health Centres or PHCs. ANMs work at health sub-centres and also perform outreach activities. The sub-centre is a small village-level institution that provides primary health care to the community. The sub-centre works under the PHC. Each PHC usually has around six such sub-centres. ANMs are expected to fulfil multiple responsibilities. Their responsibilities include providing basic maternal and child health services along with family planning services, health and nutrition education, and efforts for maintaining environmental sanitation, immunisation, treatment of minor injuries, and first aid in emergencies and disasters.

ANMs being responsible for emergencies and disasters were supposed to take care of ailing children. However, they didn't seem to be fulfilling their responsibilities in this case. Furthermore, they are also accountable for the lack of health and nutrition education among the people.

According to the Revised Standard Operating Procedure for treatment of AES framed in 2018, the roles of ASHAS, Anganwadi Workers and ANMs are as follows:

- The patients of AES should be treated with the same direction of the do's and don'ts which are followed in the case of Japanese Encephalitis.
- If the patient is not unconscious, he/she should be immediately given ORS or served glucose.
- If ASHA or ANM possess a glucometer, then the sugar level of the patient should be immediately checked.
- Ambulance should be contacted on toll-free number 102/108 immediately.
- Upon referral, the nearest PHC or District Hospital should be told about the patient's expected arrival time.
- Generate awareness about the symptoms and protective measures regarding AES in the society.
- Patient should be taken to the nearest health centre with all the necessary precautions being taken.

The functions which the ASHA, ANM and Anganwadi workers were supposed to be carrying out have clearly not been adhered to.

RECOMMENDATIONS

- Health Services in villages need to be examined immediately and infrastructural upgradation is a must.
- Not only ASHAs, ANMs and Anganwari Workers need to be made aware about their duties but also the people.
- A special committee should be set up under the Department of Health, Government of Bihar which will visit each and every village and keep a check on the health facilities at village level.
- The water facilities should be checked and each and every public hand pump should be repaired and PHED should be made responsible for the water facilities.
- There needs to be some quality standards that should be set for the food to be delivered through PDS.
- There is need to conduct a quality check of Midday meal being served in the schools.
- There is an immediate need to update the list of people getting PDS facility in the villages.
- A proper chart of all the children enrolled in the government schools need to be maintained at the end of every month in which the following details can be recorded:

    a. Name

    b. Age

    c. Height

    d. Weight

    e. Body Mass Index

    f. Details of the disease or illness if any

This record should be inspected by an officer not below the rank of District Education Officer and District Programme Officer.

- Proper implementation of schemes by the government and a follow up on the Standard of Procedure established in 2015.
- According to the Rural Health Statistics, 2018, of the Ministry of Health and Family Welfare, there are only 0.3 allopathic doctors per 100,000 population in Bihar compared to an all India average of 3.4. This number is quite alarming in the face of crisis. Thus, the doctor-patient ratio needs to be increased in the State.
- PHCs need to be better equipped.
- Awareness drives need to be properly carried out throughout the state.

A photograph of the banner displayed by the Department of Health, Government of Bihar depicting that Rs. 400/- will be reimbursed if the patient has to avail private transportation facility.

CONCLUSION

Thus, the failure on the part of the government to take precautionary as well as preventive measures has led to the disaster caused in Bihar by the AES. Lack of proper facilities, coupled with problems like malnutrition and administrative negligence has resulted in the large death toll in the state. What is now required is a pragmatic approach to the problem and effective action by the governmental authorities to control the present situation and to prevent it from happening in the future. Deaths caused by Encephalitis in Bihar have revealed cracks in the healthcare system that require immediate action.

4. Poor State of District Hospital, Senapati, Manipur

INTRODUCTION

Manipur has been portrayed as a progressive state in terms of literacy and gender equality and is often recognized for its fight for gender justice; its sex ratio is higher than India's average and is counted as one of the highest amongst the Indian states. However, despite the progressive state of affairs in Manipur, the issues relating to health outcomes, coverage and infrastructure in the state have been neglected. The state has two Tertiary Health Centres, seven District Hospitals, 16 Community Health Centres (CHCs), 85 Primary Health Centres (PHCs) and 421 Health Sub-Centres (HSCs).

Senapati district is located in the northern part of Manipur, bordering Nagaland. The Senapati district hospital has about 50 beds and covers a population of about 3 Lakhs. As Manipur Government is still reluctant in providing the best possible health facilities to the people of this district, a team of lawyers and activists visited the District Hospital Senapati to assess the facilities and health services at the hospital.

Visit to District Hospital, Senapati

The fact finding team interacted with Dr. Dihe Mao the Superintendent of District Hospital Senapati and found a myriad of issues and improvement required in various areas in the hospital. The Superintendent provided the fact finding team with some material covering details about staff strength and equipment. He further informed the team that he recently took charge as Medical Superintendent and right after he took over the charge, several representations have been submitted to the higher authorities requesting an increase in staff and equipment but no action had been taken by the concerned authorities. The following were found to be major areas of concern at the District Hospital, Senapati:

Manpower

There was acute shortage of manpower in the hospital. The total number of vacant posts was 91 as against the total sanctioned post of 161. The actual strength of staff working at the hospital was 71 doctors who were undergoing post-graduation courses and were enlisted under the payroll of the hospital but the vacancy arising during their absence was not filled because the data of the employees was being maintained in the Manipur Government Employment List (MGEL) now CPIS. Four staff nurses who were posted at the hospital were being utilized at other hospitals. The number of specialist doctors who were posted at the hospital was only five as against the sanctioned post of 18, leaving 13 specialist posts vacant. Further, the team was informed that despite the request made by the hospital authority to the concerned department for providing adequate staffs, the concerned department had not taken any positive steps.

Staff Strength in the District Hospital, Senapati

Sl.No	Name of Posts	Sanctioned post	Staff in Position	Present Status	Vacant Post
1	Medical Supdt	1	1	working	Nil
2	Sr. Specialists	8	2	-do-	6
3	**Specialists**	**18**	**5**		**13**
3.1	Anaesthesiology	1	1	-do-	Nil
3.2	Medicine	1	1	-do-	Nil
3.3	Obst& Gynae	1	1	-do-	Nil
3.4	Opthalmology	2	1	-do-	1
3.5	Bio-Chemistry	1	1	-do-	Nil
3.6	Dermatology	1	Nil		1
3.7	Orthopaedics	1	Nil		1
3.8	ENT	1	Nil		1
3.9	Psychiatry	1	Nil		1
3.10	Surgery	1	Nil		1
3.11	Paediatrics	1	Nil		1
3.12	Microbiology	1	Nil		1
3.13	Pathology	1	Nil		1
3.14	MC & H	1	Nil		1
3.15	IHTM	1	Nil		1
3.16	Radiology	1	Nil		1
3.17	Dental	1	Nil		1
4	Sr. Dental Surgeon	1	Nil		1
5	Dental Surgeon	3	2	1-PG	1
6	Sr. M.O.	2	2	working	Nil
7	Homeopathic Physician	2	Nil		2
8	MO (C&T) Centre	10	6	3-PG	4

Sl.No	Name of Posts	Sanctioned post	Staff in Position	Present Status	Vacant Post
9	MO General duty	14	11	3-PG	3
10	Nursing Supdt.	1	1	working	Nil
11	Nursing Sister	4	4	1-retired	Nil
12	Steward	1	Nil		1
13	Medical Record Tech	1	1	working	Nil
14	Consultant	1	Nil		1
15	Pharmacist (Allo)	3	3	working	Nil
16	Homeopathy	2	Nil		2
17	Staff Nurses	33	18	4-utilised at Imphal, 3-transferred, 3-retired	15
18	CSRT	1	1		Nil
19	Lab.Technician	4	3	2-retired	1
20	Driver (L)	2	2	working	Nil
21	Dresser	1	Nil		1
22	Oph. Asst	1	1	working	Nil
23	LDC	3	1	-do-	2
24	F.H. Worker	2	2	-do-	Nil
25	Radiographer	1	1	-do-	Nil
26	Lab. Asst	1	Nil		1
27	Ward Attendant	17	16	working	1
28	Cook	3	3	-do-	Nil
29	Chowkidar	2	2	-do-	Nil
30	Ayah	3	Nil		3
31	Cleaner	2	Nil		2
32	Dhobi	3	1	working	2
33	Masalchi	1	Nil		1
34	Peon	2	Nil		2
35	Sweeper	6	1	-do-	5
36	Mali cum W/C	1	1	-do-	Nil
	Total	**161**	**91-20=71**	**20**	**70+20=90**

Equipment

It was found that the Operation Theatre (OT) was under construction and a lot of equipments were lying uninstalled. During the interaction with the Medical Superintendent, it was observed that the District Hospital, Senapati also required a number of equipment and even though requests had been sent to high

authorities there had been no action taken to provide the equipment in question. The following is the list of equipment required at the hospital.

Sl. No	Item	Number required
1	Anaesthesia work station	1
2	Soda Lime canister	1
3	Cardiac Monitor CO2 indicator	2
4	Face Mask (Paediatric to adults)	2 sets
5	Defibrillator	1
6	Cardiac Table	5 sets
7	Infusion/syringe pump	5 sets
8	Brains circuit	5 sets
9	Oxygen mask (adult paedia)	5 sets
10	Portable USG	1
11	Peripheral nerve stimulator	2 sets
12	Laryngoscope Set	2 sets
13	Nasal airway (paedia adult) set	2 sets
14	Guedel's airway (paedia adult)	2 sets
15	LMA set (paedia to adult)	3 sets
16	Revolving chair for OT use	5 sets
17	Gum elastic bougie	3 sets
18	Ambu bag	3 sets
19	Stylet	5 sets
20	Armoural tube (paedia to adult)	2 sets
21	IV stand	3 sets
22	Cautery patient plate	2 sets
23	Weighing machine	1
24	Foot suction	1
25	Stethoscope	3
26	Suction machine	1
27	O2 flowmeter	5 sets
28	ENT Endoscopy set	1 set
29	Audiometry set	1 set
30	Tonsillectomy set	2 sets

Sl. No	Item	Number required
31	Mastoidectomy set with Micromotor	2 sets
32	Nasal packing forceps 4/5	5 pieces
33	Crocodile forceps 4/5	4 nos. (small & medium)
34	Long laryngeal forceps ¾	4 nos.
35	Heine otoscope	1 no.
36	Ear sickle knife (thin)	1 no.
37	Indirect laryngeal mirror	1 no. (large)

Power Supply

The hospital lacked regular power supply due to frequent power cuts in the region. The hospital had no source of power back up during emergency. The generator installed in the hospital was not functional. The solar power plant installed in the year 2017 was also not functional. Given the circumstances, the district hospital remained non-functional when there was no supply of electricity.

Water supply

The hospital had one water reservoir which received water supply from the water source located at Kataomai village. The water reservoir at the water source was being shared with the Kataomai village and other places of the district headquarter. The small water reservoir at the water source was not able to meet the increasing demand of water, as a result the hospital was facing acute shortage of water. The concerned authority had not taken any measures to construct a bigger water reservoir in order to meet the increased demand of water which is a paramount amenity required for the functioning of a hospital.

Ambulance

The district hospital had two old ambulances and one new advanced lifesaving ambulance. However, it was found that none of the ambulance at the district hospital was functional. Patients were facing great

difficulties during referral due to lack of ambulance. Lack of ambulance does not only cause great inconveniences to the patients but pose a great threat to life during medical emergency. Scheme such as JSSK guarantees free referral services to the pregnant women and children, however, due to lack of ambulance, the district hospital failed to ensure proper implementation of such schemes.

Mortuary Van

The district hospital did not have any mortuary van for carrying the dead bodies. Mortuary van is essential for transportation of the dead bodies from the district hospital to other places and vice versa. Due to unavailability of mortuary van, the dead bodies were being transported using private vehicle. Availability of mortuary van is an essential feature stipulated under the Indian Public Health Standard guidelines.

Staff Quarters

The district hospital lacked adequate staff quarters. It had one Type-IV building and two small houses which were being used as staff quarters. Most of the doctors posted at the hospital come from other districts and as such, they required staff quarters. However, due to shortage of adequate quarters, the doctors and staff coming from other parts of the state were not stationed at the district hospital which was leading to absenteeism or cases of coming late to work. In the given circumstances, the efficiency in the functioning of the district hospital was greatly affected by the shortage of adequate staff quarters.

Other facilities that are required improvement at the hospital were :

- **Kitchen-**There was no kitchen for cooking food at the district hospital.
- **Toilet-**There was no public toilet for the hospital visitors.
- **Public waiting shed-** Waiting shed for the hospital visitors was not available and the hospital did not have any chairs in the waiting area where the patients/visitors can sit while waiting for their turn.
- Library-Library facility was not available at the district hospital which is essential for the doctors/nurses/staffs and others to be informed with the latest updates.
- Office vehicle-The department did not provide any vehicle to be used for the official purpose of the district hospital including the Medical Superintendent vehicle.

RECOMMENDATIONS

- Immediate appointments of Specialists, doctors, staff nurses and other staff at District Hospital, Senapati.
- Take steps and make necessary arrangement for construction of adequate staff quarters.
- Provide adequate equipment at the District Hospital, Senapati.
- Address issues pertaining to shortage of water and power supplies.
- Make provision for mortuary van.
- Make ambulances functional so that they are available for patients for free.

5. The Condition of Mohalla Clinics and the Facilities Available to Pregnant and Lactating Mothers, Delhi

INTRODUCTION

Health is a fundamental human right and a global social goal. It is pertinent for the realization of basic human needs and for a better quality of life. Health is a causative factor that affects country's aggregate level of economic growth. Since development is a consequence of good health, even the poorest developing countries should make it a priority to invest in the health sector. Unfortunately, health has been poorly invested in by countries with low human development, and the health sector still remains largely untapped and continues to suffer neglect.

India has a population of over 134 crores. Ensuring the well-being and providing adequate healthcare facilities to suit the needs of every class of the Indian population is one of the primary responsibilities of the Indian Government. However, over the years, it has been noticed that there is a substantial difference in the functioning of private and public health care providers. India's rank in the Human Development Index Report 2018 (130 out of 189 countries) issued by the UNDP depicts the level of ignorance of the health sector in a country like India.[1] The Ministry of Health and Family Welfare is responsible for providing public health care services. Each state has their own Directorate of Health Services and Department of Health and Family Welfare.

In 2014, 58% Indians in rural areas and 68% in urban areas said they use private facilities for inpatient care.[2] Various studies have shown the rising out-of-pocket expenditures on healthcare is pushing around 32-39 million Indians below the poverty line annually.[3] District-level health services provide a link between each

[1] *http://www.in.undp.org/content/india/en/home/sustainable-development/successstories/india-ranks-130-on-2018-human-development-index.html*

[2] *71st round of the National Sample Survey Source: India Spend, January 2018*

[3] *https://www.firstpost.com/india/shortage-of-medicines-at-public-hospitals-forcing-poor-to-turn-to-private-pharmacies-says-chhattisgarh-study-4509233.html*

state and primary health care services. 7% of Indians fall below the poverty line just because of indebtedness due to this expenditure, as well as that this figure hasn't changed much in a decade. About 23% of the sick can't afford healthcare because of these payments.[4] At the national level, the Government of India spends a measly 2.1% of its budget on health.[5]

Health Expenditure Per Capita is the sum of public and private health expenditure (in PPP, International $) divided by the total population. The health expenditure per capita stood at Rs. 1, 112 in the year 2018 in India.

The Indian healthcare infrastructure is not able to keep pace with the demands of a growing population. The number of people who choose private healthcare over public healthcare due to the unavailability of specialist doctors, diagnostic services and medicines is increasing day by day. The Government has taken small steps to remedy this issue by creating initiatives such as Rashtriya Swasthya Bima Yojana (RSBY) scheme to improve healthcare insurance coverage and increasing the availability of cheaper medicines in government healthcare centres. However, widespread positive results from these initiatives have yet to be seen.

Access to healthcare in India is limited by a combination of factors, including, but not limited to: dysfunctional infrastructure, poor health financing, and a lack of adequate human workforce. The availability of healthcare facilities is highly unbalanced, with availability being skewed towards urban centres, despite the urban population only accounting for only 33.53 per cent of the country's entire population.[6] Even in the urban centers, the availability of healthcare facilities is tilted towards those who can afford premium private healthcare services. The remaining 67 per cent has access to only one-third of the total beds available in the country.

Healthcare delivery in India is classified under three categories – primary, secondary and tertiary care. All three levels need to work in a tenacious manner to deliver quality healthcare to all citizens.

Primary Healthcare Facilities

Primary healthcare is a crucial category of health service delivery. Primary health care constitutes the daily care needed to protect, maintain, or restore health. For most people, it is both their first point of contact with the healthcare system and their most frequently used health service. Within the first tier of primary healthcare itself, the Delhi Government created another tier comprising of the Mohalla Clinics, with the purpose of providing primary health care at the doorstep Delhi residents.

Secondary Healthcare Facilities

Secondary Health care refers to a second tier of health system in which patients from primary healthcare institutions are referred to specialists in higher hospitals for treatment. In India, the health centres for secondary health care include District hospitals and Community Health Centres (CHCs) at block level.

Tertiary Healthcare Facilities

Tertiary Health care refers to the final level of health system in which specialised consultative care is provided, usually on referral from primary and secondary healthcare institutions. Specialised Intensive Care Units, advanced diagnostic support services, and specialised medical personnel are key features of tertiary health care. In India, under the public health system, tertiary healthcare service is provided by medical colleges and advanced medical research institutes.

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[4] *https://thewire.in/health/whatever-happened-to-indias-national-free-medicines-scheme*

[5] *Retrieved from the Official National Budget of 2018-19.*

[6] *Retrieved from the World Bank Collection of Development Indicators, 2017*

HEALTHCARE SYSTEM IN DELHI

Delhi is a city-state in India, with a population of 1.68 crore (or 16.8 million) in 2011 with 97.5% of population living in urban area, 1483 km2 geographical area, and population density of 11,297 (range 3800–37,346/km2). It has nearly 18 lakh (1.8 million) or 11% population living in slums[7] and a large proportion of this population is migrants from various parts of country. Delhi is the most populous urban agglomeration in India and the 3rd largest urban area in the world. The health services in Delhi are provided by 12 different agencies. The number of health facilities available in Delhi varies depending on sources. As on March 31, 2014, there were 95 hospitals, 1389 dispensaries, 267 maternity homes and sub centers, 19 polyclinics, 973 nursing homes, and 27 special clinics in Delhi.[8] In addition, there are 15 government-run medical colleges in allopathic system of medicine.

Agencies providing health services in Delhi, India
State Government of Delhi
Government of India
Central Government of Health Services
Directorate General of Health Services
Antonomous institutions (i.e., All India Institute of Medical Sciences)
Employee's State Insurance Corporation
Ministry of Defense
Ministry of Railways
New Delhi Municipal Council
North Delhi Municipal Corporation
South Delhi Municipal Corporation
East Delhi Municipal Corporation
Private Organizations and providers
Voluntary organization and nongovernment organizations

The Government of Delhi owns nearly one-fourth to one-fifth of all health facilities with nearly 10,000 hospital beds, over 200 dispensaries and polyclinics, among many others. The health facilities run by the Government of Delhi examine around 3.35 crore outpatients and treat nearly 6 lakhs hospitalized patients, every year. There is high density of private providers and large private hospitals and small clinics in the city-state. Nearly 55% of hospital care in urban areas is from private sector. In addition, 87% of males and 71% of females in Delhi attend private providers for their outpatient (national average 76% and 73%, respectively).[9]

Hence, introduction of better primary health care facilities in Delhi became a necessity.

[7] *Government of Delhi. Delhi Population: Statistical Abstract of Delhi; 2014. Delhi: Department of Statistics and Economics; 2015.*

[8] *Government of Delhi. Economic survey 2016-17 Department of Health and Family Welfare, Govt. of Delhi. 2016.*

[9] *National Sample Survey Organization. Key Indicators of Social Consumption in India: Health. 71stRound: January – June 2014. Ministry of Statistics and Program Implementation. New Delhi. 2014:1–99.*

AAM AADMI MOHALLA CLINICS (AAMC)

The Delhi government has allocated 12% of its total budget for health as compared to just about 2.1% in the Union Budget. As stated in the Delhi Budget 2018-2019, the Delhi government has allocated Rs. 7,485 crores for the health care, which is an increase of Rs. 756 crores from last year's 6, 729 crores.

Aam Aadmi Mohalla Clinic (AAMC) is an initiative taken by the current AAP government in Delhi, aiming at decentralising and improving the primary health care system in Delhi. AAMC come under the primary healthcare category, and is a flagship project of the present government aimed at providing free primary healthcare to residents closer to their homes. The pre-existing equivalent to AAMCs were the Primary Healthcare Centers (PHCs), which are not as vast in number as the number of Mohalla Clinics AAP wishes to establish. The Mohalla Clinic initiative by the Delhi Government is a big hit among a huge number of people in Delhi. These clinics were set up by the AAP government in Delhi as neighbourhood health centres, providing basic and essential health services, including medicines, diagnostics, and consultation, free of cost to all.

The primary goal of the AAMCs is to reduce the load on the PHCs, and the AAMCs coordinate with the centers in regard of restocking of the medicines in the clinic. The AAMCs focus on providing basic healthcare services to the people - services such as primary check-ups and basic tests are to be covered by the AAMCs. The Mohalla Clinics offer basic diagnostic tests. It claims to provide about 212 tests, which includes common medical tests including blood pressure, blood sugar, heart rate, blood haemoglobin, urine protein and glucose. Also, it tests for diseases such as malaria, dengue, hepatitis, HIV, and typhoid. Mohalla clinics are expected to have 110 medicines with them. These are the basic medicines of varied dosage and are prescribed to the patient on a three-day basis.

Why Mohalla Clinics Despite Government Hospitals And Dispensaries?

Many people complain that some sort of Babu culture always existed in the government hospitals. Moreover, finding doctors and paramedics is not an easy task. Patients would have to wait endlessly to see a doctor. Most of the time, doctors are absent from the hospitals, and when they are present, they are found giving preferential treatment to their relatives or acquaintances.

On the other hand, although Delhi always had a few primary health centres, they were not able to provide medical facilities near the doorstep. Patients at these major government clinics complain that they often had to struggle to get medicines.

AAP's Mohalla Clinic initiative has certainly improved the scenario on these counts for the poor in Delhi. For one thing, they are operational right within the residential colonies, making it convenient for patients to visit them without the hassle of getting transport. Secondly, they are well-stocked, so that getting timely care and medicines is not an issue.

By introducing Mohalla clinics, the Delhi Government is creating a new tier of healthcare delivery without looking into the existing one, not doing anything about the existing tiers. The fact that only 189 Mohalla Clinics have been opened in the last four years should be a cause of concern for the government. The tardy pace of building such clinics has stood in the way of a larger and more far-reaching transformation of Delhi's health sector.

The first ever Mohalla Clinic was inaugurated by Delhi Chief Minister Arvind Kejriwal on July 20, 2015 in Rajiv Gandhi JJ Punjabi Colony, a relief camp in Peeragarhi. The aim was to bring down the ever increasingburden on big government hospitals. These clinics are air-conditioned, and exude a private hospital-like atmosphere.

Earlier, people would have to wait for hours to get basic medical treatment at the big government hospitals, but ever since the Mohalla Clinic opened, it has become much easier for locals to access timely medical attention and quality treatment. These clinics, according to Ismail, maintain a sufficient stock of medicines and people never face problems in getting them.

<table>
<tr><th colspan="2">PRIMARY HEALTH CARE</th></tr>
<tr><td>Personal and / or Curative Health Services</td><td>Population and/or Public health services</td></tr>
<tr><td rowspan="2">Mohalla Clinics</td><td>Mohalla Clinics</td></tr>
<tr><td>U-PHC (under NUHM)</td></tr>
<tr><td>U-PHCs and Polyclinics</td><td rowspan="2">Other Government agenices</td></tr>
<tr><td>Private Sector</td></tr>
<tr><td>Agenicies other than the Govt. of Delhi</td><td>Urban Local Bodies</td></tr>
</table>

The Mohalla Clinic initiative by Delhi Government is a big hit among a huge number of people in Delhi. These clinics were set up by the AAP government in Delhi as neighbourhood health centres, providing basic and essential health services, including medicines, diagnostics, and consultation, free of cost to all.

The paper seeks to identify the health needs of the citizens of Delhi with regard to the two branches of healthcare, i.e. public health and healthcare delivery systems. Two of the many problems that were identified were then taken up for further analysis. These two problems were (a) access to primary healthcare and (b) Issues related to public health and preventive health care.

Delhi needs a robust, decentralised primary healthcare sub-centres that tend to people's primary healthcare needs as well as a mechanism that addresses the loopholes in preventive public health systems. The Delhi Government has come up with the concept of 'Mohalla Clinics' which tries to bring primary healthcare delivery systems right to the doorsteps of citizens. This paper reviews the Mohalla Clinics system keeping in mind that the policy is still at its nascent stage. The paper also recommends modifications to the Mohalla Clinics scheme in order to synergize with public health services and emerge as a Wellness Clinics

The Delhi Government has presented Rs 60,000 crore budget for 2019-20 in the Delhi Assembly. A total of Rs 7,485 crore which amounts to 14 percent of the budget allocation, has been towards the healthcare sector. However, the allocation towards the much touted scheme of 'AamAadmi Mohalla Clinics' has been reduced by 6.9 per cent.

Mohalla Clinics were started by the AAP government in Delhi as primary health centres, which offer a basic package of essential health services including medicines, diagnostics, and consultation free of cost. For this, the Delhi government has received huge praise in the past. But the scheme seems no longer to be the priority of the government.[10]

[10] *https://www.financialexpress.com/economy/delhi-budget-2019-20-arvind-kejriwals-favourite-mohalla-clinic-scheme-gets-little-attention/1499889/*

Improving the Quality of Healthcare in Delhi

The Aam Aadmi Mohalla Clinic is conceptualised as a means to render quality primary health care in every locality in Delhi. The physical infrastructure is made up of pre-engineered insulated box type movable structures, manufactured and installed through the Public Works Department.

Out of 1000 Mohalla Clinics planned by the Delhi government, a total of 189 Mohalla Clinics are presently operational in the national capital. While most of the Mohalla Clinics run in portable cabins, a few operate from rented premises. Some of the locations where these clinics are functional include Model Town, Chandni Chowk, Karol Bagh, Kondli, Patparganj, Delhi Cantt, Rajendra Nagar, Bawana, Ghonda, Gokulapur, Mustafabad, Mangolpuri, Rohini, Kirari, Sultanpur Majra, Shahdara, Babarpur and Najafgarh among many.

According to the AAP website, Mohalla Clinics distribute 109 essential medicines. There are facilities for 212 diagnostic tests in these clinics. Some of the key tests include urine pH, stool routine, haemoglobin, peripheral smear examination, platelet count, reticulocyte count, bone marrow smear examination and malaria among others.

A majority of the Mohalla Clinics have Swasthya Slate—a medical device of the size of a cake tin which performs 33 common medical tests. It costs around Rs 60,000. The device uploads its data into a cloud-based medical record management system that can be accessed by the patient. It can diagnose blood pressure, blood sugar, heart rate, blood haemoglobin, urine protein and glucose. It also runs tests for diseases like malaria, dengue, hepatitis, HIV and typhoid. The government says around 40 lakh Delhiites have availed health services at Mohalla Clinics, as of December 2018.

In the recent budget of 2019-20, AAP has made a further provision for allocating Rs 7,485 crore for the healthcare sector. This is a whopping increment in comparison to the Rs 6,729 crore allocated in the 2018-19 Budget. The Delhi Government would thus be spending an extra Rs 375 crore for setting up more Mohalla Clinics and polyclinics.

Key Problems Identified in the Health Sector

The three aspects of healthcare –primary, secondary, and tertiary healthcare – can be arranged in a pyramid. In the ideal scenario, the pyramid should have a developed primary health care section which "streamlines upward" to more specialised care (Institute for Work & Health,2016). However, in Delhi's present scenario, the pyramid is inverted. Delhi has mature tertiary health care with high technical ability attracting medical tourism from around the world in stark contrast with its coverage-lacking primary healthcare (Roychowdhury V., 2014)

So far, the government has looked at public health problems with a mission-led lens, but largely missed the preventive aspect. For example, in Delhi, various public health related schemes have been instituted to tackle issues like tuberculosis, HIV/AIDS and provide maternal and child health. But these schemes only target a specific section of the population and miss the preventive component (they deal directly with diseases). Current public health schemes do not cover preventive public health issues like sanitation, drinking water, importance of hygiene, awareness about nutrition, and environmental concerns like poor air quality– reported to reduce lifespan in Delhi by 6 years (Rohatgil M., 2016). While vertical health programs may be helpful in reducing a specific disease burden in the short term, they often cause disruption in routine primary healthcare provision (Devadasan, Boelaert,et al., 2007).

Difference between Mohalla Clinics, Dispensaries and Polyclinics

The government has launched several schemes to provide free medicines, tests and several life-saving surgeries through a three-tiered network of Mohalla Clinics, Polyclinics and Hospitals.

Mohalla Clinics are neighbourhood clinics set up by Delhi government in 158 locations across the city at an extremely low cost and are providing high-quality primary health care to previously unserved communities. Diagnosis, medicines and tests are all provided free of cost in Mohalla Clinics. Mohalla Clinics are set up either in porta cabins or in rented properties.

To build a robust 3-tier universal healthcare system in Delhi, the Government has launched 23 Polyclinics that offer specialised diagnosis and treatment to patients for free, thereby preventing the hassle to visit crowded hospitals. This, in turn, reduces the out-patient burden on government hospitals and allows them to focus on quality in-patient care.

At the Government Hospitals, the Delhi government has made all medicines, tests and surgeries at these hospitals completely free of cost. Further, if patients who are residents of Delhi are waitlisted for a life-threatening surgery at a Delhi government hospital for more than 30 days, the hospital refers the patient to an empanelled private hospital which treats the patient for free. Even tests like CT scans and MRIs are being conducted for free.

Government Hospitals

Polyclinics

Mohalla Clinics

LIST OF MEDICINES AND TESTS CONDUCTED

The medicines available at the Aam Aadmi Mohalla Clinics are those which are generally prescribed for OPD patients. Below is the photograph of the medicines kept at the Mohalla Clinics at Sanjay Colony and Hari Nagar.

The photographs of the list of tests which are conducted at labs affiliated with the Aam Aadmi Mohalla Clinics are below. The samples for the test are collected at the clinic and sent on a daily basis to the laboratories.

FACT FINDING

The fact-finding was conducted across nine Mohalla Clinics and one polyclinic on 17th June 2019. Six interns, in a team of two members each conducted the fact-finding across nine districts in Delhi. The interns were from different Law Universities. Hence, the teams, by adopting a survey method of research and assessment, obtained information on the following issues:

a. Availability of doctors at the Mohalla Clinic

b. Availability of medicines at the Mohalla Clinic

c. Tests being conducted at the laboratory of the Mohalla Clinic

d. Sanitation conditions at the Mohalla Clinic

e. Facilities provided to pregnant and lactating mothers at the Mohalla Clinic

f. The treatment meted out to the patients at the Mohalla Clinic

g. Availability of facilities at nearby dispensaries

h. Difference in services provided by Public Dispensaries and Mohalla Clinics

i. Conditions of the doctors and staff of the Mohalla Clinic

Patient No. 1: Sugad Devi
Age: 70 Years
Occupation: Home-maker

Ms. Sugad Devi had been visiting the Mohalla Clinic since a long time. She was suffering from sugar and other issues. She was extremely happy and satisfied with the Mohalla clinic and asserted that more such clinics must be instituted soon. She assured the team that the doctors arrived on time and that consultation was free of charge there. All the necessary tests were conducted free of cost as well. She was also satisfied with the sanitation facilities and hygiene of the clinic.

Patient No.2: Anita
ge: 25 Years
Occupation: Home-maker

Anita was a lactating mother with a 10 month old daughter. She was satisfied with the services and facilities at the Mohalla Clinic. She said that although her check-ups were carried out at the Mohalla Clinic itself, she had to go to another hospital to conduct her ultrasound. However, she was extremely happy with the medicines provided to her during and after her pregnancy, including those to her child. She also said that there had been instances when the dispensary did not have adequate stock of medicines or when the government hospitals ill-treat them, but the Mohalla Clinic always had a well-stocked medicine cabinet which was generally effective.

Staff: Manish Kumar
Age: 35 Years
Occupation: Doctor at the Mohalla Clinic, Sanjay Colony

Dr. Manish stated that he was a graduate from Yerevan State Medical University, Armenia. He referred emergency cases to either Malviya Nagar Hospital or to Safdurjung. He said that the local dispensary did not have an adequate stock of medicine, while the Clinic received all necessary OPD medicines on a monthly basis. The lab assistants collected samples of patients and they were then sent to the nearby laboratory at Chattarpur. The results come within a day. He usually received his salary on time and felt that the

government had allocated adequate funds for the functioning of the Clinic.

OBSERVATIONS

The clinic was well functional and did not seem to have any problems. However, given the large number of patients who visit the clinic on a daily basis, the clinic requires more doctors in order to ensure a more speedy access to medical facilities for patients. Moreover, it would be beneficial if the schemes available to pregnant and lactating mothers are also explained to them at this clinic. The team also felt that if there was at least one woman doctor present, the women may feel more comfortable. However, the team believes that the Mohalla Clinic has had commendable effect on the locality.

CASE STUDY 2: VIDYUT VIHAR

The Vidyut Vihar clinic could not be located at first. However, after speaking to the local people, the team was informed that the clinic had been shut down. Babloo aged 37, said that the clinic was closed because of the burglars who were addicted to drugs or alcohol stole the machines and other things. The man also stated that now the Sunlight colony in Vidyut Vihar has only one functional Mohalla Clinic and one is under construction in Bhagwan Nagar.

CASE STUDY 3: HARI NAGAR ASHRAM

- The Mohalla Clinic was situated on a rented land and paid Rs. 7, 500 as a monthly rent to the owner.
- The clinic covered a population of almost 10, 000- 15, 000 people approximately and functioned on all days of the week except Sundays, from 8 AM to 2 PM.
- There was one doctor at the clinic, who operated the clinic along with a 3-member support staff team comprising of one lab assistant, one pharmacist, and one receptionist, who was also the owner of the building.
- The clinic on an average catered to 150-200 patients on a daily basis out of which approximately 8-10 of them were usually pregnant and lactating mothers.
- The doctor generally referred them to the nearest dispensary for delivery.
- The clinic however did not seem to inform them about the schemes available for pregnant and lactating women.
- The clinic referred emergency cases to Safdarjung Hospital or to AIIMS

Interaction with Patients

Patient No. 1: Pinky
Age: 29 Years
Occupation: Home-maker

Pinky was a pregnant woman who had been going to the Mohalla Clinic over the past one year. She was extremely satisfied with the services provided at the clinic. She however felt that there were long queues at the Mohalla Clinic with an average waiting time of 30- 60 minutes. She had persistently been coughing and was being treated for the same. She said that the doctors helped her with family

Patient Name: Kanta

Kanta, aged 47 lived with her family of four. She was a housewife and suffering from cholesterol and sugar. According to her 90% of medicines were available in the clinic. She was satisfied with the facilities of Mohalla Clinic as she felt they were better than the facilities provided by the government hospitals. She claimed that the clinic had all the necessary equipments for conducting lab tests. She wanted more Mohalla Clinics to be established so that people don't have to travel far to seek health care. She gave the instance of Mahipalpur where people have to come to Mehramnagar for treatment as there are no Mohalla Clinics there.

Staff Name: Dr. Acopic Vyas

31 year old Dr. Acopic Vyas was doctor at Mohalla Clinic. According to him the lab of the clinic was well equipped for necessary tests and that there was no shortage of medicines. He was well satisfied with the response of patients towards Mohalla Clinic. He informed that for the pregnant and lactating women there was lack of equipments in Mohalla Clinic such as ultrasound essentially because the clinics do not have enough budget to provide these facilities. That is why pregnant and lactating mothers were referred to higher centre for better facilities. He was also satisfied with the fact that he received his salary on time. The clinic had an average of 90-100 patients on a daily basis.

Staff Name: Himachal

Himachal, 23 year old, worked in Mohalla Clinic as a lab technician. According to him, the lab of the clinic was well equipped for the necessary tests. He was well satisfied with the fact that he received his salary on time.

Staff Name: Priya

Priya, 22 year old worked in the clinic as Assistant. According to her monthly 10-20 pregnant and lactating women visited the clinic for check up. She felt that there was no shortage of medicines in the clinic

OBSERVATIONS

The team observed that mostly all the patients were satisfied and happy with the facilities provided by the clinic. The doctors were always on time. They did provide information about vaccination and the benefits that should be provided to the pregnant and lactating women.

CASE STUDY NO. 5: DAKSHINPURI EXTENSION, BLOCK 5, SECTOR 6, DAKSHNIPURI, NEW DELHI

Interaction with Patients and Staff

Patient Name: Neha

Neha, 15 year old studied in 10th class. She was suffering from cold and cough. According to her, the Dakshinipuri Mohalla Clinic provided best facilities free of cost. She was well satisfied as compared to government hospitals Mohalla Clinics provided all kinds of tests, medicines etc. free of cost. According to her all the medicines were available in the Clinic. She was satisfied with the services and facilities provided by the clinic. According to her more Mohalla Clinics should be established.

Patient Name: Omprakash

48 years old Omprakash, a labourer lived with his family of five. He was suffering from stomach-ache and knee pain. According to him, in case of emergency doctors referred the patients to Safdarjung Hospital and Malviya Nagar Hospital. He felt that all the medicines were available in Mohalla Clinic. He stated that the clinic had all the necessary equipments for the tests. According to him more Mohalla Clinics should be established because it helps poor families.

Patient Name: Saroj

Saroj, age36, was a housewife and lived with her family of five. She was suffering from diabetes and thyroid disorder. She stated that sometimes medicines for thyroid were not available in the clinic, and she had to purchase them from outside. She also said that in case of any emergency doctor referred the patients to Malviya Nagar Hospital. She felt that Mohalla clinics should be open twice a day. It should be open in the evening also. She informed that there was only one washroom but it was only for the use of the doctor and staff. She was happy with the facilities provided by the clinic and wanted more to be established.

Patient Name: Mehraj Fatima

Mehraj Fatima, a 71 year old woman lived with a family consisting of 12 members. She was suffering from diabetes, thyroid and eye pain. She was very satisfied with the services and facilities provided by Mohalla Clinic, and wanted more clinics to run because it saved their time as well as money. According to her, Mohalla Clinic was better than other government hospitals because in government hospitals there were long queues. She stated that in Mohalla Clinic thyroid tests were not available.

Staff Name: Dr.Vijit

Dr.Vijit, aged 35 was the doctor at the clinic. He sees 150-170 patients on a daily basis. He was also satisfied with the fact that he received his salary on time. In case of emergency he referred the patients to Safdarjung Hospital and Malviya Nagar Hospital. According to him, the lab of the clinic was well equipped for the necessary tests and that there was no shortage of medicines. He informed that 40-50 pregnant and lactating women come for check up in the clinic every month.

OBSERVATIONS

The team observed that the clinic was clean but there was a lack of sanitation nearby. There was lots of garbage around the clinic. The clinic was full of people. There were around 40-50 people in the clinic for their treatment at the time of the visit. The washrooms were found clean. The patients were very satisfied with the services and wanted more Mohalla Clinics to be established. The staff was too busy in their work that they didn't even have the time to speak comfortably with the fact finding team.

CASE STUDY NO. 6:SECTOR 17, ROHINI, DELHI

Interaction with patients:

1) ***Rishay, 17 years old,*** lived in Prakash Vihar with her parents. She was in 12th standard. She was suffering from stomach ache. She was happy with the facilities provided by Mohalla Clinic and really liked the concept of Mohalla Clinic in her area. According to her, now she did not have to wait in queue for the doctors. She said that due to fewer crowds, the doctor gave more time and attention to each and every patient. According to her she was getting the required medicines on time and on a regular basis. She said that she was not being charged for anything not even for the medicines. She told that the doctors were

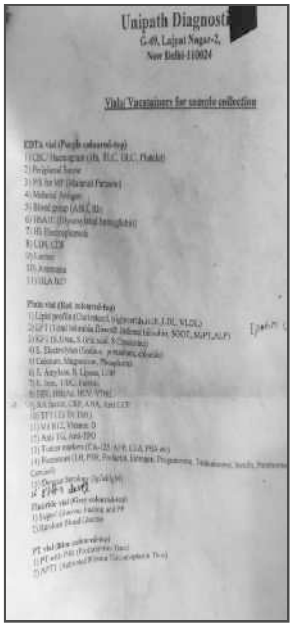
really helpful and that the clinic always opened on time. She had not faced any problem in the clinic yet. She was not aware of all the tests but said that she was aware of blood test facility which was provided by Mohalla Clinic to her.

2) ***Sanjeev Prasad age 45,*** was a labourer. He came to Mohalla Clinic with his wife, she was also a patient in Mohalla Clinic (patient no 3). Both husband and wife were suffering from viral fever and came to Mohalla Clinic to get treatment for the same. According to Sanjeev Prasad the clinic was the best gift by the Delhi Government to its people. He said that he was getting good medical facilities in his area and that too without any charges. He told that the condition of most government hospitals were bad, it was hard to find doctors in government hospitals and people had to wait there for long hours. He said that he was also happy with the cleanliness of Mohalla Clinic which is very rare to find in any government hospital. He said that he was getting all the necessary medicines from last three days and that he was satisfied with the tests.

3) ***Renuka Prasad age 39,*** was a house wife and also the wife of Sanjeev Prasad (Patient no 2). She was suffering from viral fever. According to her, she was getting all the necessary facilities and medicines for free. Doctor was really helpful and the best part according to her was that she didn't have to go too far for medical facilities.

Interaction with the staff

1) ***Dr.Pradheep Gahoi, aged 48*** was the doctor at the clinic Sector- 17 Rohini. According to him the timings of Mohalla Clinic is 9 AM to 1 PM. He said that he was getting all the necessary funds on time to run the clinic. All the staff members were getting salaries on time. He informed that the daily patient footfall in the clinic was about 80 to 100. He told that the clinic had all the equipment necessary to carry out 220 tests. He informed that they had 300 types of different medicines. The clinic had three staff members comprising of one doctor, one lab assistant and one assistant to the doctor. There was shortage of two staff members. According to the doctor there were five staff members including the doctor appointed in each Mohalla Clinic. The doctor also informed that if they don't have proper facilities then they refer the patient to Ambedkar Hospital. According to him the only problem which the clinic was facing was related to



vaccinations. The clinic was not getting enough vaccines from the government. This Mohalla Clinic was established on government's land and made of prefabricated structure.

CASE STUDY NO.7: SECTOR 16, ROHINI, DELHI

Interaction with the patients

1) ***Kaushal, a 28 year old*** woman lived in Samaypur Badli with her husband and 2 children. She was suffering from fever and stomach ache. She was a house wife and qualified up to 10th standard. According to her, the clinic provided all basic necessary medicines with proper treatment without charging a single penny. She hesitated in going to government hospitals as they are usually over crowded. She felt that treatment is much faster in Mohalla Clinics. She was very satisfied with the services and wanted more of such clinics to be established.

Interaction with the staff

1) ***Dr.Ghan Shyam Chandrakar, aged 52,*** was the doctor of Mohalla Clinic Sector-16 Rohini. According to him the condition was pretty much the same as described by Dr. Pradheep Gahoi. (Doctor no 1). They were getting 100 to 120 patients on a daily basis. He informed that the facility was providing 220 types of tests and 300 different types of medicines. According to him the clinic was facing two major problems. First, they didn't have facilities of vaccinations and second, there was a shortage of staff. The clinic only had a doctor and an assistant. The two people were doing the job of five people. The clinic was functioning in a one room rented shop at monthly rental of Rs 12000. Lack of space was also an issue in the Clinic.

CASE STUDY NO.8: AZADPUR FLYOVER, COMMERCIAL COMPLEX, AZADPUR, DELHI

Interaction with the Patients

1) ***Munni, aged 40,*** was not educated and was a housewife. She was suffering from thyroid disorder and stomach ache. According to her she was not satisfied with the services given by the doctor. She said that the doctor was very rude towards her. She was not being charged for any facilities or medicines but she did not find any major difference between government hospitals and Mohalla Clinic. She told that the doctor used to shout on her for petty issues. According to her there were some tests available but for others patients were referred to Ambedkar Hospital. The Facilities like ultrasound and x-ray were not available there.

2) ***Parveen, aged 30*** was educated till 6th standard. She was suffering from thyroid disorder. She told that she was not being charged for any facilities or medicines. All the necessary medicines were provided to her at no cost. She said that generally in all the Government hospitals the patients have to wait for hours, but in Mohalla Clinics one can easily visit a doctor.

SUGGESTIONS AND RECOMMENDATIONS

The concept of Mohalla Clinics has been instituted as a replacement of the system of dispensaries and to provide higher quality medical services to the underprivileged free of cost. While this concept began on a positive note and has received positive response from the larger section of the population, it seems to have lost its momentum of growth. The Delhi Government has not been able to deliver even close to the number of Mohalla Clinics it had promised to establish. Even after over four years of the implementation of the scheme, merely 189 Mohalla Clinics have been established yet. Most of these clinics are under-staffed.

Moreover, even in the clinics which have been established, there is no security provided, whether to the doctors or to the clinic in general. As a result, there have been reports of Mohalla Clinics, including the one at Vidyut Vihar, being shut down as a result of attacks by drug addicts. Hence, one of the most immediate goals must be to tackle the problem of security which is currently plaguing the Mohalla Clinic Scheme of the Government. It is proposed that Mohalla Clinics, equipped with their infrastructure and strategic locations, can aim higher and tackle not only the issue of lacking primary healthcare but also the issue of lacking preventive public health.

The Mohalla Clinic must also expand their horizon of operation so as to provide ultra-sound facilities for women, and introduce schemes for better counselling of pregnant and lactating mothers. Such schemes must also focus on educating them about proper and hygienic family planning methods, considering the failure of the ASHA worker to do so in several areas across Delhi as well as the reluctance of several women to approach Government Hospitals due to the treatment meted out to them. Moreover, there should also be at least one female doctor in every Mohalla clinic, who has preferably obtained a specialisation in gynaecology and obstetrics.

It is also suggested that a similar scheme be adopted by other state governments and implemented on a larger scale so as to improve primary healthcare facilities in India.

CONCLUSION

The concept of Mohalla Clinics has brought a refreshing approach to the much-ignored concept of healthcare in India, particularly in the city of Delhi. This initiative has brought health higher on the political discourse and agenda in Delhi states and there is high level of interest by Indian states. These clinics are delivering personal (curative and diagnostic) health services and improving the quality of healthcare services, particularly available to the under-privileged section of society.However, in order to attain the long term objective and to ensure better healthcare facilities across India, the strengthening of Public Healthcare Services would require a holistic approach and more attention on population and/or public health services through targeted initiatives.

Primary healthcare is intricately linked with public health and a holistic approach needs to be taken at the grassroots. Mohalla Clinics can move beyond being sub-centres with primarily curative functions and become neighbourhood-specific (Mohalla-specific) wellness centres targeting the varying health needs of respective neighbourhoods. For a wellness centre to address the health needs of the neighbourhood it must have a mechanism to monitor the current status of health and public health related problems in the neighbourhood and respond to these as they change. The National Urban Health Mission (NUHM, 2013) specifies various efforts for NGO integration in preventive and promotional capacities with existing polyclinics like Primary Health Centre (PHC).

There is need to increase the budget allocation for the health sector to improve doctor patient ratio, bed strength, number of hospitals and health professionals. Especially rural India needs better healthcare facilities. The Mohalla clinics can help in early detection and prevention of diseases as they form the bottom most layer of healthcare facilities. The feedback of the clinics in the nine clinics is positive with people saving money in consultation, medicines, diagnostic tests and transportation. There is need to improve the forward linkages for analytical research and improvement in healthcare facilities.

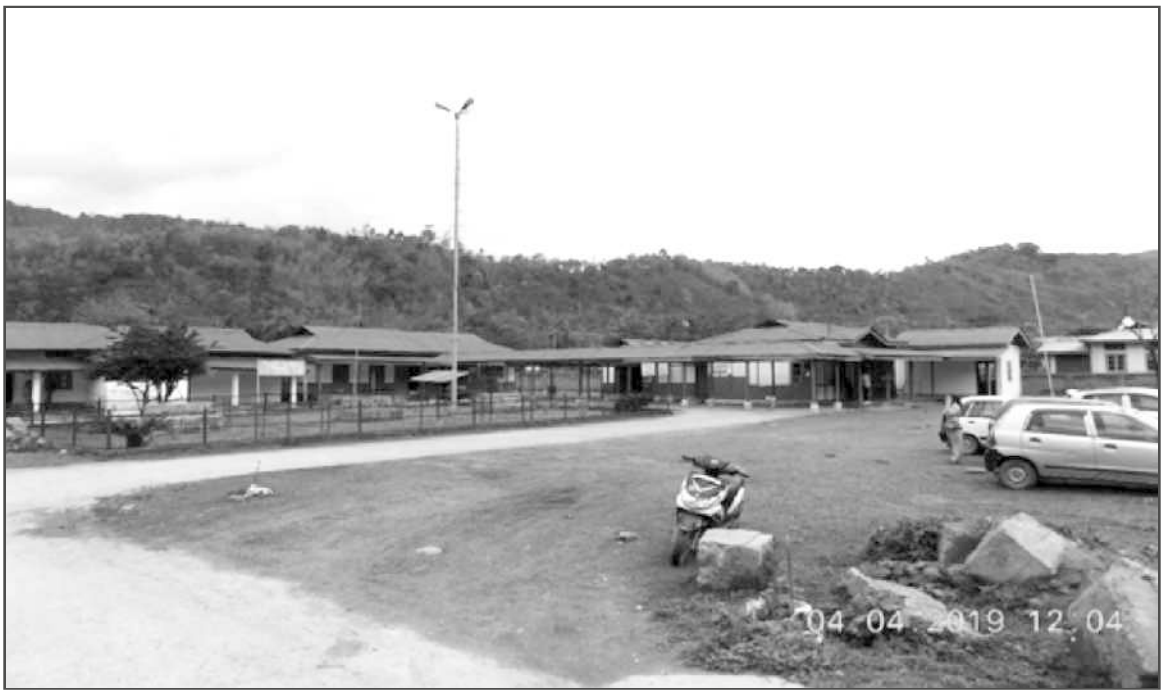

फ्री
दवाइयाँ
फ्री
जाँच
फ्री
परामर्श


विकल्प चुनने की आजादी
मुँह के स्वास्थ्य की
सदा करें देखभाल
सभी मरीजों
को अपना
आधार कार्ड
लाना है !


मोहल्ला क्लीनिक


का स्वास्थ्य
पका अधिकार
आप की दिल्ली सर
दिल्ली सरकार

6. Undermining of IPHS Standards in CHC Yazali, Arunachal Pradesh



INTRODUCTION

India continues to face numerous structural issues with regard to public health institutions all throughout the nation. In spite of the considerable progress in recent years, partly due to the successful implementation of various government programmes and schemes, various health issues with regard to access to quality healthcare still persist. One of the most pressing issues – both as a public health and as a human rights concern – is the lack of equal access to basic healthcare facilities. Although issues with public health are prevalent across the country, its intensity and frequency is often significantly higher for certain groups of people in this country. The respect, protection and fulfilment of the human right to health in India is limited towards some people and exclusive towards others. This fact finding examines these inequalities and the underlying human rights violations.

This fact finding covers three major areas:

- Geography - This fact finding report investigates access to and quality of healthcare in a fairly disadvantaged region of the country: the Lower Subansiri district in the state of Arunachal Pradesh. Arunachal Pradesh is the least densely populated state in India and also one of the country's most remote states. Due to various geographical features which inhibit the easy movement of people, services and goods.
- Quality, availability and accessibility of maternal healthcare facilities in Lower Subansiri District
- Socio-Economic States - This fact finding report scrutinises public healthcare facilities, in the form of Community Health Centre (herein "CHC") in Yazali.

The Community health centre (CHC), is the third tier of the network of rural health care institution. It is required to act primarily as a referral centre (for the neighbouring PHCs, usually four in number) for the patients requiring specialised health care services. The CHCs are accordingly designed to be equipped with: four specialists in the areas of medicine, surgery, paediatrics and gynaecology; 30 beds for indoor patients; operation theatre, labour room, X-ray machine, pathological laboratory, standby generator, etc., along with the complimentary medical and para medical staff.

In short, this fact finding report researched people's access to right to health within a geographically, thematically and institutionally challenging context:

- Geographical focus: Yazali (Ziro ii), Lower Subansiri District, Arunachal Pradesh
- Thematic focus: maternal and child health
- Institutional focus: Yazali Community Health Centre

State Profile: Arunachal Pradesh

One of India's most remote states, Arunachal Pradesh is also one of country's most sparsely populated states. Large parts of Arunachal Pradesh are in the Himalayas, covering a total area as big as 83,743 sq. km and an estimated population of 1,441,716. Almost three-quarters of households in the state reside in rural areas. The rugged and undulating terrain in combination with the innumerable rivers and streams make physical transport and communication largely difficult. In terms of infrastructure, the state still fares poorly on many fronts and still does not have an airport and only has restricted connectivity to the rest of the country through the Indian Railways.

Map of the State of Arunachal Pradesh

With its large rural population, agriculture is the primary driver of the economy. Arunachal Pradesh has the lowest Rural Human Development indexes (HDI) of all Indian states. Furthermore, the state has the lowest literacy rate of all the North-eastern states, especially amongst rural populations.

For 83% of households in Arunachal Pradesh, the public medical sector is the main source of health care (88% of rural households). For households that do not use government health facilities, the two primary reasons given for not doing so are lack of a nearby facility (50%) and poor quality of care (37%). There is a strong correlation between wealth and the use of private facilities, indicating that wealthier people are more likely to access nearby private healthcare facilities, which offer quality health care.

District profile: Lower Subansiri

Arunachal Pradesh is made up of 16 districts. The district of Lower Subansiri is comparatively close to the state capital Itanagar. The topography of the district is mostly mountainous terrain, where the hill ranges vary approximately from 1000 to 1600 metres above sea level. The district headquarter is in the town of Ziro (Hapoli). Lower Subansiri has an estimated population of 86,510.

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

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

In spite of its relative vicinity to Itanagar, Lower Subansiri is one of the worst performing districts in terms of maternal and child health.

Sub-District Profile: Yazali

Lower Subansiri district is divided into eight administrative sub-districts (also called circles). One of these is Yazali sub-district. Yazali sub-district is a mini town and includes 33 villages and shelters more than 1000 households. Yachuli is the sub-district headquarter.

The medical infrastructure of the sub-district of Yazali has one CHC, and various Anganwadi Centres (herein AWC). The Yazali CHC is the first point of medical references for both emergency and non-emergency needs, for the entire population of the sub-district. The closest other public healthcare facilities are Ziro District Hospital and State Hospital in Papumpare District both of which are at a considerable distance from Yazali CHC.

The most recent HMIS data gives a clear indication of the worrisome maternal health situation in whole of Lower Subansiri district. However, Yazali CHC works comparatively better than any other health centres of interior districts. The Yazali CHC has made active efforts to register pregnant women for antenatal care in and around Yazali town and of nearby villages. Although Yazali CHC conducts institutionalised deliveries, most of the women prefer to visit the state hospital or private hospitals in the capital.

Methodology

In light of the statistical data about both Arunachal Pradesh and Lower Subansiri, which have been presented in the introduction, this fact finding sought to investigate the fulfilment of right to health, according to the Indian Public Health Standards (IPHS) guidelines.

The IPHS does cover a range of issues on access to health, however, this fact finding specifically covered issues on maternal health. Nationally and internationally maternal health, in the context of developing areas, is a critical component of measuring the HDI of any region.The reduction in MMR and IMR across India is one of the primary goals of the NHM. Various other national health programmes hold reduction of maternal health-related problems as their central objective.

As a geographical focus, this fact finding examined Community Health Centre in Yazali since the CHC is the principal public health facility in Yazali sub district and plays a crucial role in providing decentralised healthcare in line with the IPHS guidelines.

Results and Discussion

The health centre had six beds and delivered an average of 246 OPD (Out Patient Department) services per month and an average of four IPD (In patient Department) services per month. Only four normal institutional deliveries took place in Yazali CHC in the period of 2017/2018 (12 months). Yazali CHC is 24/7 operational healthcare facility.

Medical Staff at Raga Primary Health Centre (as per February 2016)		
Medical staff function	**Current number of staff**	**IPHS Guidelines minimal essential manpower requirements**
Medical Officer (MBBS)	2	1
Gynaecologist	1	2 (Pharmacist)
General Nursing Midwife (GNM)	7	7
• *Regular*	*6*	
• *Contractual*	*1*	
Staff Nurse/ ANM	7	7
Laboratory Technician (LT)	1	1

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

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

By combining the findings from the fact finding research and an in-depth academic literature and statistical study, a comprehensive account of these issues can be given. The results and discussion of each central issue is as follows:

Basic Facilities: Electricity, Heating, Waste Management and Hygiene

Upon physical inspection of the Yazali CHC, it was noticed that the facilities were largely available, but some issues continued to persist on the following fronts:

Electricity

It was found that Yazali CHC had a Generator for power back up. Apart from the generator there was no other means like solar energy facility. However, the power backup that covered the entire CHC was very pressing, considering the instable electricity supply in Lower Subansiri given the fact that there were frequent electricity cut-offs every two or three hours.

Heating

During interviews with Yazali CHC staff members, it was recorded that there was only one single coiled heater in the delivery room, which took at least an hour or two to effectively heat up the room. Keeping in mind the frigid temperatures in Arunachal Pradesh during winters , the lack of heating leads to two major concerns. Firstly, indoor patients with weak immune systems or fragile health could face serious obstacles in their recovery or even new health problems due to persistent exposure to cold. Secondly, the lack of heating facilities strongly discouraged people to head to Yazali CHC in case of longer hospitalisation. This specifically being true in the case of institutional delivery and postnatal care for women and new-borns. According to the medical staff informants, one of the principal reasons for pregnant women's reluctance to opt for institutional delivery or PNC at Yazali CHC was the lack of heating during winter.

Medicines and Surgical Equipment

There was only one minor OT in the facility and serious cases were often referred to other institutions with better facilities. There was lack of modern equipments such as Digital X-Ray, CVC and the existing laboratory only provided for basic tests. The facility for conducting an ultrasound was available only on the 27th of every month.

The laboratory in the CHC

Waste Management and Hygiene

Though there were separate toilets for men and women, both were in an extremely unhygienic condition. The CHC had an incinerator for disposing bio-medical wastes and was operational, according to the Bio-Medical Waste (Management and Handling) Rules, 1998.

Separate washrooms for male and female

Surroundings of the CHC

Dumping area of the CHC

Infrastructure and Ambulance

The CHC had two ambulances, but only one of them was in working condition. Though one ambulance was enough in most circumstances, if there were more than one emergency a single ambulance would not serve the purpose. During such cases people are forced to arrange their own means of transportation, or access public transport, which was quite infrequent to travel to the state hospital in Naharlagun.

Most of the roads that connect the state capital to a number of villages were in a poor condition. Since, Yazali CHC could not provide all medical services, most women chose to go to the state hospital or private hospitals for deliveries and other medical services, which doubled and tripled the cost of treatment.

The 24 hour Ambulance of the CHC

Minor OT /Dressing room

The EPI Section of the CHC

General OPD

Dispensary for medicines

Medicines and Drugs

Dental OPD at the CHC

Dental Services available in the Hospital

Malaria treatment centre at the CHC

Inside view of the malaria treatment centre

Labor Room

Equipment in Labour Room

Service Delivery and Staff Capacity

The following table gives an overview of all the medical staff employed at Yazali CHC based on the information provided during the fact finding, along with the 2015/2016 Arunachal Pradesh State PIP data.

Specialisation	Current number of staff	IPHS Guidelines minimal essential manpower requirements
General Doctor / Medical Officer	2	11
Dresser/Pharmacist	1	-
Lab Technician	3	1
Obstetrics &Gynaecology	1	2
Paramedical and other staffs	19	21
Microbiology	-	0
Lab Technology	3	6
Pathology	0	1
Orthopaedics	0	1
Surgery	0	2
Anaesthesia	0	2
Paediatrics	0	2
Radiology	0	1
Dentistry	1	1
Ear, Nose & Throat (ENT)	0	1
Psychiatry	0	1
Pharmacy	2	4
Staff nurse	14	45
ANM	3	/

Maternal Health

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

Labour Room

Antenatal Care (ANC)

The percentage of women in Lower Subansiri who registered for antenatal care during their first trimester was only 37.4%. Furthermore, solely 38.3% of pregnant women received the recommended total of three ANC check-ups, which constitutes full antenatal care.

Institutional and Home Deliveries

The percentage of institutional deliveries against the total number of ANC registered pregnant women was only 43% in Lower Subansiri, compared to 59.8% for the whole of Arunachal Pradesh. Of the already undesirably high percentage of home deliveries in Lower Subansiri, only 24.1% were attended by a Skilled Birth Attendant (SBA), compared to a 60.6% state average for Arunachal Pradesh. The percentage of total reported deliveries that could be categorised as safe deliveries came to only 85.4% in Lower Subansiri, whereas at the State level this percentage was much higher at 97.2%. The most common place of delivery was at home and not a public health facility.

These highly troublesome statistics clearly indicated underlying causes for maternal mortality. As stated in the 2014-2018 Working Paper by the United Nations Research Institute for Social Development named

India's Fragmented Social Protection System: Three Rights Are in Place: Two Are Still Missing, "[a]cross India, high maternal mortality rates are attributable to the large number of non-institutional deliveries." Improving women's access to healthcare facilities for institutional delivery therefore constitutes a major step in the struggle against maternal mortality in India.

Postnatal Care (PNC)

In Lower Subansiri only 47.8% of delivering women received post-partum check-up within 48 hours of delivery, compared to 56.6% Arunachal Pradesh State average. Moreover, only 31.4% of delivering women in Lower Subansiri got a post-partum check-up between 48 hours and 14 days after delivery. One of Arunachal Pradesh's state targets for 2016/2017 was to provide at least 220 post-partum checkups within a time span of 48 hours to 14 days after delivery every year. However, according to HMIS 2014/2015, this number was still only 114.

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

Patient from around 33 villages in and around Yazali town were referred to CHC where issues related to pregnancy are examined and treated. Other emergency cases or complicated pregnancy cases were referred to State hospital in Naharlagun as the CHC could not provide quality care for the services of ANC, institutional deliveries and PNC. Moreover, it faced the challenge of improving maternal health standards in this badly performing district.

Analysis of Underperforming Maternal Healthcare in Lower Subansiri

As has been established, the district of Lower Subansiri underperformed in terms of ANC, institutional deliveries, and PNC. Based on the fact finding research, the principal cause for this seemed to be an overall reluctance amongst pregnant women, women in labour, and women with new-borns to get hospitalised at Yazali CHC. This can be because of the non-implementation of the guidelines as specified in IPHS.

The lack of basic facilities, particularly the lack of heating, made it uncomfortable for women to reside in Yazali CHC for a period of 48 hours after delivery for PNC, especially during winters. Absence of blood bank and unavailability of ultrasound also made it difficult for pregnant women to get regular check-up and so majority of them opted for institutional delivery at private hospitals or the state hospital. Since the ambulance at the CHC was used for other cases, it was hardly able to serve pregnant women, thus forcing them to arrange for means of transport on their own.

CONCLUSION

The Yazali sub-district Community Health Centre under Lower Subansiri District has an obligation to provide essential services, as prescribed in the IPHS Guidelines for District Hospitals. Analysed and argued in this report, the Yazali CHC has not fulfilled any of the IPHS Guidelines, particularly four central concerns: basic facilities (electricity, heating, waste management and hygiene), infrastructure and ambulance, service delivery and staff capacity, and blood bank. The structural problems within these four domains of the IPHS essential services altogether lead to poor maternal healthcare indicators in Lower Subansiri District. All the major statistical sources invoked in this fact finding report are uniform in identifying Arunachal Pradesh and specifically Lower Subansiri District as a highly challenging region when it comes to

the struggle for improving quality, availability, and accessibility of maternal healthcare facilities. More specifically, in terms of ANC, institutional delivery, PNC, and other maternal health-related services, the Yazali CHC does not satisfy the standards set by IPHS, which can be legally enforced by a myriad of constitutional protections, case laws, national healthcare schemes and policies, as well as international declarations and conventions.

Since the CHC was running in a clear contravention of the IPHS guidelines, it is incumbent on the State Government of Arunachal Pradesh to provide an immediate and adequate response to improve the healthcare facilities at Yazali CHC, in line with the IPHS guidelines. The response should ensure access to quality healthcare to everyone irrespective of their socio-economic status, geography or gender.

RECOMMENDATIONS

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

Basic facilities: electricity, heating, waste management and hygiene

- Solar Power back-up should be available for the entire Yazali Community Health Centre.
- Permanent heating in all the wards during the colder seasons in Arunachal Pradesh, particularly to provide the needed support and care to women prior to, during, and after child delivery should be ensured
- A minimum of 25 beds for both male and female wards should be made available.
- A hygienic environment in and around the hospital premises by having appropriate waste management systems should be ensured.
- Sufficient duty room for staff nurses mostly during night shift along with clean sanitation facilities for patients and other staff members should be arranged.

Infrastructure and ambulance

- Infrastructure to and from the Yazali town to nearby villages which fall under Yachuli sub district of Lower Subansiri District should be improved.
- Older and ailing equipments should be upgraded and updated withh newer and modern equipment such as ultrasound machines, CT scan machines and CVCs in the CHC.
- Permanent operation theatre should be built in the CHC, given that there is only a minor Operating Theatre.
- There should be better management of space and providing for a minimum area for patients to reside comfortably.

Service Delivery and Staff Capacity

- Ensure all the necessary staff as listed under the IPHS guidelines for District Hospitals.
- Fill in the existing shortcomings in staff required, both for general and specialist medical staff positions

- Hire more Emergency Medical Officers (EMOs), Anaesthesiologist and Paediatricians
- Provide quarters for hospital staff, bachelor barrack for doctors and to provide accommodation and emergency residence for those medical staff members who work in the emergency department.

Blood bank

- Establish a blood bank in the Yazali CHC
- Draft a long-term strategy for community engagement and raising awareness for voluntary blood donation in the entire district of Lower Subansiri.
- Explore new strategies for providing immediate blood transfusion in cases of emergency, in cooperation with other healthcare facilities in the region.

Maternal Health

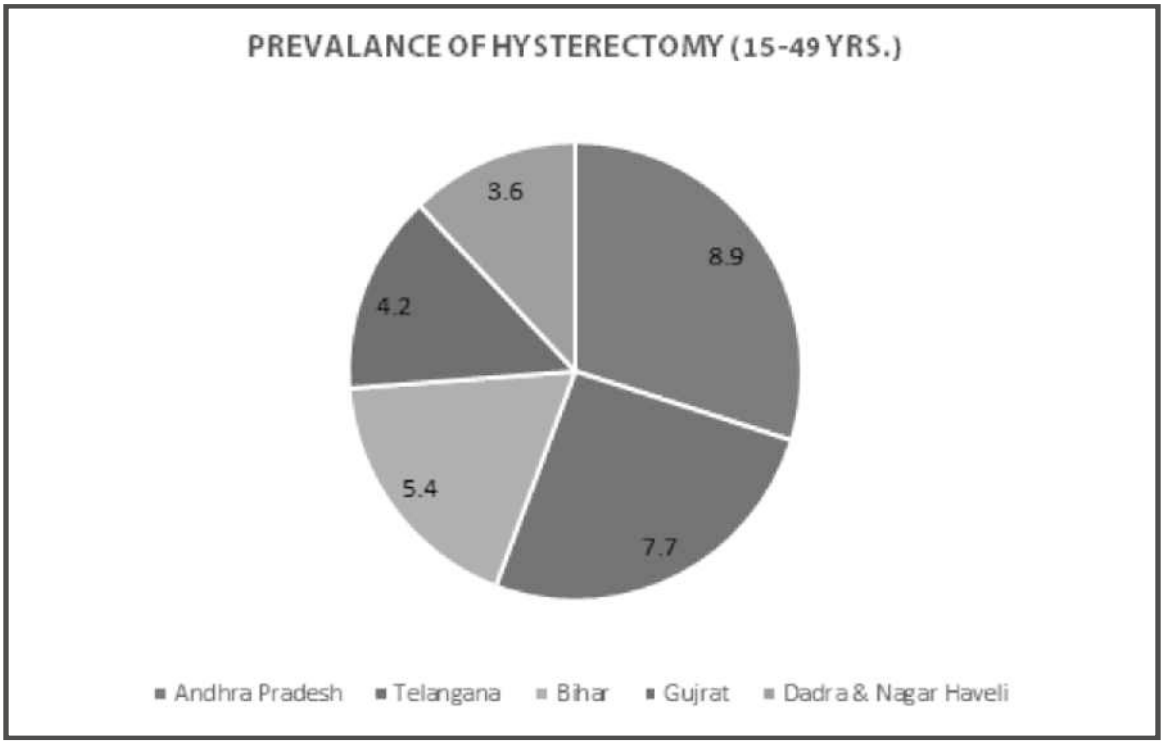
- Increase the rate of ANC, institutional delivery and PNC at the Yazali, CHC
- Draft comprehensive strategies for preventing maternal and child mortality and morbidity.
- Guarantee access to public healthcare for all persons, irrespective of their economic status, geography or gender.

7. Death of a Woman Following Hysterectomy, Bihar

INTRODUCTION

Hysterectomy is the surgical removal of the uterus which may involve the removal of cervix, ovaries, fallopian tube and other surrounding structures. Done abdominally/ vaginally or laparoscopically, it may be based on the size mobility and descent of the uterus, patient's desire and presence of other gynaecological diseases and other co-morbidities. In women, who do not wish to preserve uterus/ fertility, hysterectomy is a definitive treatment. Disadvantages of hysterectomy are the surgical and anaesthetic risks involved in a surgery of that nature.[1]

In the last few years, unwarranted hysterectomies have been a cause of concern in the country, especially among women below 40 years of age. Independent studies and information from government insurance programmes in states like Andhra Pradesh, Karnataka, Maharashtra, Gujarat, Bihar,Chattisgarh etc. have highlighted the emergence of unnecessary hysterectomy as a public health concern.[2-3] In the absence of reliable state and national level data about the extent of hysterectomy in the country, the NFHS 4, for the first time collected information about the prevalence and causes of hysterectomy. As per the NFHS-4 data, the prevalence of hysterectomy among women age 15-49 is 3.2% with six states having higher prevalence than the national average i.e. Andhra Pradesh (8.9%), Telangana (7.7%), Bihar(5.4%), Gujarat(4.2%), Dadra & Nagar Haveli (3.6%), Tamil Nadu (3.4%).



[4]

[1] *http://clinicalestablishments.gov.in/WriteReadData/4571.pdf*

[2] *https://www.karnataka.gov.in/hfw/pages/home.aspx*

[3] *https://www.theweek.in/leisure/lifestyle/2018/09/18/Experts-raise-concern-about-rising-hysterectomies-in-India.html*

[4] *https://academic.oup.com/heapol/article-pdf/16/4/395/9806438/160395.pdf*

The top three reasons given for hysterectomy are excessive menstrual bleeding/pain, fibroids/cysts and uterine rupture.The prevalence of the procedure among women in the age of 30-39 years was found to be 3.6 per cent, which is higher than that among 15-49 age group. Four states, namely Bihar, Andhra Pradesh, Telangana, and Gujarat show high numbers of women among 40-49 years having undergone the surgery (NFHS-4).[3]

The quality of care provided in case of hysterectomy is believed to be particularly important because of the potential benefits and risks of this procedure. One of the benefit is when it is used to remove the cancerous cervix or uterus, leading to a healthy and prolonged life. When used to cure irregular or painful menstruation or prolapsed uterus quality of life may be improved. However, it is a major surgery and risks involve intra- or post-operative death, non-fatal complications including urinary tract infections, incisional hernia, sepsis, intestinal obstruction, coronary artery disease, depression and other psychiatric problems.[5]

In the year 2000, a study was conducted in Gujarat on the quality of hysterectomy care accessed by members of SEWA, a community based health insurance (CBHI) scheme, found that the quality of hysterectomy care varied from potentially dangerous to excellent. The structural elements that made the care dangerous were operation theatres (OTs) without separate hand-washing facilities or proper lighting and the absence of qualified nursing staff. Procedurally dangerous was performing hysterectomy on demand, removing both the ovaries without consulting or notifying the patient, and failure to send the organ sample for histopathology even though the patient displayed symptoms suggestive of disease. The study also found that the women paid substantially even for poor quality and potentially dangerous care.

BACKGROUND

Smt. Binda Devi, wife of Jagdish Ram, lived in village Chatanwar, panchayat Chatanwar in Buxar district of Bihar. Population of the village is approximately 5000 which consists of people belonging to different communities like Rajput, Yadav, Harijan and Brahmin. The fact finding team found that the village had three AWCs, a panchayat bhawan and a middle school. There were five overhead water tanks that provided water to the village. Binda Devi and Jagdish Ram had six children-five daughters and one son, of whom three daughters were married. The other two daughters were studying in 10th and 6th standard respectively while the son was studying in 12th standard. They belonged to the SC community and Jagdish Ram worked as an agicultural labourer on the farm of their nighbours who belonged to the Rajput community.

THE CASE

Binda Devi, age 50 years, had been suffering from pain in the uterus since 2018 for which she took treatment from a private doctor, Dr. Rajnikant Pandey, at the block headquarter Dumranwa in January 2019. The treatment gave her some relief but the pain recurred for which she again consulted the same doctor in February 2019. The doctor advised her to get a sonography done, which she got performed at a private diagnostic centre in Dumranwa itself. Based on the sonography report, the doctor informed that there was swelling in her uterus and it would need to be removed eventually. He gave her some medicines but the pain persisted. The family members then decided to take Binda Devi to the government hospital in Arrah and get her operated.

On 11 March 2019, at around 10 AM Binda Devi, her husband Jagdish Ram, his brother Rambadan Ram and neighbours Chandrama Ram and Shivprasanna Ram were waiting at theTudiganj railway station to take the train to Arrah where they were approached by Akhilesh Kumar Mahto who introduced himself as a doctor and said that his clinic was close to the station and he could do Binda Devi's operation there itself. To

convince Jagdish Ram he said that they would not need to go far and the operation would be done closer to their house, which would be much more convenient and beneficial than going all the way to Arrah. Jagdish Ram told him that they belong to the SC community, are poor and do not have much money to pay him, to which Akhilesh Kumar replied that they can pay him a lesser fee and can also pay it later in instalments. Akhilesh Kumar thus convinced Binda Devi and Jagdish Ram to seek services from his clinic.

At the clinic, Binda Devi's operation was performed between 12 PM and 1 PM the same day. Only one nurse was present at the time of the operation. After the operation, the family was informed that the operation was successful and Binda Devi would be discharged in a few days. They were charged Rs. 50000 for the operation but no receipt was given. While Binda Devi was to be kept in the hospital under observation just for a few days but even after 15 days of stay her condition did not improve. On 26 March 2019, in the morning around 9 AM when the family members were checking upon Binda Devi, they realised that stool (faeces) was coming out from the place where she had the bandage, and stitches at the site of operation had also become infected. They informed the same to the doctor to which the doctor responded that it would get alright soon. Jagdish Ram also asked the doctor to refer the case further as Binda's condition was deteriorating. Jagdish had already paid Rs. 50000 to the doctor for the surgery by then. However when Jagdish kept insisting for referral, the doctor got annoyed and started misbehaving with him. Not only that he asked him for the payment of the rest of the Rs. 50,000 but also started abusing him. Jagdish Ram then realised that the doctor was cheating them, and his wife's life could be in danger. Soon Jagdish Ram along with his other family members, took his wife and the doctor to the area police station inKrishnabrahm.The officer at the police station immediately recorded their complaint and called for a private ambulance to take Binda to other hospital. They reached Indira Gandhi Institute of Medical Sciences (IGIMS) in Shekhpura, Patna around 11 AM by the hired ambulance for which Jagdish paid Rs. 5000. Akhilesh Kumar Mahto was also with them at the hospital.

At IGIMS, Binda Devi was immediately admitted in the general surgery ward. The doctor asked Akhilesh Kumar the details of the operation he had performed and asked for the case papers. Akhilesh Kumar responded that the papers were at his clinic and he would get them later. He verbally informed the doctor that Binda Devi's intestine had got cut at three places with the operation blade while he was performing the operation. Following this Binda Devi was again operated at the IGIMS. Akhilesh Kumar also stayed at IGIMS for two days but did not pay for any of the treatment expenses but kept on saying that he will bring money from home and contribute. Two days later, when Jagdish went home for some important work, Akhilesh Kumar also came along with him on the pretext of arranging money for Binda Devi's treatment. However, after arriving at the village, Akhilesh Kumar fled and never returned. On 1 April 2019, an FIR was filed at the Krishnabrahm police station regarding the wrong operation performed by Akhilesh Kumar Mahto, cheating and putting Binda Devi's life in

Jagdish Ram with the fact finding team

danger. Jagdish Ram went back to IGIMS where Binda Devi was going through the treatment. Two more operations were performed on her in the next few days but despite one month of treatment at IGIMS, Binda Devi's condition did not improve. On 2 May 2019 the surgeon at IGIMS discharged Binda Devi saying that she would not survive more than a couple of days and better to take her home so she could be amidst her family members in her last days. Jagdish thus brought Binda home by a private vehicle which cost him Rs. 5000, and soon after three days of coming home Binda Devi passed away. Police from Brahmapuri police station visited Jagdish the day she died and prepared an investigation report (panchnama). The family spent almost Rs. 3 lakh on Binda's treatment at IGIMS.

Discussion with Wardpanch :

The wardpanch informed that Akhilesh Kumar Mahto was contacted after the incident and he accepted that he had performed Binda Devi's operation. He also said that during the operation the blade cut at three places by mistake but Akhilesh did not take any responsibility for it and refused to participate in any follow-up action. This conversation is available in the form of a video recording.

Discussion with the AWW :

Neither the AWW Urmila Devi, nor the helper Manju Devi and ASHA Mamta Devi knew about Binda Devi's uterus related problem. They said that they came to know about it only when the case became complicated after operation at the local clinic.

Jagdish Ram's house

Private clinic (in black circle)

IGIMS Patna

Binda Devi at IGIMS during treatment

GUIDELINES AND GUARANTEES

MoHFW, GoI's standard treatment guidelines on obstetrics and gynaecology states that:

- Treatment modality in case of gynaecological morbidities that might require hysterectomy should be individualised to each patient after considering patient's age, severity of symptoms, need for fertility preservation, presence of other gynaecological diseases and any other co-morbidity.
- Referral to a higher facility is indicated if laparoscopic hysterectomy is planned and adequate facilities/equipment/skilled laparoscopic surgeon/anaesthetist are not available at the facility where the patient is under treatment or if the patient has co-morbidities like cardiac diseases, pulmonary diseases etc.

The Department of Health and Family Welfare, Government of Karnataka issued the clinical practice guidelines for hysterectomy in 2016 considering the high rates of unwarranted hysterectomies being performed in Karnataka (Annexure-1). The guidelines state that "hysterectomy is the treatment of choice for only certain gynaecological conditions. The predicted advantages must be carefully weighed against the possible risks of the surgery and other treatment alternatives. In a properly selected patient, the surgery should result in improvement of the quality of life. For benign conditions of the uterus, alternatives to hysterectomy should be mandatorily offered especially when the woman is less than 40 years. Two consultants should agree and document their consent for hysterectomy if the woman is less than 40 years of age. The woman should be counselled thoroughly prior to planning the surgery and the practitioner should discuss the short and long term implications of hysterectomy when counselling. There should be enough evidence to justify hysterectomy e.g- failure of medical treatment and there should be clear documentation of what other treatments have been tried. The indication for hysterectomy should fall into one of the categories listed below and the indication should be clearly documented…":

- Large fibroids.
- Symptomatic fibroids – HMB and pressure symptoms.
- Fibroids with associated adenomayosis and endometrial hyperplasia.
- Cervical and broad ligament fibroids.
- Uterine artery embolization and MRgFUS (MRI guided focused ultrasound surgery) are special procedures to be considered in a very few patients. The procedures have definite indication and contraindications.
- All gynaecological malignancies need hysterectomy in peri-menopausal and post-menopausal women. Younger women can have fertility sparing surgeries in early stages of ovarian and endometrial cancers.[6]

RECOMMENDATIONS

- A criminal case be filed against (Dr.) Akhilesh Kumar Mahto for causing Binda Devi's death due to incompetent and negligent clinical practice.
- Binda Devi's family be awarded suitable compensation for the expenses they incurred in her treatment, loss of life and mental agony they went through. They spent Rs. 3.5 lakh on her treatment.
- Regulation of the private health centres/facilities: Steps be taken for registration of private health facilities after proper investigation and only if they meet the necessary standards of care, e.g., implementation of the Clinical Establishments Act including standard treatment protocols to ensure the rationality of procedures in private hospitals, should they be allowed to function. Private facilities that do not meet the necessary standards should be shut down.
- Public health services at various levels must be majorly strengthened to ensure that screening and basic treatment for gynaecological ailments is available at primary level, while more advanced forms of non-surgical treatment, as well as operative management when necessary, should be made available in a guaranteed manner at all secondary and tertiary facilities within the public health system.[7]
- Patient education regarding the indications and need for hysterectomy should be carried out.
- IEC activities be undertaken by the health department to caution people against taking treatment from unqualified practitioners.

CONCLUSION

There is no medical confirmation that Binda Devi indeed needed hysterectomy. It was only suggested by one doctor based on a sonography report. It cannot be said whether the doctors at the government hospital in Arrah would have advised hysterectomy if Binda Devi had reached there.

It is as if Akhilesh Kumar Mahto performed Binda Devi's hysterectomy on demand, though as a clinician he should have got the necessary investigations done as laid down in the GoI's STGs for ObGy and confirmed

[6] *https://www.karnataka.gov.in/hfw/pages/home.aspx*

[7] *Harvest of Uteruses, Abhay Shukla and Seema Kulkarni, Commentary, July 20, 2019 Vol LIV no. 29 Economic & Political Weekly*

the need for hysterectomy. Even if he felt hysterectomy was necessary, he should have referred her to a higher centre with more facilities as mentioned in the GoI's STGs. Also, since no pre-operative investigations were performed, (Dr.) Mahto did not rule out co-existing morbidities as mentioned in the guidelines, subjecting Binda Devi to additional risk.

The presence of such untrained "doctors" amidst the large unregulated private medical sector in the country takes advantage of the knowledge and power asymmetry between the medical professionals and patients, exploiting the common people not only financially but also putting their lives in danger, as happened in the case of Binda Devi.

8. Denial of Reproductive Health Services to Homeless Women at Public Health Facilities, Rajasthan

INTRODUCTION

According to the government's definition, homeless or houseless people are those who live in "the open or roadside, pavements, inhume-pipes, under flyovers and staircases, or in the open in places of worship, mandaps, railway platforms etc."[1]

Homelessness arises from inadequate income supports, lack of affordable housing, change in the industrial economy leading to unemployment, de-institutionalization of patients with mental health problems, physical or mental illness, disability, substance abuse, domestic violence, relationship breakdown, childhood trauma, and neglect.[2]

According to Census 2011, there are close to 1.8 million homeless people in India and this population is declining but this is still a huge number and is more than the entire population of some countries of the world[3]. Out of total houseless population in India, around 65.3% lives in five states such as Uttar Pradesh (UP), Maharastra, Rajasthan, MP, AP and Gujarat. Homeless in Uttar Pradesh constitute 18.6% of the total homeless population of India[4]. Rajasthan stands third in terms of proportion (10.2%) of homeless population among Indian states. It is interesting to note that Rajasthan ranks 5th in terms of number of homeless people per lakh among Indian states[5] . The states/UTs in order of rankings are Chandigarh, Daman & Due, Dadra & Nagar Haveli and NCT of Delhi where the number of homeless per lakh population is higher than Rajasthan. As far as urban areas are concerned, Rajasthan ranked 1st (with 430 homeless per lakh population) in number of homeless per lakh population. Three cities in Rajasthan with significant number of homeless people are Jodhpur (11138), Jaipur (8930), and Kota (4679)[6].

Further, the 2011 census pegged the number of people residing in urban slums at 65 million. Approximately one in six Indians who reside in cities lives in unsanitary slums. Although 44 Indians are lifted out of poverty every minute, millions continue to live below the poverty line – with manifold effects on development and wellbeing ranging from vulnerability to diseases to poor sanitation to higher levels of maternal and child mortality[7].

For homeless, health vulnerabilities are far-reaching: the risk of violence, particularly sexual assault in the case of homeless women, often fatal exposure to the elements, and mental illness[8]. Under-5 mortality, malnutrition and tuberculosis rates, for example, are substantially higher among urban poor communities, such as the homeless[9]. Research on health and homelessness in India shows that people on the streets

[1] *https://thecsrjournal.in/csr-the-homeless-people-in-india/*

[2] *http://www.ihrn.org.in/files/editor/Surviving%20in%20the%20Street:%20A%20Note%20on%20a%20Study%20of%20the%20Urban%20Homeless%20in%20Jaipur,%20Rajasthan%20-20Motilal%20Mahamallik.pdf*

[3] *https://thecsrjournal.in/csr-the-homeless-people-in-india/*

[4] *http://www.ihrn.org.in/files/editor/Surviving%20in%20the%20Street:%20A%20Note%20on%20a%20Study%20of%20the%20Urban%20Homeless%20in%20Jaipur,%20Rajasthan%20-%20Motilal%20Mahamallik.pdf*

[5] *http://www.ihrn.org.in/files/editor/Surviving%20in%20the%20Street:%20A%20Note%20on%20a%20Study%20of%20the%20Urban%20Homeless%20in%20Jaipur,%20Rajasthan%20-%20Motilal%20Mahamallik.pdf*

[6] *http://www.ihrn.org.in/files/editor/Surviving%20in%20the%20Street:%20A%20Note%20on%20a%20Study%20of%20the%20Urban%20Homeless%20in%20Jaipur,%20Rajasthan%20-%20Motilal%20Mahamallik.pdf*

[7] *https://www.healthissuesindia.com/2019/10/10/homelessness-an-indian-crisis/*

[8] *https://thecsrjournal.in/csr-the-homeless-people-in-india/*

[9] *http://www.ihrn.org.in/about/workingareas/Physical-Health*

suffer multiple serious illnesses, such as mental disorders, infectious diseases, and are routinely denied proper treatment in government hospitals[10].

Homelessness constitutes the worst violation of the human right to adequate housing; homeless people, especially women, are among the most marginalized, ignored, and discriminated against in the country[11]. Living on the streets without any form of shelter greatly increases the vulnerability of homeless women to abuse, sexual violence, injury, disease, mental illness, and death[12]. At the same time, a large number of women are homeless because they have escaped situations of violence at home or are turned out of their homes for various reasons, including HIV and mental illness. Homeless women, particularly young women, suffer the worst kinds of violence and insecurity, and are vulnerable to sexual abuse, exploitation, and trafficking. Instances of rape, molestation, and women spending sleepless nights guarding their young adolescent girls are a common feature among homeless women[13].

Accessing healthcare is a tremendous challenge for homeless people, especially women. There are countless incidents of women being denied treatment and turned away from hospitals. "Women and children who are homeless experience particular forms of violence or are more vulnerable to them. The lack of access to medical services for homeless women, owing to their status, has a disproportionate impact, particularly during pregnancy and childbirth. Many homeless children and women suffer from severe malnutrition."– Special Rapporteur on adequate housing, Report on Mission to India, January 2017.

Accessing healthcare is a tremendous challenge for homeless people. Most shelters do not provide any form of healthcare for homeless residents; including for women. Homeless persons, including women and older persons, suffer from several diseases and illnesses due to inadequate living conditions and extreme weather conditions. They are vulnerable to the heat, rain, and cold, and have insufficient clothes, bedding, and shelter[14]. This reduces their immunity and increases their vulnerability to numerous health problems. In most instances, their illnesses go untreated or are detected too late, making them more susceptible to infection and death. There are countless incidents of women being denied treatment and turned away from hospitals[15]. This has resulted in homeless women being forced to deliver babies on the road, thereby increasing their and their infants' mortality. Shelters for homeless women, including for pregnant and lactating women, continue to be insufficient and inadequate[16].

Homeless women are a highly vulnerable group for risks of pregnancy and childbirth-related complications. They may also face multiple challenges to access and utilize maternity healthcare services. The stress of homelessness can have significant negative impacts for pregnant women[17]. Due to compromised health, people who are pregnant and experiencing homelessness face greater health risks. They often have difficulty accessing healthcare and prenatal programs. No one should be without a safe, stable place to call home, especially during pregnancy since this additional strain on the body can be life-threatening[18].

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[10] *http://www.ihrn.org.in/about/workingareas/Physical-Health*

[11] *https://www.hlrn.org.in/documents/Shelters_Homeless_Women.pdf*

[12] *https://www.hlrn.org.in/documents/Shelters_Homeless_Women.pdf*

[13] *https://www.hlrn.org.in/documents/Shelters_Homeless_Women.pdf*

[14] *https://www.hlrn.org.in/documents/Shelters_Homeless_Women.pdf*

[15] *https://www.hlrn.org.in/documents/Shelters_Homeless_Women.pdf*

[16] *https://www.hlrn.org.in/documents/Shelters_Homeless_Women.pdf*

[17] *https://www.homelesshub.ca/blog/homelessness-reproductive-health-pregnancy*

[18] *https://www.homelesshub.ca/blog/homelessness-reproductive-health-pregnancy*

OBJECTIVES AND METHODOLOGY OF THE FACT FINDING:

The objectives of this fact finding exercise was to review the incidents where homeless women in Jaipur have been denied essential reproductive health services and the reasons for the same.

The methodology included discussions with two affected women (Sita and Shaarda) taking their accounts of what they experienced when they visited public health facilities seeking reproductive care.

CASE DETAILS

Case 1: Mrs. Sita

Details of Sita	
Woman's name and age	Smt. Sita, 35 years
Village	Kekri (Jodhpur)
Age at marriage	18 years
Education status	Illiterate
Total children	4
Occupation	Labour/wager
Husband's name	Late Mr. Jagdish
Education status	Illiterate
Hospital name	Mahila Hospital Sanganeri Gate

Background

Sita was a homeless woman from Kekdi region of Jodhpur and was eight months pregnant when the fact finding team met her. Sita had come to Jaipur from Jodhpur four months ago. She lived on the roadside near Jalebi Chowk. She was illiterate and was married at the age of 17 years. Her husband too was illiterate and he passed away seven years ago. She worked as a labourer to make a living. She had two sons and two daughters from her marriage. The sons were aged 17 years and 15 years while the daughters were 13 years and 7 years old during the time when the fact finding was conducted. Her first three children lived with her in-laws in Jodhpur as it used to become difficult for her to work keeping all the children with her. However, the youngest daughter used to stay with her.

Her first two deliveries took place on the road side and she did not get any kind of health benefits for them. At the time of her third delivery, when she developed labour pains, the women around her took her to a private hospital where she delivered.

At the time of her fourth delivery, a woman living next to her, called Adi, took her to the Sanganeri Gate Government Hospital. At the hospital Sita was asked for her Aadhar card, which she didn't have. Adi

pleaded with the hospital staff to admit her, but they wouldn't because Sita did not have an Aadhar card. However, when she started delivering right there, the hospital staff had no option but to admit her and manage her delivery.

During her past pregnancies, she never got herself registered at any anganwari; being an indigent and homeless woman, she did not have the requisite documents such as Aadhar card, Bhamashah card, bank pass book or voter ID, to register for health facilities.

She got to know about her fifth pregnancy, four months into the pregnancy when she missed her period. Over the past few days, her abdomen had begun to swell.

Getting a Sonography in a government hospital – sans documents

On 1/9/2019, Neelam, a staff of Centre for Equity Studies (CES), took Sita to the Women's Hospital, Sanganeri Gate for health check up regarding her fifth pregnancy. CES is an organisation that works with homeless people. The hospital asked for Sita's Aadhar card and Voter's ID in order to register her pregnancy. In the absence of documents, they refused to register Sita. Neelam requested the hospital authorities time and again to register Sita in their records, but they refused. She then provided them the organisation's (CSE) ID card. She convinced them that Sita was a homeless woman who didn't have any documents, but she needed health services nevertheless. At this the doctor present wrote out a prescription for investigative procedures such as blood test, urine, HIV test and sonography. The blood and urine tests were done. However, when she went to get the sonography, the technicians asked for her documents. Either the husband's or wife's Aadhar card was mandatory for conducting the sonography they told. Even the CSE ID card was not accepted. Neelam and Sita thus returned from the hospital without getting the sonography

Sita in her dwelling place

done. However, they went to the hospital again on 2nd and 3rd September 2019, and attempted to get the sonography done; but to no avail. On the evening of 22/10/2019, Sita experienced sharp pain in her abdomen. When the pain became unbearable Sita called up Neelam for help. Neelam advised her to rush to the government hospital accompanied by someone. She also told her to ask the person accompanying her to carry his or her ID card. Thus, Sita went to the hospital with a person named Kailash and his Aadhar card. The hospital authorities registered Sita and Kailash as husband and wife. She was then able to get the sonography and other services without any difficulties.

Case 2: Mrs. Shaarda

Details of Shaarda

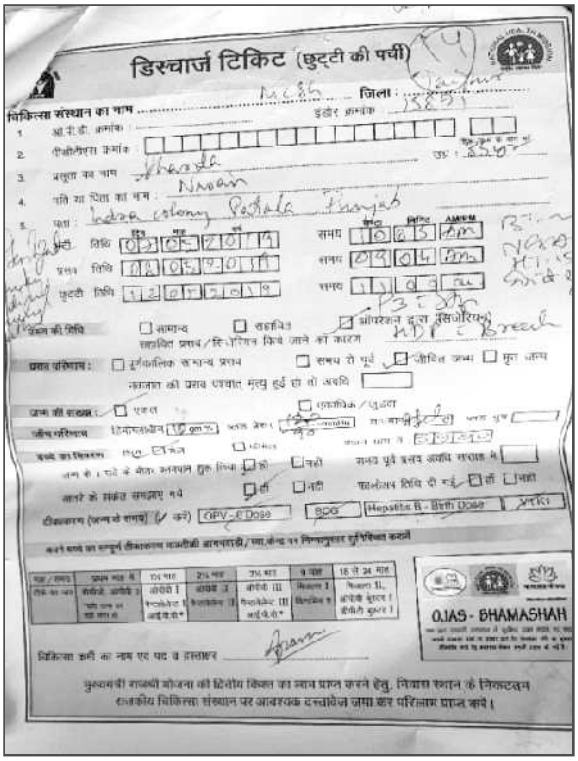
Woman's name and age	Mrs. Shaarda
Village	Chennai
Age at marriage	19 years
Education status	Illiterate
Total children	5
Occupation	Domestic help
Husband's name and age	Mr. Narayan , 45 years
Education status	Illiterate
Hospital name	Mahila Hospital Sanganeri Gate

Shaarda was a 38 year old woman from Chennai who kept shuffling between Chennai, her native place, and Jaipur to make a living. Her husband Narayan was 45 years old. She was a homeless and lived on the footpath near Jalebi Chowk in Jaipur. She was illiterate and worked as a domestic help in a few houses. Her husband worked as a rag-picker. The couple had five children, three girls and two boys, including the youngest one she gave birth to in May 2019 in Jaipur. Narayan did not live with Shaarda and the children. However, he would often come up to them and beat them up for no reasons.

On 24/04/2019, when Shaarda was close to completing term of her fifth pregnancy, Neelam, a worker from CES took her to the Women's Hospital, Sanganer Gate, for check up. When they reached there they were asked for Shaarda's identity documents such as Aadhar card or voters ID for registration. However, Shaarda didn't have any of those documents with her at that time. Hence, Neelam requested the staff to not deny registration to Shaarda as she was homeless and in dire need of health care. She also showed them her organisation's ID card assuring that she was from a credible organisation and not lying. Finally the authorities relented and got her registered. The doctor examined Shaarda and prescribed some blood and urine tests and sonography. However, by then it was too late in the day and diagnostic services had closed, so Neelam and Shaarda decided to come back to the hospital again the next day. On 25/04/2019, Shaarda got blood and urine tests done at the hospital, however, when they went for sonography the staff there demanded her Aadhar card. Shaarda showed the Aadhar card that she had, but since the card had the address of a state other than Rajasthan, the staff refused to accept it and refused to carry out sonography. Neelam requested time and again that Shaarda was in her last term of pregnancy and a sonography is quite crucial at that point, but to no avail. Neelam then presented her own Aadhar card which had a Rajasthan address and insisted that Shaarda be provided the required service. Surprisingly, the medical staff accepted Neelam's Aadhar Card and agreed to carry out Neelam's sonography on account of it. The sonography report revealed that the foetus was in a horizontal position and normal delivery would not be possible. The medical staff also suggested that Shaarda should undergo tubectomy as a permanent contraception measure to avoid further pregnancies.

Shaarda went back to the health facility on 07/05/2019 when she started to experience labour pains. After an examination the doctor suggested that Shaarda will have to be admitted as she will have to undergo cesarean section. Thus, on 08/05/2019 the operation was conducted and both Shaarda and the baby were in good health. Together with this Shaarda also underwent tubectomy. She was discharged from the hospital on 12/05/2019 but was not provided any vehicle to drop her off. She had to hire a private vehicle and payed Rs. 100 towards it. She also didn't receive any incentive under Janani Surakhsa Yojana (JSY) and nor was she provided incentive for undergoing sterilisation operation. The reason she was denied these benefits was because her Aadhar card was issued by another state.

Shaarda



Shaarda's discharge certificate from Women's Hospital Sanganeri Gate

Guarantees and Guidelines

- **National Health Mission**

  In 2013, the Centre Government launched the National Health Mission (NHM) as an umbrella program with two main prongs: the National Rural Health Mission (NRHM), first launched in 2005, and the National Urban Health Mission (NUHM). The purpose of these schemes is to improve health infrastructure and health outcomes in India's rural and urban areas. A major focus of the NRHM is improving maternal and infant health, which is revealed in the NRHM Service Guarantees. Reducing the maternal and infant mortality is a key goal for Reproductive and Child Health Programme under the National Rural Health Mission (NRHM). Several initiatives have been launched by the Ministry of Health and Family Welfare (MOHFW) under the Mission including Janani Suraksha Yojana (JSY), a key intervention that has resulted in phenomenal growth in institutional deliveries with more than one crore women being benefited from the scheme annually. JSY was launched to promote institutional deliveries so that skilled attendance at birth is available and women and new born can

be saved from pregnancy related deaths. However, even though institutional delivery has increased significantly, out of pocket expenses being incurred by pregnant women and their families are significantly high. Another initiative is Janani Shishu Suraksha Karyakram (JSSK) which is aimed at providing cashless institutional delivery.

a) Janani Suraksha Yojana (JSY):

Since its implementation in 2005, the JSY scheme has aimed to reduce maternal and neonatal mortality by providing women with conditional cash assistance for registering their pregnancies and choosing institutional delivery. All women are eligible for JSY benefits, regardless of their age or number of children. To receive JSY benefits, women must present a JSY card and a referral slip from an Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM), or Medical Officer (MO). JSY guidelines specify that a woman's state of residency (not the state in which she delivers) determines the amount of the JSY cash benefit. Therefore, even though many women in India return to their mother's home to deliver, which may be located in another state, these women must be given a JSY payment at the rate of their own home state.

JSY BENEFIT FOR INSTITUTIONAL DELIVERIES
(in Rupees)

	Rural			*Urban*		
Category of States	Assistance to mother	Assistance to ASHA	Total	Assistance Mother	Assistance to ASHA	Total
LPS*	1400	600	2000	1000	400	1400
HPS**	700	600	1300	600	400	1000

* Low Performing States (LPS) include Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and Uttaranchal.

** High Performing States (HPS) include all states that are not LPS.

b) Janani Shishu Suraksha Karyakram (JSSK):

Through the NHM, the government also coordinates the JSSK scheme, which the Government launched in June 2011 as a means of eliminating out-of-pocket expenses incurred by pregnant women and sick new-born, which are "without doubt, a major barrier" for pregnant women and children, many of whom "die on account of poor access to health facilities." Therefore, the JSSK scheme provides that pregnant women seeking institutional delivery and sick new-borns until 30 days after birth are entitled to absolutely free care in all government health facilities. JSSK services are available to all women who deliver in government health facilities, regardless of age, number of children, or economic status. These free JSSK services include delivery (including Caesarean section), medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery and 7 days for Caesarean section), free transportation to and from the facility (and between facilities in cases of referral), and exemption from all user charges. The JSSK scheme provides essentially the same free services to sick new-borns that are available to pregnant women.

- **United Nations Convention on the Rights of the Child**

  India is a signatory to this convention according to which all decisions concerning children will be taken keeping the best interest of the child in mind; the child is entitled to the right to health and health care and the state should ensure health care services.

- **Standards for Female Sterilisation**

  As per standards of female sterilisation laid down by the Ministry of Health and Family Welfare, adequate care must be given to case selection, pre-operation counselling, safety standards while operating, post-operation care counselling and information. Men and women who opt for sterilisation are also eligible for cash incentive of Rs. 600 for Below Poverty Line (BPL) women. During hospitalisation for sterilisation, diet, medicine and transport are also to be provided free of cost.

- **The National Urban Livelihoods Mission – Scheme of Shelter for Urban Homeless (NULM–SUH)**

  The National Urban Livelihoods Mission – Scheme of Shelter for Urban Homeless (NULM– SUH) was launched by the Ministry of Housing and Urban Poverty Alleviation in 2014. It provided policy direction to the Supreme Court's orders on homelessness4. The Scheme aims to provide permanent shelter and essential services to the urban homeless population in the country. It sets specific norms and standards for the distribution, location, and design of permanent and all-weather shelters for the urban homeless, who presently have no access to shelter or public services such as health, education, food, water, and sanitation. Further, the Scheme specifies that the requirements for vulnerable homeless groups vary, and hence, the nature of the homeless population in a location should dictate the type of shelter to be constructed4. There should thus be separate shelters for men, women, families, and special shelters for older persons without care, persons with mental illness, and recovering patients and their families. The Scheme also provides for convergence of service delivery and provision of entitlements including social security, food, education and healthcare, as well as identity proof, address proof, pension, Below Poverty Line (BPL) cards, ration cards, Integrated Child Development Services (ICDS) centres, free legal aid, and admission to government schools and public hospitals for urban homeless residents4.

Violation of Rights

- Shaarda's right to incentives under JSY had been violated as she did not receive cash incentive in spite of delivering in a government health facility
- Shaarda did not receive cash incentive for tubectomy that she was entitled to. In addition, she was eligible for food and medicine and transportation costs during hospital stay for sterilization. She
- According to standards for female sterilization, women who undergo sterilization must receive counselling before the procedure and after the procedure on care to be taken during post operative period and also advise on adequate rest and nutrition post-surgery. It is not apparent whether Shaarda was provided any of these and this is a violation of standards for female sterilization.
- She was not paid transportation charges to and from their place to the hospital where delivery was done

- Shaarda's and Sita's health rights had been violated as neither woman was registered with the anganwari during pregnancy and did not receive Ante or Post Natal Care
- By making both women visit the government hospital repeatedly for availing the sonogrpahy test, their right to livelihood has been violated because they must take time away from wage labour to visit health facilities.
- Denying sonography facility merely on the pretext that they did not have requisite documents or appropriate documents, is a violation of health rights that are universal and unalienable. The denial of the right to health amounts to denial of the fundamental Right to Life as enshrined in the Indian Constitution, for the Right to Life cannot be enjoyed without the Right to health.
- The Scheme for Urban Homeless under the National Urban Livelihoods Mission stipulates that the urban homeless population be provided shelter and essential services. It provides for integration of all service delivery schemes and states that the homeless must be helped to gain appropriate documents. These policies have been violated as Sita was not provided with documents or essential health services; Shaarda was denied services because she did not have documents from local authorities.
- Sita and Shaarda did not have adequate shelter which is a violation of the directions under Scheme for Urban Homeless which states that the homeless must be provided safe and secure shelter. It also mandates separate shelter for men and women, special shelters for those who are ill; howeverShaarda had to go back to the street after the delivery of her child.
- Sita and Shaarda's children had been denied health rights – after delivery mothers went back to living on the streets with no access to health check up either for themselves or for the newborns. The two women's children will grow up on the streets without a secure shelter and face many risks as street children – such as lack of education, health, nutrition and threat of violence and abuse; denial of rights to education, health and housing amounts to denial of right to life and liberty.
- India is a signatory to the United Nations Convention on the Rights of the Child, which states that rights of the child shall be given utmost priority and all decision must be made taking into consideration the best interests of the child. However in these two cases, the children's interests have not been considered at all and they have been consigned to a life on the streets.

RECOMMENDATIONS

- Ensure that Sita and Shaarda are immediately provided cash incentives under JSY that is due to them.
- Ensure that they and their children are provided adequate and safe shelter and nutrition.
- Ensure that their new born children are provided adequate health care such as immunization, nutrition.
- Ensure that Shaarda and Sita receive adequate PNC – make sure that they are registered with the nearest Anganwari for this purpose.
- Ensure that their children are not denied the right to education; make sure that the women's children are enrolled in schools.
- Ensure that the two women are provided documents such as Aadhar card, voters ID card, etc.

- Ensure that frontline staff in hospitals are made aware of special schemes and concessions available for homeless persons so that they do not insist on documentation when such people approach them
- Sensitise hospital staff to the needs of the poor and indigent so that they do not deny services to such people.
- Make allowance in hospital rules for such people so that there is no insistence on documentation prior to provision of services; ensure that documentation provided by any state in India is acceptable across India
- Ensure that enough shelters are set up in urban areas for the benefit of the homeless; make sure that these shelters meet requirements prescribed in the Scheme for Urban Homeless, such as safety, cleanliness, separate shelters for men and women, as well as for those with special needs such as the elderly, ill, persons with mental illness and so on.
- Ensure that anganwaris are tasked with identifying the homeless women and children in their area so that such persons are registered at anganwadis and provided health services. Anganwari staff must be encouraged to reach out to such communities and provide services rather than waiting for them to approach the anganwari.
- Ensure that schools too identify and enrol homeless children in their vicinity.
- Sensitise town municipal/corporation authorities towards needs of homeless people so that special drives are organized to provide documentation to homeless people.

CONCLUSION

The cases of Shaarda and Sita point to the callous attitude of health care providers; they refused services to the poor and homeless on the pretext of non-availability of documents. Women such as these, often the most needy of the society, are deprived of the most basic of services because of lack of documents. It is shocking that in spite of the doctor having prescribed many tests including sonogrpahy, the concerned staff refused to conduct the test because Sita did not have documents and Shaarda's Aadhar card was from a state other than Rajasthan. Both women had to visit the hospital many times before they were able to get the service due to them.

The insistence on documents is often just a matter of procedure and used as a means of bureaucratic red tape and to deny citizens their rights as is evidenced in the case of Sita – when she presented the Aadhar card of the person accompanying her to the hospital they registered her and the person as her husband without even bothering to verify. As the man is not actually her husband it is clear that insistence on documents is merely a formality and not a genuine need for service provision. Such being the case, it is quite clear that such formalities which come in the way of service provision may be done away with.

It is absolutely important for health care facilities to recognize circumstances of homeless persons and provide them all possible treatment/service. Especially in such cases, where people lack official documents, the lack should not be used as an excuse to deny rights and services.

India has a large number of homeless people – many of them migrants who move cities in search of work. They are already vulnerable as they lack a regular source of livelihood. Not only do they lack all facilities such as housing, education, and health care, they also do not have social support systems as many of them

are uprooted from their native places. They are also vulnerable to violence and abuse and at risk for many health issues. Given such circumstances, denial of health services to such people amounts to criminal negligence on the part of the state. It is therefore imperative that the state governments take proactive measure to ensure that the health care needs of the homeless are met – by identifying such people, ensuring they are provided documents, ensuring they have access to free and quality health care facilities in their vicinity and ensuring education for homeless children.

9. A Case of Maternal Death, Madhya Pradesh

Late Smt. Rajkumari Adiwasi

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 Madhya Pradesh, 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.[1-2-3]

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 Madhya Pradesh found that after the launch of JSY, over 50% of women who had their previous deliveries at home opted for institutional

[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/*

delivery. NFHS-4 also shows the rise in institutional delivery from 26.2% in 2005-06 (NFHS-3) to 80.8% in 2015-16 in Madhya Pradesh. 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.[4] The institutional births in public facilities increased from 18.4% in 2005-06 (NFHS-3) to 69.4% in 2015-16 (NFHS-4) in MP.

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.[5] The MMR of Madhya Pradesh is higher than the national figure, at 173 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.[6]

BACKGROUND

Rajkumari Adiwasi, resident of village Jhamanpani, tehsil Silwani, district Raisen, got married to Siyaram Adiwasi, resident of village Bichua, tehsil Silwani, district Raisen in 2010. Both of them could not study due to poor economic conditions of their respective families. The fact finding team researched the profile of the village and found that village Bichua was part of Gram Panchayat Pratapgarh. According to census 2011, the population of village Bichua was around 684. The village had a school up to 8th standard and an anganwari attached to the school. The village was connected to the tehsil headquarter by a pucca road but there weren't adequate means of public transport. People belonging to two caste groups, namely Adiwasi and Chaudhary resided in the village with around 70 households belonging to the Adiwasis. Since Adiwasi families did not own much agricultural land, they would migrate to Bhopal, Gujarat and Rajasthan (Kota, Jaipur) for work. The ANM posted at the Health Sub Centre (HSC) lived in tehsil headquarter, Silwani. She did not perform deliveries at the HSC because of which women had to go to PHC Jethari (10km away) or CHC Silwani (35km away). In case of any complications, women would go to the district headquarter, Raisen, 125 kms away, which coasted about Rs. 2500 if the free government ambulance service was not available.

THE CASE

Siyaram Adiwasi informed the fact finding team that this was his wife Rajkumari's third pregnancy. She had first become pregnant in 2012, two years after their marriage. At that time, first two ANCs were done at the village AWC while the last two ANCs were done in Rajkumari's parental village, Jhamanpani. On 21/04/2012, she started having labour pains and the family members took her to CHC Silwani by a private vehicle that cost them Rs. 800. At the CHC, the nurse told them that the foetus had stopped moving and the uterus was not opening up because of which she needed to be taken to the district hospital for a caesarean section. Rajkumari was hence moved to the district hospital in Raisen the same day by the government ambulance, Janani Express. She was admitted at the district hospital around 4:30 PM and Dr. S. Thakur examined her and informed the family that the foetus had died. Immediately an operation was performed

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

to take out the dead foetus. Smt. Rajkumari was kept under treatment at the district hospital for next 12 days as she was very weak, and discharged on 01/05/2012. She got the JSY money of Rs. 1400 but no ambulance was provided to drop her back home and she was brought back by a private vehicle that cost Rs. 1600. Siyaram told that nobody from the health department came to check upon Rajkumari after she came back home from the district hospital. (Discharge card of district hospital, Raisen is available).

In 2017, Rajkumari again became pregnant and received four ANCs from the village AWC. As per her records, she seemed to be anaemic during pregnancy as her Hb was around 9gm/dl in all the four ANCs and weight had increased only 3 kg between the first and the last ANC. On 14/02/2018, Rajkumari started having labour pains and the family members took her to CHC Silwani where she gave birth to a still born baby girl the same night. Though she had a normal delivery, yet she was kept at the CHC for treatment and recovery for five days. Siyaram asked the doctor at the CHC the reason why the same thing would have happened on both the occasions. The doctor told him to get investigations done in a private hospital so that the reasons could be known. The government ambulance dropped her back home free of cost and she got the JSY amount of Rs. 1400 in her account. (Smt. Rajkumari's ANC card of the second pregnancy is available).

Rajkumari became third time pregnant in 2019. She underwent first ANC at the village AWC. Her Hb seemed to have reduced further to 8gm/dl this time around as indicated by her ANC card. Siyaram took her to CHC Silwani also for check-up where the doctor examined her and prescribed medicines for 20 days. As advised by the doctor, Rajkumari and her husband went back to the CHC for check-up after 20 days. The doctor carried out investigations such as Hb, sugar, HIV, blood group, VDRL etc. and prescribed medicines. Further ANC was performed at the AWC. She did not get supplementary nutrition from the AWC regularly. The AWW used to tell that she had not got the supplies. Though Rajkumari's ANC card showed three ANCs at AWC, the ASHA diary at AWC had record of only two ANCs.

Rajkumari's pregnancy and death record in the ASHA diary of Anganwari Centre Bichua

Rajkumari went to her parents' place in the latter part of her pregnancy since there was nobody at her in-laws' place to take care of her. On 17/05/2019, when she started having labour pain, the family members took her to CHC Silwani by Janani Express, the government ambulance. Her mother and husband accompanied her to the CHC. The nurse at the CHC examined Rajkumari and informed her family that she was carrying twins because of which she should be taken to the district hospital for delivery. Thus she was referred to the district hospital, Raisen by the Janani Express. Rajkumari was admitted in the district hospital and administered IV fluid. Medical officer and gynaecologist, Dr. Deepak Gupta advised sonography. When Siyaram went to the laboratory he was told that the lab was closed because of two days holiday. Siyaram told Dr. Gupta that sonography was not being done in the hospital lab. Dr. Gupta insisted that the sonography was urgently needed and suggested that they get it done from a private lab outside the hospital. Since Siyaram did not have enough money, he requested the doctor to get it done somehow at the district hospital, but the doctor said he was helpless. Siyaram then went back home that day itself to arrange money for the sonography. His mother-in-law stayed back at the hospital with Rajkumari. With no other option, Siyaram borrowed Rs. 2000 on interest from the money lender in the village. However, by the time he returned to the hospital next day, on 19/05/2019, Rajkumari had already passed away. The doctor had performed the caesarean in the night and a baby girl was born. The newborn child survived but Rajkumari did not.

Fact finding team at late Smt. Rajkumari's residence

Siyaram went to meet Dr. Gupta and asked the reason for his wife's death. The doctor told him that he had to perform the caesarean in emergency. He also told that Rakumari was severely anaemic and died essentially because she could not be given blood on time. Siyaram questioned the doctor that he never told him that his wife was anaemic and blood would be needed, otherwise he would have tried to arrange for blood just as he had arranged to get sonography done. Siyaram told the fact finding team that his wife did not get the correct treatment because he was poor and did not have money and she died because of lack of money. They brought her dead body back in a government ambulance and the newborn child was now being taken care of by her grandmother.

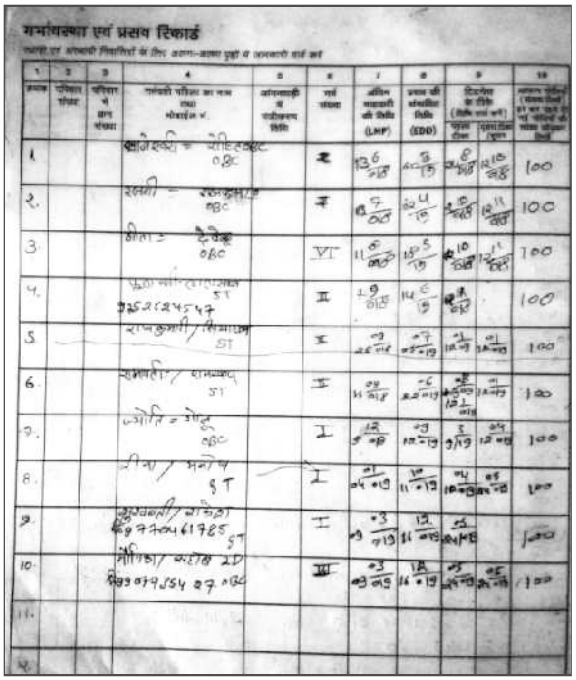
DEATH CERTIFICATE

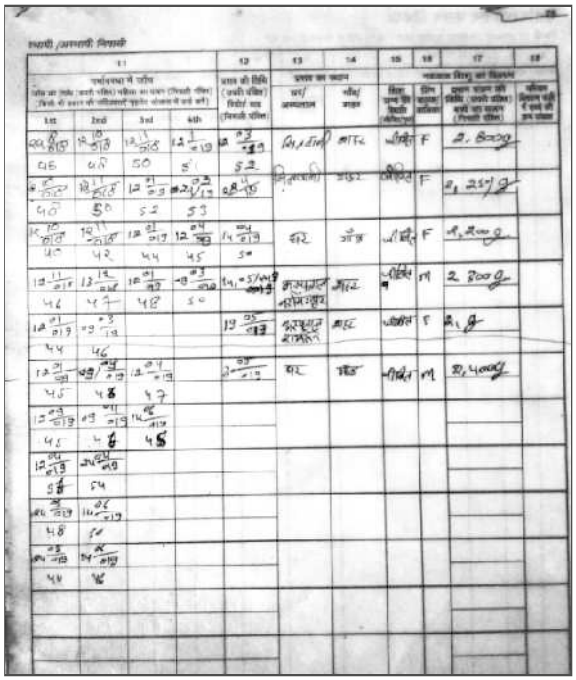
Rajkumari's death certificate

Siyaram informed the fact finding team that the newborn girl's weight at birth was 2.7 kg because of which she was admitted in the newborn care unit of the district hospital for about 14 days and discharged on 01/06/2019. However, the child's discharge card showed that she was admitted for 19 days and the date of discharge had been over-written to indicate that she was discharged on 07/06/2019.

Discussion with the AWW and ASHA at the AWC

The fact finding team reviewed AWC records pertaining to late Smt. Rajkumari's pregnancy and ANC, in which it found several inconsistencies. The anganwari records showed that she had got two ANCs whereas the ANC card filled by the ANM showed that she had got three ANCs. The dates of ANC in ASHA diary did not match with those in the ANC card. This indicates the carelessness with which services are being provided and records maintained at the village level.





Newborn girl in her grandmother's care who feeds her cow/goat milk.

GUIDELINES & GUARANTEES

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)[7]; the right to live with dignity[8]; 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."[9] 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.[10] This duty arises from multiple international conventions to which India is a 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).[11]

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

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

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

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

[10] *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).*

[11] *http://www.nrhmhp.gov.in/sites/default/files/files/Entitlements_JSSK.pdf*

LPS, including MP, 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.

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.[12]

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.[13]

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.

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

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

- 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.[14]

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.

Operational 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.

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

- 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.[15]

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.[16]

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.

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 Rajkumari's untimely death.
- DoHFW should undertake an investigation about why was sonography not arranged by the district hospital, Raisen instead of putting the onus on the patient, especially when the family did not have money to get it done privately. Enquiry should also be conducted about blood transfusion not being made available to the deceased at the district hospital. Why did the treating doctor not arrange for blood before hand?
- In all her three pregnancies, Rajkumari had sought care at the AWC as well as the CHC. However, she was not provided comprehensive care at any stage which would have revealed the reason for still birth during two previous pregnancies and care to be taken in future. DoHFW needs to seriously review the quality of services provided to pregnant women so that such carelessness does not take any other woman's life.
- Rajkumari's family should be given appropriate compensation for the loss of life, emotional and mental trauma, and for the care of the newborn child.

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

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

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

CONCLUSION

Rajkumari Adiwasi's family took full care of her during all her pregnancies and ensured that she got the ANC timely and took her for institutional delivery on all the occasions. It is sheer carelessness and apathy on the part of the health system that she lost two of her children before finally losing her own life. Had a thorough check-up been done to identify the risk factors that she faced and care advised accordingly, there is no reason why Rajkumari Adiwasi and her family had to go through this ordeal. The inefficiency and incompetence of the public health system took Rajkumari's life. In all probability, had she belonged to a financially better off urban family, her fate would have been different.

Losing such young women in the process of child birth is a matter of shame for us as a society. The fact that despite central government's various health programmes and schemes, women like Rajkumari Adiwasi continue to die, indicates that the public health system needs to do serious introspection and take moral responsibility for such mishaps. Unless hospital administration and staff members take ownership to run their facilities more effectively, no amount of central guidelines and schemes will help. India cannot allow such tragedies to happen if it is to achieve the SDGs.

जिला अस्पताल बदहाल, अव्यवस्थाएं पड़ रहीं भारी

डॉक्टरों की लापरवाही से फिर एक प्रसूता ने गंवाए अपने प्राण

परिजनों ने डॉक्टरों पर लगाए मनमानी व लापरवाही के आरोप

पत्रिका न्यूज नेटवर्क
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रायसेन. जिला अस्पताल की व्यवस्थाएं सुधरने का नाम नहीं ले रही हैं। आएदिन लापरवाही की वजह से कोई न कोई घटना होना आम बात हो गई है। जी हां, आलम ये है कि गर्भवती महिलाओं की सुरक्षित प्रसव की बात सिर्फ स्वप्न बन कर रह गई है, क्योंकि जिला अस्पताल के प्रसूति केंद्र का बिगड़ा ढर्रा सुधरने का नाम नहीं ले रहा है। डॉक्टरों की आपसी खींचतान व गुटबाजी का नतीजा जिला अस्पताल में भर्ती मरीजों को भुगतना पड़ रहा है। जिला अस्पताल की मेटरनिटी विंग में बिछुआ गांव तहसील सिलवानी की एक प्रसूता पिछले तीन रोज से भर्ती थी। गरीब परिवार की बहू राजकुमार आदिवासी का जिला अस्पताल के मेडिकल ऑफीसर व स्त्री रोग चिकित्सक द्वारा ऑपरेशन किया गया। ऑपरेशन के तीन घंटे बाद ही प्रसूता ने दम तोड़ दिया। जबकि उसका बच्चा एसएनसीयू में वार्मर मशीन में है।

प्रसूता की मौत की खबर सुनकर परिजन सदमे में आ गए। परिजनों ने जिम्मेदार डॉक्टर पर मनमानी व लापरवाही के आरोप लगाए। सूचना मिलते ही जिला अस्पताल प्रबंधन के अधिकारी मामले की लीपापोती करने पहुंच गए। गौरतलब है कि तीन दिन पहले भी जिला अस्पताल के प्रसवोत्तर केंद्र में एक प्रसूता

रायसेन. प्रसूता वार्ड में बदहाली। **इनसेट :** नाराजगी जताते प्रसूता के परिजन।

ये है सारा मामला

जिले की तहसील सिलवानी की बिछुआ गांव निवासी 26 वर्षीय राजकुमारी आदिवासी पत्नी सियाराम आदिवासी को सिलवानी के सरकारी अस्पताल से तीसरे बच्चे की डिलेवरी के लिए जिला अस्पताल रैफर किया गया था। प्रसूता राजकुमारी को शुक्रवार को सुबह 11 बजे भर्ती कराया गया। केस को हैंडिल कर मेडिकल ऑफीसर एवं महिला रोग विशेषज्ञा डॉ. दीपक गुप्ता ने उसके पति सियाराम को प्रसूता की सोनोग्राफी कराने को कहा। पर हीमोग्लोबिन की कमी की बात नहीं कही। गरीब आदिवासी सोनोग्राफी कराने तीन दिन भटकता रहा। पर इस अस्पताल में इमरजेंसी में भी गरीब प्रसूता की सोनोग्राफी नहीं की जा सकी। जबकि डॉ. गुप्ता खुद सोनोग्राफी विशेषज्ञा हैं। उनका कहना था कि डॉ. रजनीश सिंघई ही सोनोग्राफी करते हैं। पता चला है कि डॉ. सिंघई पर उदयपुरा बीएमओ का भी प्रभार है। बाकी समय वह जिला अस्पताल में भी सोनोग्राफी करने आते हैं। रविवार को सुबह महिला रोग चिकित्सक गायनिक डॉ. सुनीता अतुलकर और डॉ. दीपक गुप्ता द्वारा ऑपरेशन थिएटर में 6 प्रसूताओं के ऑपरेशन किए गए थे। इनमें राजकुमारी भी शामिल थी।

डॉक्टर ने खून की कमी नहीं बताई थी

राजकुमारी के पति सियाराम आदिवासी सहित उनके परिजनों ने डॉक्टरों पर घोर लापरवाही के आरोप लगाए हैं। उसका कहना है कि डॉ. गुप्ता ने उसकी पत्नी को खून की कमी होना नहीं बताया और समय पर सोनोग्राफी नहीं कराए जाने की वजह से उसकी मौत हुई। उनका यह भी कहना था राजकुमारी की तरह किसी दूसरी प्रसूता को डॉक्टरों की लापरवाही में दम न तोड़ना पड़े। पति सियाराम आदिवासी ने आरोप लगाते हुए कहा कि मैं शनिवार को दोपहर वह जरूरी काम से बिछुआ गांव गया था। रविवार को सुबह मेरे आने के पहले ही मेरी बिना मर्जी लिए डॉ. दीपक गुप्ता द्वारा ऑपरेशन किया गया। बच्चे को जन्म देने के बाद उसकी तबियत बिगड़ने के बाद तीन घंटे में ही उसने दम तोड़ दिया।

रुकिमणी रघुवंशी और उसके बच्चे की मौत हुई थी। महिला ने तीन बच्चों को जन्म दिया था, दो बच्चे स्वस्थ हैं। आरएमओ डॉ. यशपाल सिंह बालयान ने परिजनों को मामले की जांच कराने का आश्वासन दिया है। इससे पूर्व में भी प्रसूताओं के शिशु को जन्म देने के बाद मौत की खबरें व डॉक्टरों की लापरवाही के मामले जब तक उजागर होते रहे हैं। मगर अभी तक इन मामलों में किसी एक भी लापरवाह डॉक्टरों के खिलाफ उचित कार्रवाई नहीं की जा सकी है।

मरीजों से बदसलूकी

सियाराम ने यह भी बताया कि अस्पताल की नर्सें, स्वास्थ्य कर्मचारी, दाई आदि मरीजों प्रसूताओं के साथ दुर्व्यवहार करते हैं। डिलेवरी होने पर रुपयों की मांग करते हैं। कोई जब उनको ईनाम नहीं देता तो वह बदसलूकी करते हैं।

राजकुमारी की मौत के मामले की बारीकी से जांच कराई जाएगी। शरीर में रक्त की अल्पता और समय पर सोनोग्राफी की जांच रिपोर्ट नहीं आने की वजह से ही उसकी मौत हुई है। यदि ऑन ड्यूटी डॉक्टर की गलती सामने आई तो उचित कार्रवाई की जाएगी।

- डॉ. यशपाल सिंह बाल्यान

प्रसूता शारीरिक रूप से कमजोर थी। उसे हीमोग्लोबिन की कमी थी। इसके साथ ही सोनोग्राफी रिपोर्ट भी समय पर नहीं आ सकी। रविवार को सुबह जब राजकुमारी की जान का खतरा बढ़ा तो मजबूरी में सीजर ऑपरेशन करना पड़ा।

- डॉ. दीपक गुप्ता, मेडिकल ऑफीसर

पत्रिका Mon, 20 May 2019
epaper.patrika.com/c/39560548

Copy of local newspaper dated 20/05/2019 carrying the news of Smt. Rajkumari's death

10. Losing a Child Due to Apathy of the Medical Staff, Bihar

INTRODUCTION & BACKGROUND

India accounts for 26% of all neo-natal deaths in the world. Every year there are 1.34 million deaths of children under age 5 in India. More than half of these deaths are in the states of Bihar, Rajasthan, Madhya Pradesh and Uttar Pradesh.[1]

Most of these deaths can be prevented by improving quality of care during delivery and after-birth care. Simple measures such as skilled birth attendance and access to emergency obstetric care can greatly bring down the rate of mortality.

This is the case of death of new born child of Pooja Devi and Gagan Kumar due to criminal negligence of staff of the Community Health Centre (CHC), Kumarkhand – negligence tantamount to murder of the child.

Pooja Devi

Gagan Kumar

THE CASE

Background of Kumar Khand Village

Kumarkhand is a village situated in Kumarkhand block of Madhepura district in Bihar. As per the Census 2011, there were total of 2,699 families in the village. The total population of Kumarkhand was 11,650 out of which 6,073 are males and 5,577 are females. The population of Children of age 0-6 years in Kumarkhand village was 2099 which was 18% of the total population. There were 1081 male children and 1018 female children between the age of 0-6 years. The literacy rate was 58.4% with the male literacy rate being 68.13% and the female literacy rate 47.69%.

[1] *http://unicef.in/Whatwedo/2/Neonatal-Health-*

Caste Data as per Census 2011

Schedule Caste (SC) population in the village constituted 22.8% of the total population while there was no Schedule Tribe (ST) population in Kumarkhand village.

Working Population as per Census 2011

In Kumarkhand, out of total population, 5,032 were engaged in some form of work or income generating activities. 73.2% of workers described their work as Main Work (Employed or earning more than 6 Months in a year) while 26.8% were involved in Marginal activity (providing livelihood for less than 6 months). Of 5,032 workers engaged in main work, 1,738 were cultivators (owner or co-owner) while 1,656 were agricultural labourers.

Sr. No	Total	Male	Female
Main Workers	3,684	2,472	1,212
Cultivators	1,738	1,196	542
Agriculture Labourer	1,656	1,083	573
Household Industries	75	23	52
Other Workers	215	170	45
Marginal Workers	1,348	591	757
Non Working	6,618	3,010	3,608

Pooja and Gagan's house

CASE DETAILS

Pooja devi was 16 years old when she got married in 2016 to Gagan Kumar who was 19 years old at that time. Gagan Kumar was a daily wage worker who would often migrate to Punjab for work. He would work there sometimes as an agricultural labourer and sometimes as a construction worker. They were an extremely poor family that would often struggle to make ends meet. They did not own any land. They lived in a kuccha house with no constant source of electricity or running water. They did not have a toilet facility and practiced open defecation. Gagan's mother and younger brother lived in a separate house in the same compound. Gagan's father died five years ago. The family had a common hearth where the food was cooked for the whole family.

Gagan and his family belonged to the Musahar community which is a Mahadalit community. Mahadalits in Bihar generally do not own land and live in colonies away from the main village. They work on the lands of prosperous farmers, working in their fields, guarding their fruit trees and doing other farm related work. The prosperous families of this village had houses close to the main road. The houses of the Mahadalit community were located 2.5 km away from the main village in the middle of the fields. There were 30-35 Mahadalit families living in this locality and no other community lived there. These houses were earlier connected by a kuccha road, but later they were partly connected by a concrete road.

Pooja and Gagan had a 2-year old child named Uma Shanker. When Pooja became pregnant for the second time, she couldn't get herself registered at anganwari centre because there was no anganwari in her village. The anganwari was situated in the neighbouring village which was across a river. The workers there, Draupadi Kumari and Renu Chauhan, did not visit this village and hence Pooja did not receive any Ante Natal Care (ANC).

The Community Health Centre (CHC) was situated in the Gram Panchayat head quarters of Kumarkhand and the Auxiliary Nurse Midwife (ANM) of that CHC visited Ram Tola Nagar and provided services. During her first pregnancy Pooja received two TT shots. She did not receive any other ANC care such as nutritious food, IFA tablets, regular screening for BP, weight gain, etc. Her delivery took place at the CHC. During her second pregnancy too she did not receive any ANC except for a booster dose of TT shot. However, Pooja did not have any difficulty or complications such as swelling during the course of her pregnancy.

Reference Card issued by CHC

On completion of her term, Pooja experienced labour pains around 7 PM on 26-08-2019. The family hired a private tempo and took her to the CHC. They paid Rs. 400 out of their pocket towards this. She was accompanied by her family members and was admitted to the hospital around 7.30 PM. Around 9.00 PM Pooja gave birth to a baby girl through normal delivery. Since the infant was not in good health, she was kept in the incubator of the Intensive Care Unit (ICU). After about 10 minutes, the ANM came and demanded Rs. 1000 from the family to continue care for the infant. Only the women from the family were present at that time and they requested the ANM to wait till the next day or till such time as the men came over as they did not have any money with them. However, the ANM did not heed their pleas and asked them to provide money immediately or take the baby elsewhere for treatment. She then got angry and removed the infant from the baby warmer. At this, the women huddled together with the baby in their laps, covering her with whatever clothes they had. Around 11.30

PM, Gagan's uncle came to the hospital and was surprised to see the women sit thus. The women narrated their ordeal to him. He removed the clothes covering the baby and found that she was dead. He informed the hospital staff at which they declared the baby dead. They handed over a reference certificate to the family and asked them to go away; no other documents were provided. By early morning the remaining members of the family came to the CHC and they raised a hue and cry over the turn of events. Later they filed a complaint against the doctor and the ANM in Kumarkhand police station, pleading for action to be taken against them.

Gagan Kumar was not provided any documents while leaving the hospital. He took his wife and the infant's body home in an auto rickshaw, which cost him Rs. 400. The infant's last rites were conducted on 27-08-2019. Pooja Devi was paid Rs. 1400 as incentive under the JSY scheme.

The news of the event appeared in a local newspaper as well as in an online news website. The Station in Charge of Kumarkhand police station questioned the doctor, Dr. Arun Kumar and nurses Kanchan Kumari and Uma Kumari. They denied having demanded money for treating the baby. However, they had no answer for why the baby was removed from the baby warmer all of a sudden. In spite of the police complaint, no action was against the hospital staff nor was the family provided any compensation.

मौत, हंगामा

सामुदायिक स्वास्थ्य केंद्र में नवजात की मौत

कुमारखंड. सामुदायिक स्वास्थ केंद्र में प्रसव के बाद नर्स को एक हजार रुपया नहीं देने पर आईसीयू के वार्मर में रखे नवजात को वार्मर से बाहर निकाल दिया. वार्मर से निकालने के कुछ देर बाद नवजात ने दम तोड़ दिया. इसे लेकर परिजनों ने अस्पताल में हंगामा किया तथा ड्यूटी पर तैनात एएनएम व चिकित्सक के विरुद्ध थाने में आवेदन देकर कार्रवाई की मांग की है. कुमारखंड पंचायत के वार्ड एक रामनगर टोला निवासी गगन ऋषिदेव पत्नी पूजा देवी को प्रसव कराने के उद्देश्य से सोमवार की शाम सामुदायिक स्वास्थ केंद्र में भर्ती कराया था. इस दौरान पूजा ने बच्ची को जन्म दिया. बच्ची का वजन कम था व शारीरिक रूप से कमजोर थी, जिसे तत्काल आईसीयू के वार्मर में रखा गया था. जननी कक्ष में तैनात एएनएम कंचन कुमारी व उमा कुमारी ने गगन ऋषिदेव से एक हजार रूपये की मांग करते हुये रूपया नहीं देने पर सदर अस्पताल रेफर कर देने का भय देखाना शुरू कर दिया. पैसा देने में आनाकानी करने पर नव जात शिशु को आईसीयू के वार्मर से बाहर निकाल दिया. वार्मर से बाहर आते ही नवजात कुछ देर के बाद दम तोड़ दिया. नवजात के दम तोड़ते ही दर्जनों दलित समुदाय के लोग सामुदायिक स्वास्थ केंद्र कुमारखंड पहुंचकर हो हंगामा किया. इस दौरान लोगों के समझाने बुझाने पर परिजन शांत हुये. नवजात के मौत की घटना को लेकर पुलिस ने भी अस्पताल पहुंचकर छानबीन की. इस संबंध में एएनएम कंचन कुमारी ने कहा कि मैं जननी या उनके परिजनों से किसी प्रकार की कोई मांग नहीं किया और नहीं किसी प्रकार का भय दिखाया है.

जयपाल पट्टी के एक क्लिनिक ले गये. इसके बाद इलाज नहीं होने के तीसर

दलाल अस्पताल प्रशासन के सामने मरीज को ठगते हैं. इसका खामियाजा

News of the incident in 'Prabhat Khabar', Madhepura, dated 28-08-2019

हिंदी न्यूज / बिहार / मधेपुरा

मानवता शर्मसार: 1000 रुपये के लिए नवजात को दी ऐसी सजा, तड़पकर हो गई मौत

Publish Date Wed, 28 Aug 2019 03:44 PM (IST)

DEMO PIC

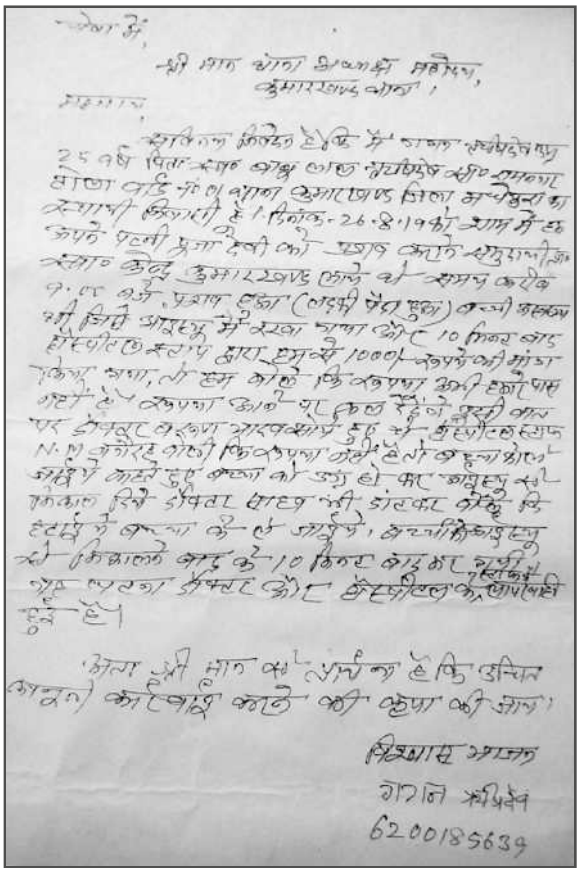
मधेपुरा जिले में एक अस्पताल में मानवता को शर्मसार करने वाली घटना सामने आई है। मात्र एक हजार रुपये के लिए नवजात को एएनएम ने वार्मर से बाहर निकाल दिया जिससे उसकी मौत हो गई।

मधेपुरा, जेएनएन। जान बचाने के लिए बने अस्पतालों में मौत का खेल खेला जा रहा है। मधेपुरा जिले के सामुदायिक स्वास्थ्य केंद्र, कुमारखंड में एक नवजात की जान हजार रुपये से भी सस्ती है। परिजनों ने एएनएम को हजार रुपये देने से आनाकानी की तो आइसीयू के वार्मर में रखे गंभीर बच्चे को बाहर निकालकर रख दिया गया। वार्मर से बाहर निकालने के कुछ ही देर में नवजात ने दम तोड़ दिया। उसके बाद परिजनों ने कुमारखंड थाना में एएनएम और चिकित्सक के विरुद्ध आवेदन देकर कर कार्रवाई की मांग की है। जानकारी के अनुसार कुमारखंड पंचायत के वार्ड संख्या एक रामनगर टोला निवासी गगन ऋषिदेव की पत्नी पूजा देवी को प्रसव के लिए सोमवार को केंद्र में भर्ती कराया गया था। पूजा ने बच्ची को जन्म दिया। जन्म के दौरान बच्ची का वजन कम था और शारीरिक रूप से कमजोर थी। उसे तत्काल आइसीयू के वार्मर में रखा गया।

परिजन ने आरोप लगाया कि जननी कक्ष में तैनात एएनएम कंचन कुमारी और उमा कुमारी ने पिता गगन ऋषिदेव से एक हजार रुपये की मांग की। रुपये नहीं देने पर सदर अस्पताल रेफर करने की बात कही जाने लगी। इसके बाद परिजनों पर रुपये के लिए दबाव डालने के लिए नवजात शिशु को आइसीयू के वार्मर से बाहर निकाल दिया। वार्मर से बाहर आते ही नवजात ने कुछ ही देर के बाद दम तोड़ दिया। नवजात के दम तोड़ते ही दर्जनों लोग सामुदायिक स्वास्थ्य केंद्र, कुमारखंड पहुंचकर हंगामा किया। नवजात की मौत की घटना को लेकर कुमारखंड पुलिस ने भी अस्पताल पहुंचकर छानबीन की। इस सम्बन्ध में एएनएम कंचन कुमारी ने कहा कि उन्होंने किसी से कोई मांग नहीं की। हालांकि इस बात का कोई जवाब नहीं दिया कि एक दिन के गंभीर नवजात को आखिर वार्मर से बाहर क्यों रखा गया।

Posted By: Kajal Kumari

News of the incident in an online publication



Copy of Complaint filed in Kumarkhand police station

GUIDELINES & SCHEMES

National Health Mission

In 2013, the Centre Government launched the National Health Mission (NHM) as an umbrella program with two main prongs: the National Rural Health Mission (NRHM), first launched in 2005, and the National Urban Health Mission (NUHM). The purpose of these schemes is to improve health infrastructure and health outcomes in India's rural and urban areas. A major focus of the NRHM is improving maternal and infant health, which is revealed in the NRHM Service Guarantees. Reducing the maternal and infant mortality is a key goal for Reproductive and Child Health Programme under the National Rural Health Mission (NRHM). Several initiatives have been launched by the Ministry of Health and Family Welfare (MOHFW) under the Mission including Janani Suraksha Yojana (JSY), a key intervention that has resulted in phenomenal growth in institutional deliveries with more than one crore women being benefited from the scheme annually. JSY was launched to promote institutional deliveries so that skilled attendance at birth is available and women and new born can be saved from pregnancy related deaths. However, even though institutional delivery has increased significantly, out of pocket expenses being incurred by pregnant women and their families are significantly high. This often has a major barrier for the pregnant women who still deliver at home as well as for sick neonates who die on account of poor access to health facilities. Another initiative is Janani Shishu Suraksha Karyakram (JSSK) which is aimed at providing cashless institutional delivery.

a) Janani Suraksha Yojana (JSY)

Since its implementation in 2005, the JSY scheme has aimed to reduce maternal and neonatal mortality by providing women with conditional cash assistance for registering their pregnancies and choosing institutional delivery. All women are eligible for JSY benefits, regardless of their age or number of children. To receive JSY benefits, women must present a JSY card and a referral slip from an Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM), or Medical Officer (MO). JSY guidelines specify that a woman's state of residency (not the state in which she delivers) determines the amount of the JSY cash benefit. Therefore, even though many women in India return to their mother's home to deliver, which may be located in another state, these women must be given a JSY payment at the rate of their own home state.

JSY BENEFIT FOR INSTITUTIONAL DELIVERIES (in Rupees)

	Rural			Urban		
Category of States	Assistance to mother	Assistance to ASHA	Total	Assistance Mother	Assistance to ASHA	Total
LPS*	1400	600	2000	1000	400	1400
HPS**	700	600	1300	600	400	1000

* Low Performing States (LPS) include Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and Uttaranchal.

** High Performing States (HPS) include all states that are not LPS.

b) Janani Shishu Suraksha Karyakram (JSSK):

Through the NHM, the government also coordinates the JSSK scheme, which the Government launched in June 2011 as a means of eliminating out-of-pocket expenses incurred by pregnant women and sick newborns, which are "without doubt, a major barrier" for pregnant women and children, many of whom "die on account of poor access to health facilities." Therefore, the JSSK scheme provides that pregnant women seeking institutional delivery and sick new-borns until 30 days after birth are entitled to absolutely free care in all government health facilities. JSSK services are available to all women who deliver in government health facilities, regardless of age, number of children, or economic status. These free JSSK services include delivery (including Caesarean section), medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery and 7 days for Caesarean section), free transportation to and from the facility (and between facilities in cases of referral), and exemption from all user charges. The JSSK scheme provides essentially the same free services to sick new-borns that are available to pregnant women.

c) Mamta

Mamta is a state sponsored scheme which seeks to reduce the Infant Mortality Rate (IMR) and MMR, by insisting on post-delivery hospital stay for 48 hours of the mother and new born. Any complication arise during this period is attended by skilled doctors available at the government hospital.

Convention on the Rights of Child

India has ratified with the United Nations Convention on the Rights of Child and as a signatory it is imperative for India to protect the children of the country.

Article 3 of the convention states that:

1) In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2) States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3) States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform to the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

VIOLATIONS OF RIGHTS

- Pooja Devi was not provided ANC at her village because there was no anganwari centre there. Workers from neighbouring village too did not visit her to provide services or guidance. This is in violation of Guidelines for Ante Natal Care laid down by the Ministry of Health and Family Welfare (MOFHW) that all pregnant women must be monitored systematically and provided four ANC with all components such as investigations for blood pressure, Hb, abdominal examination to monitor foetal health, provision of iron tablets, vaccinations, etc. All ANC guidelines as laid down by the MOHFW have been flouted.
- Under Janani Suraksha Yojana, a pregnant woman is to be provided transport to and from the hospital for delivery. Pooja was taken to the CHC and back by tempo, the fare for which was paid by her husband. JSY guidelines have been violated
- Pooja's and Gagan's child's right to survival as guaranteed in the 'Convention on the Rights of Child' (to which India is a signatory) has been violated.
- The Child's right to life as laid down by article 21 of the Indian Constitution has been violated.
- Under the Janani Shishu Suraksha Yojana (JSSK) sick new-borns are entitled to free health care in all government facilities. This right was violated by the nurse who demanded money for treatment of the baby.
- Mamta is a state-sponsored scheme which seeks to reduce the Infant Mortality Rate (IMR) and MMR, by insisting on post-delivery hospital stay for 48 hours of the mother and new born. Any complication

arises during this period is attended by skilled doctors available at the government hospital. The scheme guidelines have been violated in the case of Pooja and Gagan's child.

RECOMMENDATIONS

1. Ensure that immediate action is taken against the erring staff of the CHC who committed the egregious error of denying care to a sick new-born
2. Ensure that there is enough awareness among the poorest and marginalized communities about health services and their rights so that they can demand services and question lack of the same. Governments must make special efforts to reach out to such communities through special campaigns and provide the whole range of health services in areas where they live
3. Ensure that adequate compensation is provided to the family to cope with their loss and the trauma suffered by them.
4. Sensitise field level and higher-level health staff to act with empathy and respond effectively to health seekers, especially the poor and marginalised.

CONCLUSION

This most unfortunate case is evidence of the sorry state of the state health care system. It failed to provide adequate care to Pooja and Gagan's family – a family belonging to a poor, vulnerable community that cannot afford any other care. It is shocking that the staff of the government CHC demanded money for treatment of a sick new-born when such care is absolutely free in all government facilities. In spite of several schemes and guidelines to ensure the health of the population, many communities, especially the poorest, continue to be deprived of services due to lack of implementation.

The family has received neither compensation nor justice as no action has been taken against the erring health care staff in spite of a police complaint against them.

List of Acronyms

AAMC	Aam Aadmi Mohalla Clinic
AES	Acute Encephalitis Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwari Centre
AWW	Anganwari Worker
AYUSH	Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BPL	Below Poverty Line
CBHI	Community Based Health Insurance
CEDAW	Convention on the Elimination of all form of Discrimination Against Women
CES	Centre for Equity Studies
CFR	Case Fatality Rate
CHC	Community Health Centre
CMO	Chief Medical Officer
CRC	Convention on the Rights of the Child
DGO	Diploma in Gynaecology and Obstetrics
DQAC	District Quality Assurance Committee
EAG	Empowered Action Group
EMO	Emergency Medical Officer
EMT	Emergency Medical Technician
FPIS	Family Planning Indemnity Scheme
FRU	First Referral Unit
GNM	General Nursing Midwife
HDI	Human Development Indexe
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSC	Health Sub-Centre
ICCPR	International Covenant on Civil and Political Rights
ICDS	Integrated Child Development Services
ICESCR	International Covenant on Economic Social and Cultural Rights
ICU	Intensive Care Unit
IGIMS	Indira Gandhi Institute of Medical Sciences

IPHS	Indian Public Health Standards
IUD	Intra Uterine device
IV	Intravenous
JEV	Japanese Encephalitis Virus
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojna
LHV	Lady Health Visitor
LPS	Low Performing States
LT	Laboratory Technician
MDSR	Maternal Death Surveillance and Response
MGEL	Manipur Government Employment List
MMR	Maternal Mortality Rate
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MPW	Multi-Purpose Worker
MRgFUS	MRI guided Focused Ultrasound Surgery
MRI	Magnetic Resonance Imaging
NFHS	National Family Health Survey
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
NULM-SUH	National Urban Livelihood Mission Scheme of Shelter for Urban Homeless
NVBDCP	National Vector Borne Disease Control Programme
OCP	Oral contraceptive pill
ORS	Oral Rehydration Solution
PDS	Public Distribution System
PHC	Primary Health centre
PIPs	Program Implementation Plans
PNC	Post Natal Care
PPIUD	Postpartum Intra Uterine Device
RCH	Reproductive and Child Health
RSBY	Rashtriya Swasthya Bima Yojna
RTIs	Reproductive Tract Infections

SBA	Skilled Birth Attendant
SC	Schedule Caste
SC	Sub-centre
SDGs	Sustainable Development Goals
SNCUs	Special New-born Care Units
SOP	Standard Operating Procedure
SQAC	State Quality Assurance Committee
SRS	Sample Registration System
ST	Schedule Tribe
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
VDRL	Venereal Disease Research Laboratory Test
VHND	Village Health & Nutrition Day

Annexure

Annexure-1

Department of Health and Family Welfare
Government of Karnataka

26th April 2016

Guidelines on Hysterectomy as Choice of Treatment

Hysterectomy is the treatment of choice for only certain gynecologic conditions. The predicted advantages must be carefully weighed against the possible risks of the surgery and other treatment alternatives. In the properly selected patient, the result from the surgery should lead to improvement in the quality of life. For benign conditions of the uterus, alternatives to hysterectomy should be mandatorily offered especially when the woman is less than 40 years.

Two consultants should agree and document their consent for hysterectomy if the woman is less than 40 years of age. The woman should be counseled thoroughly prior to planning the surgery. The practitioner should discuss the short- and long-term implications of hysterectomy and or bilateral salpingo-oophorectomy and document when counseling a woman for hysterectomy. The risk of premature ovarian failure(20%) inspite of conserving the ovaries should be clearly understood by the practitioner before subjecting the lady for hysterectomy.

There should be enough evidence to justify hysterectomy eg- failure of medical treatment and there should be clear documentation of what other treatments have been tried. The indication for hysterectomy should fall into one of the categories listed below and the indication should be clearly documented.It is now recommended that ovaries are not removed upto the age of 65 years for benign conditions (exclusion -severe pelvic endometriosis, family history of ovarian cancer)

A. Indications for Hysterectomy

1. Benign Disease

    a. Leiomyomas:

        i. Asymptomatic fibroids should be left alone if the uterus is less than 14 weeks size clinically (less than 800grams on Ultrasound scan)

        ii. For symptomatic fibroids, hysterectomy provides a permanent solution to menorrhagia and the pressure symptoms related to an enlarged uterus. (I-A)However myomectomy should be considered as an option in younger woman and or desire fertility

    b. Abnormal uterine bleeding: Endometrial lesions must be excluded and medical alternatives should be considered as a first line of therapy. (III-B)

    c. Endometriosis: Hysterectomy is often indicated in the presence of severe symptoms with failure of all other treatments- medical and or conservative surgical procedures and when fertility is no longer desired. (1-B)

d. Pelvic organ prolapses: A surgical solution usually includes vaginal hysterectomy, but must include pelvic supporting procedures. (II-B) In women less than 40 or desirous of fertility, uterus preserving surgeries with Fathergills, slings etc to be considered.

e. Pelvic pain: A multidisciplinary approach is recommended, as there is little evidence that hysterectomy will cure chronic pelvic pain. When the pain is confined to dysmenorrhea or associated with significant pelvic disease, hysterectomy may offer relief. (II-C)

2. Pre-invasive Disease

   a. Hysterectomy is usually indicated for endometrial hyperplasia with atypia. (I-A)

   b. Cervical intraepithelial neoplasia is not an indication for hysterectomy. (I-B)

   c. Simple hysterectomy is an option for treatment of adenocarcinoma in situ of the cervix when invasive disease has been excluded. (I-B)

3. Invasive Disease 1. Hysterectomy is an accepted treatment or staging procedure for endometrial carcinoma. It may play a role in the staging or treatment of cervical, epithelial ovarian, and fallopian tube carcinoma. (I-A)

4. Acute Conditions

   a. Hysterectomy is indicated for intractable postpartum hemorrhage when conservative therapy has failed to control bleeding. (II-B)

   b. Tubo-ovarian abscesses that are ruptured or do not respond to antibiotics may be treated with hysterectomy and bilateral salpingo-oophorectomy in selected cases. (I-C)

   c. Hysterectomy may be required for cases of acute menorrhagia refractory to medical or conservative surgical treatment. (II-C)

B. Complications of a hysterectomy

As with all types of surgery, a hysterectomy can sometimes lead to complications.Some of the possible complications are described below.

1. General Anesthetic: It is very rare for serious complications to occur after having a general anesthetic (1 in 10,000 anesthetics given).Serious complications can include nerve damage, an allergic reaction, and death. However, death is very rare – there is a 1 in 100,000 chance of dying after having a general anesthetic.

2. Bleeding:As with all major operations, there is a small risk of heavy bleeding (haemorrhage) after having a hysterectomy.

3. Ureter damage:The ureter may be damaged during surgery, which happens in around 1% of cases. This is usually repaired during the hysterectomy.

4. Bladder or bowel damage:In rare cases, damage to abdominal organs such as the bladder or bowel can occur. This can cause problems such as infection, incontinence or increased frequency. It may be possible to repair any damage during the hysterectomy. Might need for a temporary colostomy.

5. Infection:There is always a risk that an infection will develop after an operation. This could be a wound infection or a urinary tract infection.

6. Thrombosis:The risk of developing deep venous thrombosis increases after having operations and periods of immobility.Considerthromboprophylaxis with Inj. Heparin 5000 units twice a day SCor Low molecular weight heparin egEnoxapain 40mg once a day SC

7. Vaginal problems:Vault prolapsed especially after a prolapse surgery

8. Ovary failure/ Early menopause: Even if one or both ovaries are left intact, they could fail within five years of having hysterectomy. This is an important consideration if woman is under the age of 40, because early onset of the menopause can increase risk of developing brittle bones (osteoporosis) and cardiovascular problems

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