FACT FINDING MISSION REPORTS ON REPRODUCTIVE RIGHTS

Human Rights Law Network 2017

HRLN
HUMAN RIGHTS LAW NETWORK

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These publications would not have been possible without the continued efforts of the reproductive rights team, namely Sarita Barpanda, Debashish Mohanta, Sanjai Sharma, Deepak Kumar Singh, Zahra Wynne, Sangeeta Banerjee, Shaoni Mukherjee, and Monalisa Barman.

Finally, we would like to thank HRLN's founder Colin Gonsalves, for his constant, fierce, unapologetic work on behalf of all marginalized and vulnerable communities in India for the past three decades.

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Introduction

Human Rights Law Network (HRLN) is an organization comprising of social activists,researchers, and lawyers. HRLN works to uphold a myriad of rights, including women's rights, prisoner's rights, the rights of sexual minorities, and refugee rights. A large part of the organization dedicates itself to upholding reproductive rights and ensuring that people, especially women, adolescents, and girls, have bodily autonomy. Upon this belief, the Reproductive Rights Initiative (RRI) was founded.

In 2016, the European Union began contributing funds to the RRI, and the 3-year EU-RRI project began with HRLN partnering with Prayas, a Rajasthan-based NGO. During this project, HRLN is working to upholding reproductive rights by working on variety of issues, including, but not limited to: access to contraception, safe abortion services, ending child marriage, maternal health, HIV/AIDS, quality of care, infant health, preventing disrespectful and abusive healthcare, and working to stop obstetric violence. In order to do this, HRLN sends its social activists to the field to conduct fact finding missions on rights violations, which it then uses to file public interest litigation petitions in State High Courts and the Supreme Court, aided by background research collected by researchers. In addition to this, HRLN designs and disseminates awareness campaign materials in English, Hindi, and local languages, to ensure that people are aware of their rights and able to enforce them when necessary.

Although HRLN works across India, the EU-RRI has a specific focus on 10 states: Assam, Arunachal Pradesh, Bihar, Chhattisgarh, Delhi, Manipur, Madhya Pradesh, Nagaland, Odisha, and Rajasthan. A substantial amount of work has also recently been carried out in Uttar Pradesh due to an influx of negligence cases in healthcare settings that caused multiple infant fatalities. As HRLN is an organization that operates under an intersectional praxis, fact findings are often conducted in impoverished districts and villages, where those who have experienced rights violations are often members of Scheduled Tribes and Castes. These are the people who consistently suffer from coercive population control tactics, the denial of family planning services, and discrimination in the healthcare setting – their financial and educational background renders them unable to use the legal route to challenge rights violations. HRLN and Prayas are using the EU-RRI project to empower communities to both recognize and claim their rights.

Over 100 fact finding reports have been conducted in 2017, leading to some incredibly progressive and strong petitions being filed. This publication consists of 10 fact finding reports, which were conducted in a range of states and cover a range of issues. This should enable the reader to have a nuanced view on the RRI's work and its normative approach to violations of reproductive rights.

HRLN is extremely grateful to the European Union for their continued support, and looks forward to the following two years of working to uphold reproductive justice.

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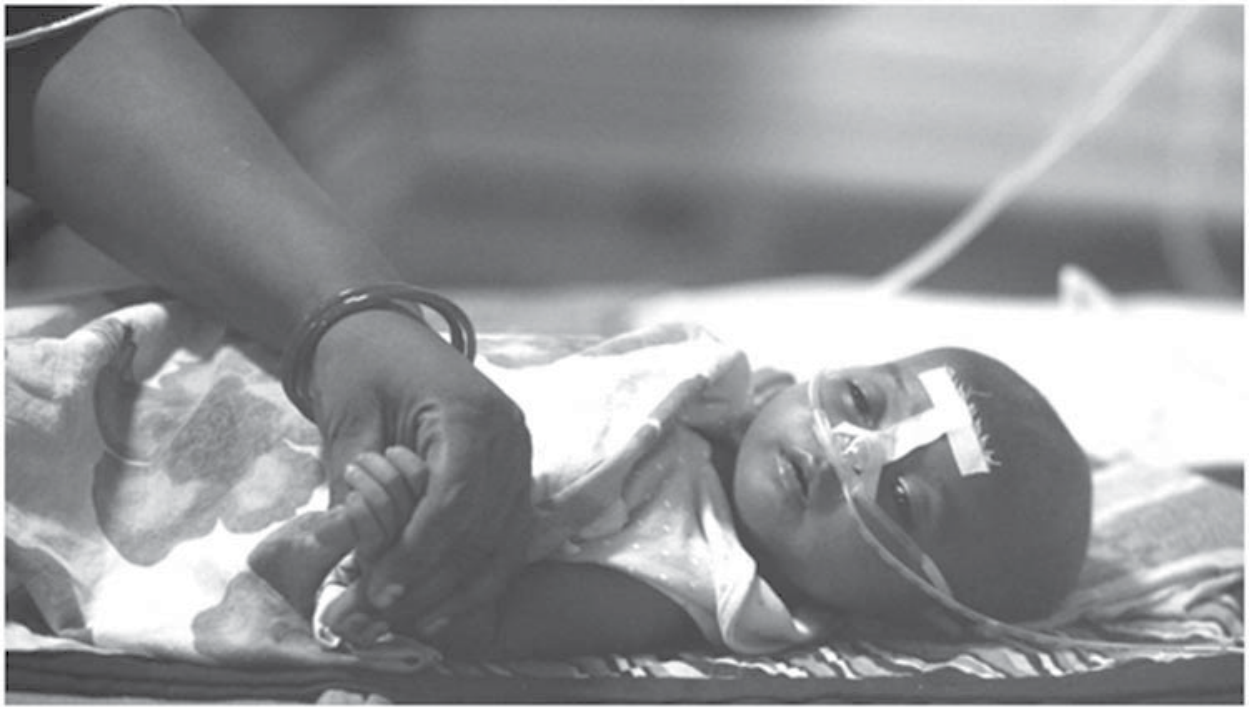

Tragedy strikes UP again : Horrific Farrukhabad Incident

Fact-finding Exercise in the Villages of Farrukhabad, Uttar Pradesh

HRLN Representatives: Aman Khan, Advocate; and
Shaoni Mukherjee, Researcher

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After the shocking Gorakhpur tragedy that occurred in August 2017, news emerged of a similar incident in Farrukhabad, another district in Uttar Pradesh. In Gorakhpur, more than 100 children lost their lives due to medical negligence. Now, in Farrukhabad, newspapers are again filled with accounts of 49 deaths that occurred in Farrukhabad Govt. Hospital (Ram Manohar Lohia Hospital) between July 21 and August 20, 2017.[1]

Uttar Pradesh has the second highest maternal mortality ratio (MMR) in India, at 258 deaths per 100,000 live births[2], as well as the highest infant mortality rate (IMR) of 64 deaths[3] per 1000 live births, and 78 deaths per 1000 live births when it comes to children under-5. Farrukhabad itself has a staggering IMR of 78, and an under-5 Mortality Rate of 54 per 1000 live births. Farrukhabad, a rural district situated in northern Uttar Pradesh has many children dying due to diarrhea, anemia, and respiratory infections, making it necessary to shed light on the hazardous environmental conditions in this district. A mere 6.9% of children in Farrukhabad receive an adequate nutritional diet. 38.7% of children are diagnosed with anemia, 31.4% are underweight, and a staggering 49.10% have stunted growth[4]. The figures reflect the dire situation of this district, especially regarding the health of infants.

August 2017 onwards, Gorakhpur, another district in the state of Uttar Pradesh witnessed the deaths of more than 100 children within a week due to medical negligence in the treatment of a potentially fatal disease, Acute Encephalitis, and the lack of oxygen supply needed for its treatment. Subsequently, Farrukhabad fell prey to a similar situation, where 49 children died in the span of a month. The media reported that these children too suffered the same fate of those in Gorakhpur, where there was a lack of oxygen supply, and that this incident related not to Encephalitis but to easily treatable issues such as premature delivery and breathing complications.

"Mortality in such children is quite high. Often, we get children who weigh less than a kilo or two kilos. At times, the children are born with complications or there is a delay in being referred to the hospital from primary health centres. All these are the reasons [for their deaths]," remarked Dr Kailash Kumar, the SNCU in-charge, Ram Manohar Lohia Hospital[5].

A Chief Judicial Magistrate of Farrukhabad himself filed an FIR against the Chief Medical Officer (CMO) and Chief Medical Superintendent (CMS) and a senior child specialist of the Ram Manohar Lohia (RML) district hospital and took the case suo moto, alleging the unavailability of oxygen supply in the hospital and ordered a probe into the matter. The doctors, in response, went on a strike to protest against the FIR and criminal case against them.

Whilst the investigation in the criminal case is going on, a public interest litigation petition has been filed by Human Rights Law Network in order to address the grievance before the Allahabad High Court.

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1. Hindustan Times (Dated- 1st Sept, 2017), Article – "http://www.hindustantimes.com/india-news/up-49-children-die-in-far-rukhabad-govt-hospital-in-a-month-dm-order-probe/story"

2. Newslaundry.com (Dated- 5th Sept, 2017), Article – "https://www.newslaundry.com/2017/09/05/gorakhpur-far-rukhabad-in-fant-mortality"

3. Source: National Family Health Survey, 2015-16 (NFHS-4)

4. Ibid.

5. Hindustan Times (Dated- 1st Sept, 2017), Article – "http://www.hindustantimes.com/india-news/up-49-children-die-in-far-rukhabad-govt-hospital-in-a-month-dm-order-probe/story"

METHODOLOGY

Aman Khan, a HRLN representative, conducted a fact - finding mission in Farrukhabad over the course of three days between September 7 and 10, 2017. The methods used for research consisted of qualitative, informal, unstructured interviews with various groups of people associated with the incident to gain a nuanced view of what occurred, why it occurred, and what the response was. Aman visited the houses of the victim's families and interacted with medical officials from the PHCs, Lohia Hospital, private hospitals, and also spoke to journalists who covered the incident.

PURPOSE OF THE VISIT

- The primary need was to ascertain the cause of death of the children in Farrukhabad.
- An additional issue to address was ascertaining the reasons behind the high Infant Mortality Rate in the district.
- It was also necessary to understand the role of private hospitals and government hospitals, regarding both the incident and relating to infant health in Farrukhabad in general.

LIMITATIONS

Limitations of the fact-finding mainly consisted of the three-day time constraint and the geographical constraint, since the affected families were spread across entire district. Considering this, covering the entire district within three days was difficult. Research was also constrained by refusal of doctors and nurses to cooperate with the investigation; they would not entertain any questions by the researcher.

FINDINGS

The following are the observations and conclusions reached from the research conducted by engaging with all of the stakeholders and litigation respondents during the field visit.

The situation at Lohia Hospital

At first glance, Lohia Hospital appeared like any other government hospital, however the lack of patients there became apparent very quickly. The hospital is a huge building with plenty of rooms, several doctors, and an adequate amount of equipment, but there were hardly any patients. This seemed highly unusual given the general state of affairs in Uttar Pradesh government hospitals, where overcrowding is rife. In Gorakhpur, overcrowding was a crucial problem and the previous Chief Minister of UP, Akhilesh Yadav, had sanctioned the construction of new ICU with 100 beds.

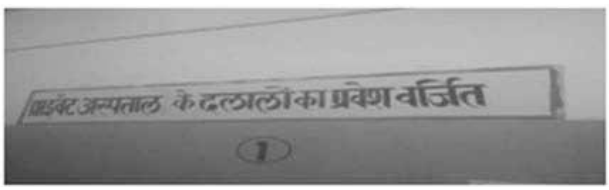
The doctors and nurses at Lohia Hospital categorically refused to entertain any of our questions. Our team was not allowed to see the Neonatal Intensive Care Unit (NICU) ward. The labor room and other rooms appeared to be almost empty. This can be seen in the photos of the hospital taken during the field visit, annexed herewith.



The empty hospital premises during the busiest time of the day

Surprisingly, we were told that it was the first time over years that Lohia Hospital was witnessing such a huge crowd, which seemed bizarre since there were hardly any patients there. The deserted hospital had many signboards situated around the premises. The most prominent of them were "Private aspatalo ke dalalo ka pravesh varjit" ('Brokers of Private Hospital are not allowed') and "Kisi ke behkawe me aakar apna mareez private hospital me na le jayein, is aspatal ki saari sewayein nishulk hain" ('Don't be lured into taking your patient to private hospital, this hospital has all the facilities and one can avail them free of cost').

The signs are ironic. The actual problem faced by the hospital is not only competition from private hospitals, but also presence of brokers who solicit almost all patients and take them to private hospitals nearby.

The hospital with signs saying, "Don't get lured by brokers of private hospitals", whereas this was, in reality, the exact practice several staff indulged in

TESTIMONIALS BY FAMILIES

1. PLACE: Mehmadur Amaliya (From Sadar Block, Farrukhabad)

Child: Three-day-old, Name of Child: Unnamed,

Date of Birth (DOB): 25/08/2017, 10 PM

Date of Death (DOD): 28/08/2017, 5 AM

Names of hospital where admitted: Care Hospital, then moved to Lohia Hospital

Testimony given by Akhilesh Kumar (father):

"My wife was admitted in Care Hospital. My child was born at 10 pm, and at around 3 am, doctors told me that he had a heart problem and asked me to take him to Lohia Hospital for further treatment. I took my child immediately to Lohia Hospital. I gave Rs 300 to get him admitted while my wife remained in Care Hospital. I don't know what happened to my child because I was never allowed to go inside the ICU. Only my mother was allowed to go inside once only to wash up the child. My child needed oxygen and nurses would ask me to pay them for putting my child on oxygen. My mother paid them Rs 500 to put him on oxygen but they removed it after some hours. She again gave them Rs 300 to put him on oxygen again. We were not provided with any ambulance after my son was declared dead at 5 am."

2. PLACE: Pattiya Cheda Singh (From Sadar Block: Kamalganj, Farrukhabad)

Child: Three-day-old, Name of Child: Unnamed,

Weight of Child: 1.5 kilogram

DOB: 21/08/2017, 10:30 PM

DOD: 24/08/2017, 11 PM

Names of hospital where admitted: CHC Kamalganj, then moved to Care Hospital, then moved to Lohia Hospital

Testimony given by Virendra Singh (father):

"I took my wife to CHC, Kamalganj and one of the nurses who came to attend her referred us to a private hospital named Care Hospital and not Lohia Hospital, saying that C-section was required in the case and that normal delivery was not possible. I admitted my wife to Care hospital and just one hour after my child's birth, he was referred to Lohia

Hospital. I immediately took my child to Lohia Hospital at 11 pm, where I was told that doctors were not present and hence we were there for the whole night without any medical attention. My child was recovering, and on 24/08/2017, doctors asked us to bring breast milk to feed the child the next morning. My wife was still admitted in Care Hospital. Then I don't know what happened, but my child was suddenly pronounced dead at 11 pm. I did not see any oxygen or saline being given to my child. I got the death certificate but since it was of no use for me, I tore it up. I was not provided any ambulance to carry my child. Over the past three years, I have lost three sons just after birth."

3. PLACE: Bhikampura (Block: Balpur, Farrukhabad)

Child: Female, Named of Child: Unnamed

Weight of Child: 2.5 kilograms

DOB: Unknown

DOD: Unknown (died within 12 hours of birth)

Names of hospital where admitted: Care Hospital and then to Lohia Hospital

Testimony given by Khalid (father):

"We went to Lohia Hospital at around 3 am but were refused admission. A lady doctor said, "Ja ja le ja, yaha kya marne ke liye layi hai?" ("Take her back, have you brought her here to be killed?") Then the next day at 3 pm, a nurse took us to Care Hospital. There, my child was delivered through C-section at 9 pm and immediately we were asked to admit our child in Lohia, because of breathing complications. Within 15 minutes, we admitted our child to Lohia Hospital. After sometime, my child started crying and moved around, but at around 12 or 1 am, we were told that had died. However, my mother-in-law noticed that the baby was still alive and brought this to the my child attention of doctors, after which, she was put on oxygen again and regained movement. But the next day, at 9 am, she died."

Testimony given by grandmother:

"All the doctors and nurses were very angry. Previously, the child had been taken to Lohia Hospital but nobody paid attention so we had to go to a private hospital. We never got any money for delivery and no ambulance was provided. While we went to admit our daughter to Lohia, they asked us to submit Rs 5,000 and arrange for five bottles of blood. After that, there was no one to attend to us. A nurse told us that if we paid Rs 7,000, she would take us to a good private hospital which we had to agree to and she took us to Care hospital. I am ready to identify the nurse for you. After the child died, my husband insisted for the relating documents, but we were denied them. After the death of the child, we did not even inform the mother, so that she wouldn't cry and her stitches wouldn't open up."

Testimony given by grandfather:

"Lohia Hospital is full of brokers; everyone there kept dragging us into the private hospitals. My daughter-in-law was in pain but was kept unattended and hence, I took her to a private hospital. We spent around Rs 25,000."

4. PLACE: Kamalganj, Farrukhabad

Child: Four-day-old; Name of Child: Unnamed,

Weight: 2.5 kilograms

DOB: 19/08/2017, 11 PM

DOD: 23/08/2017, 1:30 PM

Hospitals Admitted: Unnamed private nursing home, and then moved to Lohia Hospital.

Testimony given by Mohd Jamal (father):

"I admitted my wife to a private hospital. My child had a little breathing problem when she was born. The doctors asked me to take her to Lohia Hospital, where I admitted her but nobody gave her any attention. The nurses were chatting all the time over the phone and there was another child with ants crawling all over him. Whenever I complained, the nurses yelled at me and asked me to take my child back home. They did not allow us inside the NICU. My child was put on oxygen, and then given an ambu bag. Meanwhile, my wife was still admitted in the private hospital. The nurses in Lohia behaved inhumanely. No ambulance was provided and after my child died, I was asked to take her away immediately. I spent around Rs 35,000 in a private hospital. In Lohia, I paid Rs 400 and paid for injections, etc."

5. PLACE: Kamalganj, Farrukhabad

Child: Four-day-old, Name of Child: Unnamed,

Weight: 2.5 kilograms

DOB: 07/08/2017, 6 AM

DOD: 07/08/2017, 11 PM

Hospitals Admitted: Lohia Hospital, then moved to a Siddharth Hospital

Testimony given by Rajesh Kumar (Father):

"We went to Lohia hospital but nobody paid attention to us. They just gave pills to the child and said that if pain doesn't stop, go home. A nurse told us that the government hospital was 'bekaar' ('useless') and that it would be better if we went to a private hospital. Then, an ASHA named Mamta took us to Siddharth Hospital where we stayed for five days."

6. PLACE: Kori Kheda, Kamalganj (Farrukhabad)

Child: Four-day-old, Name of the child: Unnamed,

DOB: 10/07/2017, 10 AM

DOD: 14/07/2017, 9 AM

Hospitals Admitted: Lohia Hospital, then moved to a private hospital and back to Lohia Hospital

Testimony given by Veer Pal (father):

"We went to Lohia Hospital on July 9, but they refused to take us in saying that it was our third child and hence, no operation would be done there and so, the next day, I took her to Natraj Hospital through an ASHA worker at around 8 am. My child was delivered at around 10 am. He was born healthy, but on July 13, the doctors told me that child had diarrhea, and he was referred to Lohia hospital. The nurses there kept abusing and shouting at us, and proper medical attention was not given. My child eventually died."

7. PLACE: Tukariya Nagla, Patia Cheda Singh (Farrukhabad)

Child: Three-day-old, Name of the child: Unnamed,

DOB: 14/08/2017, 6 PM

DOD: 16/08/2017, 2 PM

Hospital Admitted: CHC, Kamalganj to Lohia Hospital

Testimony given by: Sugriv Kumar (father)

"We went to CHC, Kamalganj, on August 14, where my child was delivered but soon afterwards, he was referred to Lohia Hospital. The nurses and doctors were very careless there, and there were ants crawling all over my child, but nobody paid any attention to him. We were also not allowed to see the child or wipe the ants off. He was admitted to the NICU and was given oxygen, but we were not allowed to see our child even once. The nurses yelled at us. I lost my temper, but my mother held me back from doing anything. At 2pm, on August 16, I lost my child."

8. PLACE: Village: Jahangarpura, Farrukhabad

Child: Three-day-old, Name of the child: Unnamed,

DOB: Unknown

DOD: Unknown

Hospital Admitted: Modern Hospital, then moved to Lohia Hospital

Testimony given by Rizwan (father):

"We had twins, and the delivery was through C-section. They were born at 2 am, and one of the babies was underweight, so we had to immediately take him to Lohia Hospital. He was admitted there for three days, after which he died. I was not allowed to go inside and had to wait outside the entire time. Once my child was pronounced dead, I took him home in private vehicle. There was no ambulance to transport my dead child."

Meeting with the families of the victims

We visited nine families, each of which had lost their children in Lohia Hospital. These visits were the most challenging part of the fact-finding mission. Initially, we couldn't succeed in talking to the hospital authorities since they were on a strike and despite our efforts, we found that no one was willing to speak to us. After visiting the families, we found some common factors which almost everyone suffered from.

The following are the observations that we derived from the testimonials by the families.

A. Shuffle between two hospitals

This was strange but was the case for most of the families visited. Whenever there was a complication during birth of a child in a private hospital, they were referred to Lohia Hospital. The complications mainly consisted of diarrhea and breathing problems. While the child would be admitted to Lohia Hospital, the mothers would remain in the private hospitals.

Most of the families first went to Lohia Hospital but were refused admission. One family was refused admission because it would be the delivery of their third child. Even if admitted, no medical care and attention would be provided to them. Subsequently, the nurses would take them to private hospitals present nearby such as Siddharth Hospital and Care Hospital, despite the numerous signboards in Lohia Hospital cautioning against brokers. It is, therefore, bizarre that the brokers that the hospital is so concerned about are its own staff members. However, if there were any complications during delivery in a private hospital, they would immediately refer the child back to Lohia hospital. Out of the 10 families we spoke to, eight first went to Lohia Hospital but were not admitted and were taken to private hospitals by nurses and ASHAs. Families are therefore being shuffled between private hospitals and Lohia, with neither institution seemingly able to take responsibility for health problems.

B. Weight at the time of birth

Most families reported that their babies weighed less than 2.5 kilograms. This is alarming and reflects the poor health condition of both the mothers and newborn babies. It certainly seems to suggest that pregnant women are not being provided with adequate nutrition, which impacts the newborn as well. Since the babies are underweight, they become susceptible to diseases such as diarrhea, malnutrition and anemia.

C. No provision for medical documents and death certificate

Not a single family that our researcher interviewed had been given medical files relating to the death of their children. No documents signifying the reason of death were issued by hospital authorities. This is similar to what happened in Gorakhpur previously, where dead children were wrapped up in towels and handed to the families without providing death certificates. The sheer negligence, insensitivity and a lack of accepting responsibility is clear.

D. No ambulance services or entitlements under JSY scheme provided

Not a single family interviewed was provided with an ambulance service after their children died, and they had to arrange for transportation themselves, and paid for this out of their own pockets, which goes against government guidelines.

Let us have a look at the provisions the government has provided for the pregnant women and newborns:

National Maternity Benefit Scheme (NMBS):

Under NMBS, there is a provision for payment of Rs 500 per pregnancy to women belonging to poor households for pre-natal and post-natal maternity care up to her first two live births. The benefit is provided to eligible women aged 19 years and above.

Janani Suraksha Yojana (JSY):

The Janani Suraksha Yojana (JSY) launched on April 12, 2005 was implemented by the central government to lure pregnant women to opt for institutional deliveries and in the process, improve maternal health conditions in India.

Janani Shishu Suraksha Karyakram (JSSK):

The Janani Shishu Suraksha Karyakram (JSSK) was launched by the government of India on June 1, 2011.

This scheme supplements the cash assistance given to a pregnant woman under JSY and is aimed at mitigating the burden of out-of-pocket expenses incurred by pregnant women on herself and sick newborns.

The following are the free entitlements for pregnant women:

- Free and cashless delivery
- Free C-section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in medical institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after a stay of 48 hours

Further, the following are the free entitlements for sick newborns till 30 days after birth. This has now been expanded to cover sick infants:

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges

- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from institutions to home

There were some deliveries that took place in Lohia hospital, but here, the families reported that they had not – till the time of the interview -- received entitlements that they were owed under the JSY scheme.

E. Staff behavior and negligence

All the families reported horrific encounters with doctors. According to one family, when a pregnant woman travelled to the hospital (Lohia) to be admitted, a nurse remarked, *"Ja ja le ja, yaha kya marne ke liye layi hai?"* ("Take her back, have you brought her here to get killed?").

According to another family, the nurses were constantly talking on their phones, ignoring and neglecting patients. This is a serious violation of health staff standards.

Another family told our researcher that in Lohia Hospital, their child was covered in ants, but whenever they complained, the nurses yelled at them and asked them to take their child back home. The nurses paid no heed to the ants and simply left the child in that condition. Another family recalled an encounter where the nurse simply gave pills to the baby and told the family to go home if the pain did not subside. This demonstrates shameful, wilful negligence on behalf of the nurses and doctors and a total lack of commitment to the medical profession itself.

The most appalling incident that the researcher came to know about was the case where the hospital staff was so utterly careless that they declared a child dead even though she was alive. Members of the family noticed that their daughter was still alive and brought this to the attention of doctors after which she was admitted again.

Another family recalls a nurse telling them that it was 'bekaar' (useless) to be admitted to Lohia Hospital, and that it would be better if they went to a private hospital. An ASHA named Mamta then took them to Siddharth Hospital, where the child stayed for 5 days. One family said that she was denied admission, with the hospital citing the reason that it was their third child.

F. Corruption

The basic root of all the problems pervasive throughout Lohia hospital is corruption by the hospital staff. If a patient is referred to the hospital, they do not hesitate to ask for undue money and favors which they are in no way entitled to. This is highly immoral and obviously illegal. According to one family, they paid the staff Rs 500 to get oxygen supply for a few hours for their child. Even then, the oxygen supply was removed after a while, and the staff demanded that the family pay Rs 300 to have the supply resumed.

Another family told us that they were asked to submit Rs 5,000 and arrange for five bottles of blood in order for their child to be admitted. Subsequently, a nurse told the family that if they paid her Rs 7,000, she would take them to a good private hospital -- a clear demonstration of corruption. Despite this, the family agreed.

G. History

It is indeed indicative of the grim state of affairs that the death of infants was not a first-time experience for most families. One family lost their third new-born child in three years. Others had also encountered one or two deaths in the past. This shows us that the current situation in Lohia Hospital is not new, and has clearly been continuing for several years.

The emergence of private hospitals in the area

There are several private hospitals and nursing homes in Farrukhabad – easily over a hundred. From the situation reported above, it is clear that private hospitals play an indispensible role in the problems faced by the community there. We found that all the private hospitals were situated very close to Lohia Hospital. Some were as tiny as small houses while others showcased state-of-the-art facilities. WhileLohia Hospital lay empty, the private hospitals were overcrowded, with lines of people waiting in long queues to get scans. There were more than 20 hospitals opposite to the Lohia Hospital, out numbering pharmacies in the vicinity. This seemed bizarre but explained why a government hospital was deserted, especially given the solicitation recorded in Lohia Hospital.

We visited Siddharth Hospital which was so crowded that there was no space to stand in the reception area. We spoke to a doctor and asked whether they referred complicated cases to Lohia Hospital and why. The doctor told us that sometimes, faced with complications in the newborns -- not crying, not being able to breathe properly, etc -- they were immediately transferred to Lohia, since Siddharth hospital did not have equipment such as oxygen machines to deal with such complicated issues in newborns.

We also met a retired doctor from Lohia Hospital. He supported the administration and staff of Lohia hospital vehemently, but when asked about the presence of brokers and solicitation of patients from Lohia to private hospitals, he kept silent, neither confirming nor denying the allegations.

Some private hospitals in Farrukhabad

Requesting to remain anonymous, a journalist from a reputed newspaper told our researcher that private hospitals have always been a problem in the area. The root of the problem, he said, were the nurses and ASHAs who worked as brokers for the private hospitals. Sending most of the patients to private hospitals relieves them of their work, and for every referral to a private hospital, they receive payment ranging from Rs 3,000 to Rs 5,000.

CONCLUSIONS AND RECOMMENDATIONS

The high IMR has long been a curse for Uttar Pradesh. While it has the highest IMR of 64 (per 1000 live births), Farrukhabad has a staggering IMR of 78 (per 1000 live births). The state and central governments have failed to take significant steps to solve this issue. The situation in Farrukhabad is worse than the state's average because of the presence of several private hospitals functioning around the government hospital without proper equipment and facilities, with the sole objective of maximizing their own profits by exploiting financially weak people. There is already a nexus between private hospitals and the government hospital staff who work as brokers, solidifying claims of corruption.

All of the families we met were marginalized and vulnerable in one sense or another. While most were poor, some also belonged to socially backward sections of society -- Scheduled Caste, Tribes and Other Backward Castes. These are people who cannot afford medical expenses and need government hospitals to provide facilities at a nominal charge to them. These government hospitals, as we saw, were also supposed to offer them monetary compensation after delivery. The current scenario at Farrukhabad's Lohia Hospital totally denies the public of these needs. As a result, impoverished and marginalized people go into debt, lose their children for reasons that should be easily preventable. Nevertheless, the situation in Lohia Hospital is not novel, and we have seen similar things play out across the country. For the public healthcare system to run smoothly, it must have the support and cooperation of the hospital staff who should be striving to treat patients and save lives, not conspiring for their own monetar gain. Farrukhabad paints a stark picture of corruption, negligence, greed, and inhumane practices.

The government should take immediate and stringent measures to curb these extremely pervasive issues in Farrukhabad, which are a plague to society. There must also be clear regulations for running a private hospital or nursing home.

As a conclusion to the research conducted, we make the following recommendations:

1. To ensure that private nursing homes and hospitals are allowed to continue practising only if they have all necessary medical facilities, such as an NICU for taking care of infants with complications after birth, and oxygen machines.
2. To ensure that nurses and ASHAs do not work as brokers and do not illegally demand out-of-pocket expenses from patients. In these cases, a heavy fine or suspension should be levied to deter them.
3. The government should take measures to reduce the Infant Mortality Rate. This can be achieved if the lactating mothers are provided with adequate nutrition. Most lactating mothers are both anemic and underweight and when they give birth, there are chances of losing both the mother and the new born. Government schemes such as JSY and JSSK must be implemented properly.

4. To ensure that government schemes like monetary compensation after delivery are fully functional without any corruption, and that eligible recipients do not have to personally chase the compensation – but rather they receive it immediately.

2

The Role of ASHAs in the Delivery of Contraceptive Information and Services

Fact-finding exercise in Wazirabad (Jagat Pur Extension), Delhi and Narela (Holambi Kalan), Delhi

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LIST OF ABBREVIATIONS

AIDS - Acquired Immune Deficiency Syndrome

ANM - Auxiliary Nurse Midwives

ASHA - Accredited Social Health Activist

AW - Anganwadi Workers

CEDAW - Convention on the Elimination of All Forms of Discrimination against Women

CIS - Contraceptive Information and Services

ECP - Emergency Contraceptive Pill

HIV - Human Immunodeficiency Virus

ICPD - International Conference on Population and Development

IMR - Infant Mortality Rate

IUCD - Intrauterine Contraceptive Device

MCPR - Modern Contraceptive Prevalence Rate

MMR - Maternal Mortality Rate

MO - Medical Officer

NHM - National Health Mission

NRHM - National Rural Health Mission

NUHM - National Urban Health Mission

OCP - Oral Contraceptive Pill

PP-IUCD - Postpartum Intrauterine Contraceptive Device

TB - Tuberculosis

WHO - World Health Organisation

INTRODUCTION

Modern contraceptive prevalence rates in India are growing at an unsatisfactory rate, indicating that India will not meet its goal of extending family planning services to 48 million more women by 2020, thereby not fulfilling the commitments made at the 2012 London Summit on Family Planning[1].

As of 2017 the Government of India is failing in providing adequate access to contraceptive information and services (hereinafter referred to as CIS) in violation of women's fundamental rights to life, health, dignity, and equality under Articles 15 and 21 of the Constitution of India and various international conventions and covenants. This is confirmed by up-to-date statistics provided by the 2016 FP2020 Progress Report which reveals that the overall unmet need in India sits at 20.8%[2] -- meaning one-fifth of the couples and women who wish to delay or prevent pregnancy in India have no means of doing so. The report also provides, as of 2016, the modern contraceptive prevalence rate (mCPR) for all women is 38.6%[3], with female sterilisation providing for 75.5% of the modern contraceptive methods used[4]. The dominance of female sterilisation in India signals deficiencies in access to a full range of contraceptive options, resultant of incentivised prioritizing of female sterilization targets over women's rights to choice, bodily integrity, bodily autonomy and equality.

In order to enable women to delay and space their births, India committed at the London Summit to distribute contraceptives at the community level through 860,000 community health workers, to train 200,000 health workers to provide IUCDs and to substantially augment counselling services for women after childbirth[5]. The community health workers tasked with distributing contraceptives and counseling couples on family planning practices are the Accredited Social Health Activists (ASHA). The ASHA programme is a critical component of the National Rural Health Mission (NRHM). An ASHA is a woman selected by the community, residing in that community, who is trained and supported to function in her own village as a health activist and a front-line basic health care provider. She is tasked with improving the health status of the community by promoting positive health practices, mobilising community engagement in health planning and encouraging utilisation and accountability of existing community health services. The NRHM guarantees one ASHA worker per 1,000 people, however the numbers of ASHAs engaged under the NHM as of 2014 indicates a shortfall of approximately 340,000 ASHAs nationwide[6].

Among their numerous other responsibilities, ASHAs are the key administrators of family planning services at the community level. Instead of receiving a fixed-rate salary, ASHA workers receive incentive-based payments which are heavily geared towards encouraging female sterilisation procedures over spacing methods. For facilitating either a tubectomy or a vasectomy, ASHAs receive an incentive payment of Rs 200-300, whereas they receive a mere Re 1 for supplying condoms, oral contraceptive pills (OCPs) and emergency contraceptive pills (ECPs) and receive no payment whatsoever for family planning counselling. They receive Rs 150 for encouraging PP-IUCD or IUD insertion, however strong evidence emerged over the course of our fact-finding,

1. Government of India, Family Planning 2020 Commitment, (11 July 2012), Family Planning 2020, 1, <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/Govt.-of-India-FP2020-Commitment-2012.pdf>

2. Family Planning 2020, Momentum at the Midpoint 2015 - 2016, (2016), Indicator no. 3 <http://progress.familyplanning2020.org/uploads/08/01/FP2020_DIGITAL_Single_LoRes.pdf>

3. Ibid, Indicator no. 2

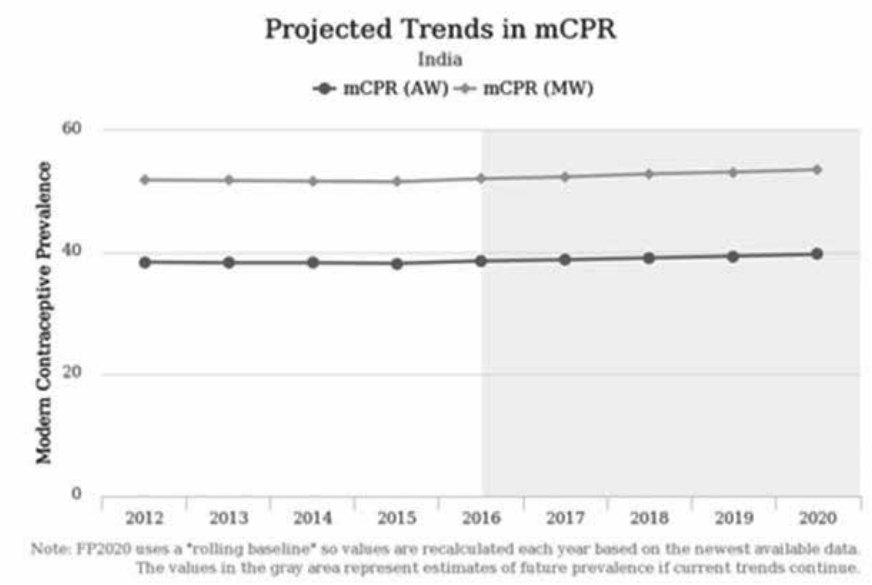
4. Ibid, Indicator no. 9

5. Government of India, above n 1, 1

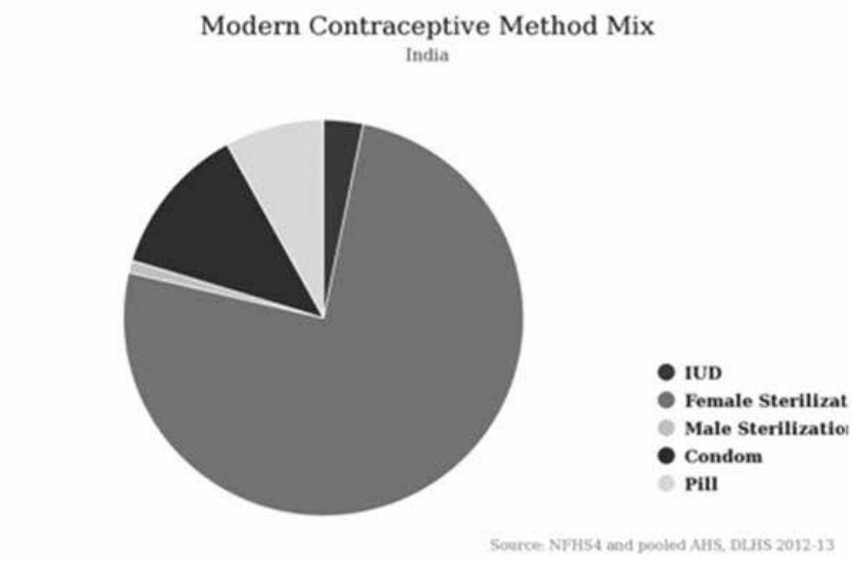
6. Press Information Bureau, Accredited Social Health Activists (ASHAS) and Auxiliary Nurse Midwifes (ANMS) Appointed under National Rural Health Mission (NRHM), (18 July 2014), <http://pib.nic.in/newsite/PrintRelease.aspx?relid=106925>

that indicated that women either did not consent to such insertions or lacked satisfactory knowledge of the device when consenting to it.

Our fact-finding team visited the Wazirabad (Jagatpur Extension) and Holambi Kalan localities and conducted a cross-sectional study which involved interviewing ASHAs, Anganwadi Workers and pregnant and lactating mothers across the two locations to ascertain a holistic perspective on the adequacy of contraceptive information and services delivered by ASHA workers. This report provides a full account of our fact-finding, an analysis of the major concerns identified and recommended action points moving forward.



Source: http://www.familyplanning2020.org/entities/76



Source: http://www.familyplanning2020.org/entities/76

OBJECTIVE

To investigate the current role that ASHAs play in disseminating CIS to communities in Wazirabad (Jagatpur Extension) and Narela (Holambi Kalan) to ascertain whether women there have adequate access to a wide range of contraceptives, knowledge about their options and the medical care necessary to effectively exercise their choices.

Further objectives included assessing the conditions under which ASHA workers performed their tasks, as well as assessing the adequacy of the remuneration and support they received to evaluate the effectiveness of current policies guiding the ASHA programme and to ascertain whether such policies are operative in practice.

METHODOLOGY

The study was carried out in two separate locations within Delhi, Wazirabad (Jagatpur Extension) and HolambiKalan, on July 1 and 4, 2017, respectively.

A cross-sectional study was conducted on ASHA, Anganwadi workers (AW), pregnant and lactating mothers across the two locations to ascertain the adequacy of contraceptive information and services delivered by ASHA workers. Enquiries were carried out in distinct group settings where a questionnaire based on NHM resources was performed. The questionnaire is annexed with this report (Annexure-1).

TARGET GROUP

To meet the objective, the target group consisted primarily of ASHA workers. ASHAs are front-line workers tasked with disseminating contraceptive information and providing family planning counselling. The number of ASHA workers in a given location depends on the size of the population and the dispensary. There are roughly ten ASHA workers per dispensary working under two Auxiliary Nurse Midwives (ANMs) and one Medical Officer (MO). The NHM is supposed to guarantee one ASHA worker per 1,000 people, however the ASHAs interviewed were responsible for around 400-700 households.

PROFILE OF LOCATIONS

Wazirabad (Jagatpur Extension)

Wazirabad (Jagatpur Extension) is a village located in northern Delhi with a total population of 1,192 families according to the population census of 2011. According to the Constitution of India and the Panchayati Raj Act, Jagatpur Extension is still administered by the head of the village, the sarpanch, who is the elected representative. There is no presence of Scheduled Tribes (ST) in the village, but it does have members from Scheduled Castes (SC) who account for 6.13% of the total population. Wazirabad (Jagatpur Extension) is a mercantile community. Most of the population generates a livelihood by running small businesses such as stationery shops, food stalls, beauty parlours and tailoring services. Many ASHA workers interviewed had undertake secondary employment, working as a Block Level Officer, etc, to supplement their irregular income under the ASHA programme.

Narela (Holambi Kalan)

Holambi Kalan is a village, located in Narela in north-west Delhi, with approximately 8,157 families. According to the census 2011, members of the SC community account for 30.10% of the total population and there are no Scheduled Tribes.

Women are primary income earners in Holambi Kalan and they generally work as housemaids, tailors, community health workers or in factories. However, Holambi Kalan is extremely unsafe for women as domestic violence is widespread and women are required to surrender their income to their husbands.

FACTS

The facts provided below were disclosed in a series of interviews undertaken on location. The interviews were conducted primarily with ASHAs, however, the team also spoke with Anganwadi Workers and pregnant and lactating mothers. They were questioned on the role and responsibilities of ASHA workers; contraceptive supplies available to them; male and female contraceptive use and attitudes; unwanted pregnancies and female sterilisation prevalence and complications. Additional focus was on the adequacy of the incentive-based remuneration scheme and the provision of on-going training for ASHA workers, and the responses given to these inquiries across the two locations, were contradictory. It should be noted that the ASHA workers interviewed in Wazirabad (Jagatpur Extension) evinced a willingness to be more open and critical of the programme, perhaps explaining the divergent responses gathered.

Strong concerns included:

a) ASHAs feeling overburdened by their workload. For example, ASHAs interviewed in Wazirabad complained that they had inadequate support from their ANMs, since one of the two ANMs they worked under had been appointed to the nearby Mohalla Clinic. They claimed it was difficult for them to work with only one ANM left at the dispensary.

b) ASHAs experiencing considerable delay in receiving incentive payments. They receive payments from two departments, the Ministry of Health and Family Welfare and National Health Mission, which are paid into separate accounts. They find this confusing and inconsistent.

c) The lack of proper and recurring training given to frontline workers.

In addition to the administrative concerns listed above, various facts emerged that demonstrated a disregard on the part of those responsible for managing and monitoring ASHA workers for the health and reproductive rights of women. Despite committing to various schemes and policies, the government of India has failed to ensure that these schemes are properly implemented or effectively monitored. Of those interviewed, there was a concerning deficit of knowledge regarding contraceptive practices and reproductive health. Considering that ASHAs are frontline agents responsible for family planning and contraceptive services in the community, this lack of clear understanding reflects the systematic failure of the programme.

Counselling by ASHAs

One of the main tasks of the ASHAs is to provide family planning counseling. They are required to counsel the following groups:

a) Newly married couples: ASHAs are required to identify newly married couples in the community and counsel them on contraceptive methods and the concept of birth spacing. After the birth of a couple's third child, ASHAs speak with them about the possibility of sterilisation or use of contraception to prevent further pregnancies.

b) Couples who refuse to use contraception: Couples identified as non-users of contraception are required to be repeatedly counselled by the ASHAs in an attempt to make them understand the importance of contraceptive use.

c) To identify these target groups, ASHAs survey the households in their district and make a list of the requirements and demographics of each family.

Pregnant and lactating mothers who were interviewed in Holambi Kalan demonstrated an alarming lack of knowledge about contraceptive options. Some women said they had never been visited by an ASHA for family planning and others seemed wholly unaware of the concept of birth spacing.

Overburdened with responsibilities

ASHAs are the key administrators of family planning services at the community level and are responsible for helping the government achieve its family planning goals. In addition to providing contraceptive counselling services (see above), ASHAs are responsible for administering mother and child immunisation services, monitoring senior citizens and providing guidance for individuals suffering from TB, HIV or AIDS.

ASHAs also counsel pregnant women and, from time to time, accompany them to medical checks to hospital (such as an ultrasound) or to the dispensary if they require medical assistance. In Wazirabad, the ASHA workers accompany pregnant women to the hospital for deliveries. After the delivery, the ASHAs help get the birth certificate issued and ensure that the newborn is immunized on time.

Their already extensive workload is often burdened with additional work and responsibilities, such as conducting community surveys required by the NRHM. This is often due to delegation by the ANMs who supervise the ASHAs. However, ANMs are also overburdened and are often shifted to Mohalla Clinics, increasing the aggregate workload for other community health workers such as ASHAs.

Some ASHAs interviewed admitted to being so overburdened that they had to resort to falsifying their reports, such as contraceptive surveys or immunisation records, to ensure they received incentives. This is particularly concerning as these records are meant for official use and forgery distorts the data collected.

The ASHAs noted that because of this overburdening, they would often prioritise responsibilities with higher monetary incentives. This is very problematic as family planning counselling and the distribution of less intrusive and user-controlled contraceptive options (condoms, OCP, etc.) with no financial incentive, were overlooked.

Anganwadi Workers interviewed in Wazirabad informed us that ASHAs are solely responsible for the provision of contraceptive information and services. Despite their involvement with pregnant and lactating mothers and young children, the AWs took no responsibility for family planning. They were adamant that CIS was the responsibility of the ASHAs and they provided no counselling or contraceptives at their centre. This division of responsibility is problematic, as the extensive task of disseminating CIS falls completely on the overworked ASHAs.

Incentive-based remuneration

Instead of receiving a fixed-rate salary, ASHA workers receive incentive-based payments for the completion of various tasks relating to pre- and post-natal care, immunization, care of senior citizens, TB, HIV and AIDS patients. If they fail to complete at least six of their twelve incentive-based responsibilities, their salary gets deducted. Many tasks given to ASHA workers by the government involve no, or nominal, financial incentive. For example, they sell condoms, OCPs and ECPs for Re 1 and receive no payment whatsoever for family planning counselling. The ASHAs interviewed in Wazirabad were unsatisfied with the incentive-based payment scheme. Further, they said that they experienced considerable delays in receiving their payments (ASHAs in Wazirabad had gone up to eight months without payment) and the payments come from two different sources. This is incredibly confusing for them as they are unable to track the payment of incentives and identify where deductions were made. They also have no designated supervisor to talk to for clarifications.

Delays in payment cause domestic problems for ASHA workers. The work they are required to do is extensive, so they are rarely able to pursue other areas of employment or attend to their domestic and familial responsibilities.

Another issue we identified was the lack of legitimacy given to their role, making it difficult for them to follow up on payments and register complaints. The appointment letter[7] presented to them is not printed on an official letterhead and is handwritten. They do carry an identification card[8] with the NRHM logo, but this is the only official document they receive.

Focus on sterilization

A primary responsibility of ASHA workers is to educate people about family planning to promote reproductive self-determination. They are required to discuss a wide range of contraceptive options to enable women to make fundamental reproductive choices and ensure that women's autonomy, dignity, health and privacy are protected. However, a disproportionate emphasis on sterilisation resultant of incentivisation is clearly apparent as the practice still accounts for 75.5% of India's mCPR[9].

According to ASHAs in Wazirabad (Jagatpur Extension), some men are open to the possibility of vasectomy, however, in Holambi Kalan the practice is essentially non-existent.

It was concerning to discover that the ASHAs in Wazirabad have frequently coerced and bribed street-dwelling men – who, they believed, had contracted HIV -- to go for vasectomies to receive the cash incentive. Even more alarming was their belief that sterilisation would stop the transmission of the disease. This indicates a gross misunderstanding of sexually transmitted diseases and the

7. Annexure 2

8. Annexure 2

9. Family Planning 2020, above 2, Indicator no. 9

role of condoms in protecting individuals and limiting the spread of STIs. This information raises serious alarm bells about the quality of training received by ASHA workers with regard to CIS.

According to the government, the ASHA programme is facilitating commitments made at the London Summit of Family Planning to shift the focus of family planning from limiting to spacing methods and to expand the choice of methods available[10]. However, certain facts suggest that this commitment is not taken seriously and sterilisation remains over-prioritised.

No incentives are provided for the provision of family counselling services to each household. Only sterilisation (Rs 150 for females and Rs 200 for males) and PPIUCD insertion (Rs150) are incentivised.

Under the NRHM, ASHAs are supposed to carry a range of contraceptives in an ASHA kit (condoms, OCP and ECP). However, the ASHAs interviewed in Wazirabad claim only to be provided with contraception after conducting a survey to identify what items are needed and by whom. This limits their ability to discreetly supply households with contraception on an ad hoc basis. They indicated that there is a social stigma attached to condom use and appearing to need multiple condoms is thought to suggest infidelity.

Conversely, when condom supplies are reaching their expiry date, ASHAs are asked to distribute as many as possible. This means that potentially or nearly expired condoms are being given to couples who, as a result, may experience contraceptive failure.

The programme's focus on sterilization has dangerous implications for the realisation of commitments made by the state to ensure that quality contraceptive information and services are freely available to people. Denial of such services amounts, in substance, to the imposition of coercive population policies which undercut women's right to health, reproductive autonomy and equal citizenship.

Condom usage

Condom usage across both locations was low. Alongside the disproportionate focus on sterilization as discussed above, a number of social and cultural factors can be attributed to low-usage rates. ASHAs cited the following stigmas attached to use of condoms:

a) Purchase and use of condoms indicated infidelity or promiscuity on the part of male or unmarried users

b) Use of condoms decreases male sexual pleasure

c) Distrust of the quality of condoms and fear of resultant contraceptive failure

d) Belief that contraception is a female responsibility and female sterilization is the best option

e) Prevalence of domestic violence which prohibits women from discussing the use of contraceptives with men

The ASHAs in Holambi Kalan said that regard for condoms was so low, that women preferred to use emergency contraception or would resort to abortion in the case of unwanted pregnancies.

10. Government of India, above n 1, 1

STIs and HIV/AIDs

As previously mentioned, there appears a misconception about the transmission of STIs, in particular HIV/AIDS. In Holambi Kalan, the ASHAs informed us that despite many cases of STIs including high instances of HIV, men and women were not interested in using condoms to prevent the infection from spreading further. Condom use in Holambi Kalan was essentially non-existent.

Unwanted pregnancies

According to the ASHAs, there are several cases of unwanted pregnancies among both married and unmarried women and adolescent girls. Generally, married women carry on with the unwanted pregnancy. When an unmarried woman becomes pregnant, she is likely to visit a private doctor and have the termination performed outside the colony. The ASHAs were concerned about this and said that they were happy to help unmarried women who find themselves in this situation, despite the social stigma attached.

Workplace harassment and uncertainty

On top of being overburdened, ASHAs experience a high degree of uncertainty in their work.

There are several scenarios in which there appeared no guiding protocols to protect ASHA workers.

a) When accompanying labouring mothers to government hospitals, the ASHA and the mother are sometimes turned away. In such situations, ASHAs are not treated with respect by hospital workers and are rarely directed to an alternate facility. One ASHA worker told us about a case where a woman gave birth near the gate of a hospital after being denied entry and assistance during labour.

b) They do not know where to submit complaints regarding workplace issues or harassment. Some ASHA workers experience harassment and are disrespected by MOs and ANMs. At other times, they are harassed by the husbands and the in-laws of the women they counsel.

c) They are often required to perform tasks which fall outside their normal workload, such as Polio Service and Mission Indradhanush, with little or no notice. This places additional pressure on them and forces them to deviate from their primary responsibilities, such as the provision of family planning services.

Working under ANMs and MOs, the ASHAs act as a link between the community, the dispensary and government hospitals. Multiple stories were shared that suggested ASHA workers were treated poorly by the government hospital staff, even when they bring in a labouring mother for an institutional delivery. Several cases were mentioned where women were forced to give birth outside the hospital having been denied care or refused ambulance service. Often, hospital staff would not allow ASHA workers to enter the hospital with the mother, leaving her to make her own way home (sometimes in the early hours of the morning). The level of disrespect experienced by the ASHAs in the government health system acts as a further deterrent to quality public healthcare delivery as ASHAs, in addition to receiving inconsistent and inadequate remuneration, and they do not feel that their efforts are valued.

RELEVANT BACKGROUND

Reproductive Rights

This report relies on the definition of reproductive rights given at the 1994 Cairo International Conference on Population and Development (ICPD), which is as follows:

"Reproductive Rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence."[11]

Reproductive rights are secured under Article 21 of the Constitution of India, which guarantees that "no person shall be deprived of his or her life or personal liberty except according to a procedure established by law". Article 21 has been interpreted by the Supreme Court to include the right to health, per Paschim Bengal Khet Mazdoor Samity & Ors. v. State of West Bengal & Anr., AIR 1996 SC 2426.

ICPD paragraph 7.2 defines reproductive health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes"[12].

Although human rights are shared equally among men and women, reproductive rights disproportionately affect women and reproductive rights violations are often resultant of severe gender inequality and discrimination.

Access to contraception and family planning information

In order to fully realise their reproductive rights, women and couples must have adequate access to a wide range of contraceptives, knowledge about their options and the medical care necessary to effectively exercise their choices.

The rate of 'unmet need' in India sits at a staggering 20.8%. According to WHO, 'unmet need' refers to married women of reproductive age who want to stop or delay childbearing but are not using any method of contraception, generally because there is a lack of availability of, or education regarding, contraceptive options.

Article 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) states that all men and women, on the basis of equality, have the right "to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise their rights"[13]. The state is thus required to ensure the availability of family planning counselling, a wide range of contraceptive options and access to safe abortion services.

Currently, the Union as well as the state government provides five primary contraceptive options

11. Chapter VII, Reproductive Rights and Reproductive Health, International Conference on Population and Development, Cairo, 1994.

12. Reproductive Rights and Reproductive Health, International Conference on Population and Development, Cairo, 1994, para 7.2

13. Convention on the Elimination of All Forms of Discrimination Against Women, 16(1)(e)

including condoms, the oral contraceptive pill (OCP), the IUCD and male and female sterilisations. In order to exercise their reproductive rights with regard to contraception, these options must be readily available, acceptable in the community and of the highest quality. Further, women and men must have the requisite information, freedom and technology to enable them to exercise contraceptive choice.

Female sterilisation

Female sterilisation is the most common method of contraception used in India accounting 75.5% of India's mCPR[14]. Sterilization is a method of birth control involving a procedure whereby a woman's fallopian tubes are closed or blocked. Sterilisation is an invasive, permanent and radical form of contraception, especially when other viable methods exist. India sterilizes more than 4.6 million women per year, a figure which accounts for approximately 37% of female sterilisations performed across the globe[15]. Preventable deaths still occur as a result of botched sterilization camps that target women from 'backwards classes' and often perform the procedure without her consent.

Despite the imposition of strict sterilisation guidelines in 2006, pursuant to the Supreme Court ruling in Ramakant Rai v Union of India, sterilization is still perceived as a means of population control and not as a mechanism to protect a woman's reproductive rights and health. Under the NRHM, ASHA workers receive incentive-based payments which are heavily geared towards encouraging female sterilisation procedures over spacing methods. Women who go for sterilisation receive cash incentives. Incentive-based policies for female sterilisation undercut the reproductive autonomy of the woman and, in substance, amount to coercive population practises.

National Population Policy 2000

Adopted in 2000, India's National Population Policy (2000) reinforces the underlying principles of the ICPD by "[affirming] the commitment of the government towards voluntary and informed choice and consent of citizens while availing reproductive healthcare services, and continuation of target-free approach in administering family planning services"[16]. The policy cites its immediate objective as addressing unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care[17].

National Rural Health Mission

In 2005 the Government of India launched the National Rural Health Mission (NRHM) with the objective of "[improving] the availability of access to quality health care by people, especially for those residing in rural areas, the poor, women and children through equitable, affordable, accountable and effective primary health care"[18]. The key objectives of the NRHM include, but are not limited to, reducing MMR to 1/1000 live births; reducing IMR to 25/1000 live births and to

14. Family Planning 2020, above 2, Indicator no. 9

15. Bloomberg Business, India's Poorest Women Coerced Into Sterilisation, (6th December 2013), <http://www.bloomberg.com/news/articles/2013-06-11/india-s-poorest-women-coerced-into-sterilization>

16. National Health Portal, National Population Policy, (October 2nd 2015), <https://www.nhp.gov.in/national-population-policy-2000_pg>

17. Ibid.

18. Framework for implementation, The National Rural Health Mission, 2005-2012, p. 8

prevent and reduce mortality and morbidity from communicable, non-communicable injuries and emerging diseases. Cities and towns with populations below 50,000 are covered by the NRHM.

Similarly, the National Urban Health Mission (NUHM), launched in 2013, seeks to improve the health status of urban populations and facilitate the access of individuals to quality primary healthcare in cities or towns with population exceeding 50,000 (as per 2011 census). Both the NRHM and NUHM are sub-missions of the overarching National Health Mission (NHM).

MAJOR CONCERNS

ASHAs are a key component of the NRHM and the Ministry of Health and Welfare, and are responsible for bridging the gap between the community and the public health system. Despite the vital role they play in promoting good health practises in the community, the ASHA workers interviewed have been placed under tremendous pressure and are denied the basic right to earn a proper livelihood. Our fact-finding team noted areas of major concern with regard to the provision of CIS in the communities we visited. ASHAs receive no flat-rate salary, and instead get irregular and inconsistent incentive-based payments; incentives are heavily geared towards permanent and long-acting methods of contraception; the training received is minimal and lacks in-depth guidance about spacing methods; ASHAs themselves do not fully understand the concept of reproductive rights and reproductive self-determination; and finally, the work of the ASHAs is consistently hampered by social and cultural barriers.

The state's failure to properly implement and monitor the ASHA scheme is particularly problematic given ASHAs act as the key administrators of family planning services at the community level. The state's acts and omissions regarding the ASHA programme are such that they violate the right to health, including reproductive health, secured by Article 21 of the Constitution of India.

Orientation/training

ASHAs are active female members of the community selected through a competitive process to provide support for various health concerns particular to the rural and urban communities they serve. She is not medically trained, however, it is generally required that she be qualified up to class 10 (this is relaxed where no other suitable candidates exist). Considering the importance of the family planning services that they administer, they require extensive, in-depth and ongoing trainings to ensure they provide correct contraceptive information. Counselling provided to an individual or couple by an ASHA could be the difference between an unwanted pregnancy and successful birth spacing. Our fact-finding mission illuminated that ASHAs across the locations did not have an acceptable understanding of the various methods of contraception, and thus, were not adequately equipped to be counselling the community on such important matters.

Indian society can be particularly divisive, with segmentation occurring between urban, urban slum and rural communities. Rural communities, in particular, are neither vocal nor inclusive in their attitudes towards sex, sexuality and the use of contraceptives. Family planning is generally considered a private matter and thus, awareness about the benefits of contraception is generally low. In light of this, it is imperative that ASHAs are properly trained to break down communication barriers regarding contraception in order to spread family planning messages.

According to ASHAs at both locations, an orientation session is conducted, however, neither group were specifically trained on how to provide family counselling and how to approach families who

do not understand the importance of contraception or those who refuse to use it on an irrational basis. They said that the orientation program was primarily administrative, as they were informed of their work responsibilities, how to report and to conduct surveys, and were shown basic medical training videos. Some ASHAs said they were not treated well during their orientation and felt it was because they belonged to a poorer section of society. After six months of their work, ASHAs were required to go for further training, however, this training too, is no more in-depth than the orientation sessions.

It appears that family planning has taken a backseat to other responsibilities such as conducting surveys, keeping mother and child immunisations up to date and providing antenatal care. While these responsibilities are obviously of equal importance, family planning services are essential to any community and must be made available. Lack of contraceptive information and services results in higher rates of MMR, IMR and unsafe abortions, and therefore, ASHA workers must be trained accordingly to provide clear and compelling contraceptive counselling.

Socio-cultural impact on contraceptive use

The ASHA initiative is built on the notion that community leaders are best placed to generate positive behavioural change in their community. However, the ASHAs face massive social and cultural barriers and their contraceptive messages are not being effectively communicated.

Contraception is a 'taboo' subject in Indian society and, particularly in rural areas, is not considered a public talking point. Couples are generally not informed about family planning until the birth of their first child, as childbirth is considered the ultimate symbol of marriage. There are also strong religious taboos associated with contraception, as the use of spacing methods indicate that couples are not abstaining between children and therefore are having sexual intercourse for reasons other than childbirth, namely pleasure. In addition to this, the use of condoms is seen to represent the presence of multiple partners and infer promiscuity and infidelity. Gender inequality is a further barrier to contraceptive use and reproductive autonomy, as many women have to be granted 'permission' to use contraception by their husbands and in-laws. The ASHAs informed us of several cases in which a woman's desire to use spacing methods has led to domestic abuse. Despite being safer, quicker and more economical, rates of female sterilisation far surpass instances of vasectomy since contraception is viewed as necessarily a woman's burden. Further, men fear their masculinity and strength will be compromised by the sterilisation procedure.

The ASHAs said they faced considerable difficulty breaking down such barriers against contraception. In Holambi Kalan, ASHAs do not speak to men about contraception as the topic is too socially sensitive. The ASHAs themselves admitted to not using spacing methods but instead using the ECP where necessary or opting for sterilization. Furthermore, they said that men and women did not trust the efficacy of condoms. ASHAs in Wazirabad reported having more success discussing contraception with men. However, they noted that some men would bypass them and procure contraception directly from the dispensary without knowing how to properly use it.

Another cultural barrier affecting the delivery of contraceptive information and services is a widespread misunderstanding of the concept of reproductive rights. While inherently connected and at times indistinguishable, reproductive rights are often conflated with sexual rights. In rural areas where sexual rights and sexuality are not yet openly discussed, a sound and distinct understanding of reproductive rights and health is needed. Where sexual rights deal with sexual identity, pleasure and expression, reproductive rights deal with the right to reproductive health,

hygiene and autonomy over one's reproductive processes. Many individuals believe reproductive rights are purely about sex and sexuality, and are not connected to severe health complications such as maternal mortality, infant mortality, malnutrition, unsafe abortion and sexually transmitted diseases. ASHAs need to be appropriately trained to introduce family planning and contraception to couples primarily as a health concept in order to break down barriers and ensure people are not avoiding contraception out of embarrassment.

Incentive- based remuneration

As outlined in the facts, ASHAs receive no fixed salary and instead receive irregular payments under an incentive-based remuneration scheme. The payments are irregular for three reasons: they are paid from different sources for different tasks; their payments are often considerably delayed; and they are not paid at all for much of the challenging work they do, such as providing family planning services. When they do receive payment, the amount received is very poor and does not meet the minimum wage requirement[19].

With regard to contraception, the guidelines only provide incentives for the encouragement of male or female sterilisation and the insertion of PPIUCD. No payment is received for the provision of family planning counselling and the encouragement of birth spacing methods. While ASHAs remain underpaid, this poses a significant threat to women's reproductive autonomy, as ASHAs neglect to provide CIS and instead promote only methods for which they receive monetary incentives. As mentioned in the facts, ASHA workers in Wazirabad have taken to forging records of tasks which receive no remuneration in order to ensure their payments are not deducted.

Aside from the issues relating to timely and consistent payment, the incentive-based remuneration scheme is not conducive to the provision of unbiased contraceptive information and services. Where ASHAs are underpaid and payments are delayed, incentivisation leads to the promotion of certain services over others and as a result undermines reproductive education and self-determination.

THE WAY FORWARD

The concerns outlined above reflect major systematic failures of a crucial initiative taken by the Indian government to ensure good health and family planning practices at the community level. There is an urgent need to conduct further research into the ASHA programme to ascertain how best to monitor and manage the initiative going forward. ASHAs are the key administrators of contraceptive information and services at the community level and the success of India's family planning commitments are dependant on the effective implementation of the ASHA scheme.

Access to a broad range of high-quality, safe, effective, acceptable and affordable contraceptive methods is a basic human right. Such access ensures that women and girls can decide freely whether, when and how many children they wish to have. The current unmet need in India exists in violation of this basic right and is attributable to unacceptable rates of maternal mortality, infant mortality and mortality or complications arising from unsafe abortion practices. Furthermore, socio-cultural barriers and rampant gender discrimination relating to contraceptive use undercuts women's right to health, reproductive and bodily autonomy and equal citizenship.

A disproportionate focus on female sterilisation, which accounts for 75.5% of India's mCPR20,

19. Incentives to ASHAs; 2016-2017; <http://www.pbnrhm.org/docs/asha/incentives_to_asha_2016_17.pdf>

reflects deficiencies in access to a full range of contraceptive options, as promised by India at the 2012 London Summit on Family Planning. This is largely due to incentivised prioritisation of permanent birth control despite India's various commitments to end target-based family planning programmes and instead adopt a rights-based approach. Therefore, ASHA workers should be paid a fixed-rate salary in order to ensure that they provide unbiased and comprehensive contraceptive information and services that facilitate freedom of choice and reproductive autonomy.

More extensive and ongoing training for ASHA workers is imperative, with a particular emphasis on counselling techniques so that ASHAs are properly trained to break down communication and socio-cultural barriers relating to contraceptive use at the community level. In their paper, 'Improving the Performance of Accredited Social Health Activists in India', Nirupam Bajpai and Ravindra H Dholakia correctly assert that "the impact of NRHM and the ASHA is only as strong as the individual ASHAs who are chosen'[21] If they are to be effective family planning advocates, investment must be made in the individual ASHAs chosen to dispense basic contraceptive information to the community. The success of the entire programme is dependant on their motivation and dedication to, and sound awareness of, good health practice and its determinants.

Listed below are recommended action points:

1) The ASHA programme must be unified under one governing body. The programme is currently administered under both the Ministry of Health and Family Welfare and the Ministry of Women and Child Development.

2) Provision of a fixed salary for ASHA workers which meets minimum wage requirements

3) Formal recognition of the ASHA programme and official mechanisms by which ASHA workers are recognised for outstanding work in the field

4) Official training for at least one week specifically on counselling techniques to allow ASHAs to break down socio-cultural communication barriers in the community

5) State-based bodies responsible for monitoring, implementing and evaluating the ASHA programme

6) The provision of smartphones for ASHA workers to enable productive communication and counselling, see footnote for a sample initiative[22]

20. Family Planning 2020, above n 2, Indicator no. 9

21. Nirupam Bajpai and Ravindra H. Dholakia, 'Improving the Performance of Accredited Social Health Activists in India' (May 2011), Working Papers Series, Columbia Global Centres, 2.

22. <http://www.thehindu.com/news/national/karnataka/35000-asha-workers-to-get-mobile-phones-to-promote-health-schemes/article5314685.ece18>

Annexure 1

Questonnaire

Question	Secondary Questions
General questions about the ASHA role and responsibilities	What are the main job responsibilities? What are the positive changes you have seen? Negative impact of their services? How has their personal life been affected? What personal family planning is being used? What level of education do you have? Do you find your work rewarding?
What mechanisms are in place for dealing with a woman who has an unwanted pregnancy?	Do you refer these cases to the MO's or Anganwadi Workers? What support/counselling is offered pre-MTP? What support/counselling is offered post-MTP?
How do you help guide women through pregnancy?	Do you return to make regular check ups? Do you keep records of the pregnancies? How alert are you to danger signs in the gestational period? Do you often get turned away from the hospital? Are you required to make your own way home? What about early in the morning? Are you aware of women having the IUCD inserted after birth WITHOUT consent?
What supplies are included in your kits?	What contraceptive items do you carry? How often can you replenish your stock? Do you have enough stock to meet demand? Is it easy to restock? Are the kits in good condition when you collect them? Are items expired? On average how many packets of condoms will an individual buy? Do you encourage them to purchase a large supply? If a woman has an OCP prescription, do you deliver the OCP to her door? How many months of the OCP will an individual purchase? Can you get back to a woman on a monthly basis in order to provide her with the OCP?

How do you counsel women or men about contraception?	What do you tell them about condoms? Do you tell them that condoms are commonly used? What do you tell them about the OCP? Do you tell them that the initial side effects go away after a couple of months? Do you tell them that the OCP is commonly used and that it is very safe? What are the main reasons women/men refuse to use contraception? Do you counsel unmarried women too?
What views do WOMEN hold with regard to different types of contraception? What are the prominent attitudes?	**CONDOMS** What are the primary concerns women have with condoms? Are they concerned with their partner's pleasure? Do they think condoms represent infidelity/ promiscuity? Do they know condoms protect against STI/RTI? Do unmarried women purchase condoms? Do they know how to use one? Are they embarrassed? Do the women who have known STI/RTI's show interest in condoms?
	STERILIZATION What do you tell women about sterilisation? Do women express concern over its irreversibility? Why do you think it is the most used method of contraception? Do you think it is preferred because it involves no male participation? Do they consider asking their husbands to be sterilised instead? Are you given greater remuneration for making sterilisation referrals? Is this why you suggest it?
	OCPs How do women respond to the OCP? Do they distrust the drug? Are they concerned with side effects? Are they unable to get a prescription? (Medical cost/ husband's permission) If they elect to take the OCP, is it readily available? Is there a social stigma connected to the OCP? Do you follow up to see if women are taking the pill correctly?

	INJECTABLES Did you hear about it? If yes, then did you use it yet or receive any notification regarding the same? Do you think women would be interested in injectables? Can they be used discreetly and are only required every 1 – 3 months?
How prevalent are STIs/RTIs?	How many cases of STI/RDI do you see? Are the women who have contracted STI/RTIs open to the suggestion of condom use? Do you push condom use for women with known STI/RTIs? If not, why not? What demographic is most affected? Age/Marital status?
What views do MEN hold with regard to different types of contraception? What are the prominent attitudes?	Do they dismiss you? Have you had any unpleasant experiences offering contraceptives to men that has made you hesitant to do so? Have these experiences made you more likely to suggest female sterilization given it requires no male participation? How important do you think it is that men involve in this issue of reproductive rights? Are you under pressure to suggest female sterilization? Are women and men aware that a Vasectomy is safer, quicker and more economical?
	CONDOMS What do you think their general attitude towards condom use is? What are their primary concerns? (Pleasure/Perception of infidelity/ Awkwardness/ Social or Religious stigma) Do they think condoms are only for STI (HIV/AIDS) prevention? Do they know how to use them? Are they being shown how to use them? Who is being shown? On an average how many packets of condoms will an individual buy if he/she decides to do so?

	AWARENESS/INTEREST Are men interested to learn about contraception? Do they approach you to discuss contraception? If you get an opportunity will you take it up to your husbands and ask them to be a part of the ASHA and talk to the male counterparts of the society regarding contraception methods and usage? Is there room/scope for male involvement? Are men aware that contraceptive use may improve their quality of life, as spacing methods aid poverty reduction?
Do you experience issues of trust in your work?	Is your lack of formal medical training a concern for some people? Is there a general distrust of ASHA's in the absence of MO's? Do people trust the drugs or procedures recommended? Do the men distrust/dismiss you and your work?
What follow up procedures are in place with regards to your work?	Is there room for growth in the ASHA program? Is there an opportunity to be promoted? Are you receiving adequate compensation for your work? Who are you required to report to? Are you getting paid your incentives?
How extensive is the orientation you receive? Is there capacity building training?	Do you receive a proper training from time to time to enhance your skills or develop the updated information? What is the depth of knowledge required in any particular area?
Is there scope for technological aid?	Do ASHA's carry smart phones? Would a portable library of information be helpful? Would utilisation of a smartphone allow for easier record keeping? Do ASHA's feel they have difficulty communicating information, such as family planning strategies? And would the aid of videos and photography help?

3

Fact-finding Mission in Ratilo Village, Cuttack District, Odisha

HRLN
HUMAN RIGHTS LAW NETWORK
Reproductive Rights Initiative
Plot No.1390/B, Sector-6, CDA Bidanasi,
Cuttack-753014

ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ANM: Auxiliary Nurse Midwife

ART: Antioretroviral therapy

ASHA: Accredited Social Health Activist

BPM: Block Project manager

CEDAW: Convention on the Elimination of all Forms of Discrimination Against Women

CHC: Community Health Center

EDD: Expected Delivery Date

HIV: Human Immunodeficiency Virus

HRLN: Human Rights Law Network

ICCPR: International Covenant on Civil and Political Rights

ICESCR: International Convention on Economic, Social and Cultural Rights

ICTC: Integrated Counseling & Testing Centre

JSSK: Janani Shishu Suraksha Karyakram

MCTS: Mother Child Tracking System

NGO: Non-governmental Organisation

NHM: National Health Mission

OBC: Other Backward Class

OT: Operation Theatre

PMTCT: Prevention of mother-to-child transmission

PPTCT: Prevention of Parent to Child Transmission

RCH: Reproductive Child Health

SCB: Sriram Chandra Bhanj Medical College & Hospital, Cuttak

TT: Tetanus Toxoid

UNCRC: United Nations Convention on the Rights of the Child

INTRODUCTION

All around the world, pregnant women with HIV are seen as a mark of disgrace. Their conditions are substandard as they are severely discriminated against and stigmatized in the society. In India, approximately 49,000 women living with HIV become pregnant and deliver babies each year. While the government of India has made progress increasing the availability of prevention of mother-to-child transmission of HIV (PMTCT) services, only about one quarter of pregnant women received an HIV test in 2010, and about one in five that were found HIV positive received interventions to prevent vertical transmission of HIV[1]. Such women are denied allotment of beds in the hospital and asked to seek treatment elsewhere. Often, staff members at medical centres abuse and misbehave with them as well.

Human Rights Law Network, Odisha, conducted a fact-finding mission on May 6, 2017, in Ratilo village in Cuttack district. The focus of the study was to investigate the serious denial of health and reproductive rights of HIV-positive pregnant women. This fact-finding report intends to shed light on the status of the Community Health Centers, hospitals, doctors, nurses and other medical staff members who neglect the rights of pregnant women with HIV.

CONTEXT

India accounts for 17% of all maternal deaths in the world. The country's maternal mortality rate is pegged at 167 per 100,000 live births, whereas infant mortality is estimated at 43 per 1,000 live births. Among the primary causes of high maternal and infant mortality are poor nutrition and inadequate medical care during pregnancy and childbirth[2].

In India, a reported 30% of women are married before they attain the legal age for marriage of 18 years[3]. This often means that girls as young as 15 begin to have children. This, in itself, carries significant risks, contributing to high maternal mortality and morbidity rates. Worldwide, 13 developing countries accounted for 70 per cent of all maternal deaths. The highest number occurred in India where 136,000 women died[4], most of which are preventable. These women face a number of health concerns during pregnancy and after the delivery of their infant. These illnesses stem from malnourishment and include anemia, low BMI and an increase in the rate of infection and length of recovery. These health concerns often continue after pregnancy and also affect the health of the infant child. There is a very high prevalence of anaemia in infants and their lactating mothers. A staggering 1.7 million children in India do not survive beyond the first year of infancy. Out of this number, 1.2 million of these children do not survive beyond the first month of infancy. Out of every 100 babies born in this country annually, six to seven have a birth defect.

1. https://www.ncbi.nlm.nih.gov/pubmed/24656059
2. http://blogs.timesofindia.indiatimes.com/toi-news/rs-6000-aid-for-pregnant-women-on-hospitalisation-says-modi/
3. http://indianexpress.com/article/explained/child-marriage-women-india-census-data-2011-2826398/
4. http://www.who.int/mediacentre/news/releases/2003/pr77/en/

In Indian context, this would translate to 1.7 million birth defects annually and would account for 9.6 per cent of all newborn deaths[5].

Another factor contributing to poor maternal health and infant mortality rate is HIV/AIDS. Around the world, laws and policies stigmatize and discriminate against people living with HIV/AIDS, violating their human rights. In reaction to this, people living with HIV are increasingly using the law to hold governments accountable for human rights violations and to ensure that others do not face the same discrimination and abuse. Pregnant women with HIV have limited or no access to health care and antenatal care due to the stigmas related to HIV positive patients. In many instances, public hospital workers regularly reject HIV positive women right away from the delivery rooms and refuse to allot beds to them.

Public health is a state subject, the primary responsibility to provide quality health care services to the people -- including in rural, tribal and hilly areas -- lies with state/Union Territory governments. To supplement the efforts of state governments in improving healthcare services, particularly in rural areas including hilly and tribal areas, the National Rural Health Mission (NRHM) was launched in 2005. NRHM has now been subsumed as a sub-mission of the overarching National Health Mission (NHM) with the National Urban Health Mission as the other sub-mission. Healthcare services in tribal areas of the country vary from state to state. Under the National Health Mission (NHM), support is provided to states/UTs to strengthen their health systems including for setting up/upgrading public health facilities, augmenting health human resource on contractual basis, drugs and equipment, diagnostics, ambulances, Mobile Medical Units, etc, for the provision of equitable, affordable healthcare to all its citizens including the poor and vulnerable population including tribal population based on the requirements posed by the states in their programme implementation plans.

To ensure focus on quality, states are also supported for implementation of National Quality Assurance Framework and Kayakalp. Under NHM, all tribal majority districts whose composite health index is below the state average have been identified as High Priority Districts (HPDs) and these districts are expected to receive more resources per capita under the NHM as compared to the rest of the districts in the state. These districts also receive focused attention and supportive supervision. Norms for infrastructure, human resource, ASHAs, MMUs, etc, under NHM are relaxed for tribal and hilly areas[6]. The Union health minister, Shri J P Nadda stated this in a written reply on dated March 15, 2016, in the Rajya Sabha.

METHODOLOGY

A fact-finding team comprising of a health activist and lawyer of HRLN's Odisha unit visited the CHC (Community Health centre) in Ratilo village under Salepur Block on May 6, 2017, to ascertain the facts behind the death of an infant born to an HIV-positive pregnant woman who was left to suffer from labour pain for 30 continuous hours. The team visited the victim's house in Ratilo village, Salepur Tehsil and SCB Medical College to interact with the victim, her family members and health care providers.

5. http://www.pib.nic.in/newsite/mbErel.aspx?relid=94602

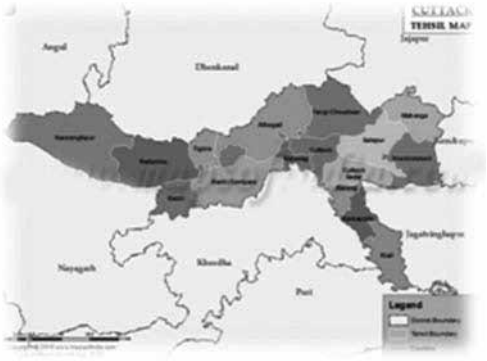
6. http://www.business-standard.com/article/government-press-release/public-health-is-a-state-subject-the-primary-responsibility-to-provide-116031500659_1.html

STATE PROFILE: Odisha[7]

Odisha (formerly Orissa) is one of the 29 states of India, located in the eastern coast. It is surrounded by the states of West Bengal to the north-east, Jharkhand to the north, Chhattisgarh to the west and north-west, and Andhra Pradesh to the south. Odisha has 485 kilometers (301 mi) of coastline along the Bay of Bengal on its east, from Balasore to Malkangiri. It is the 9th largest state by area, and the 11th largest by population. It is also the 3rd most populous state of India in terms of tribal population. Odia (formerly known as Oriya) is the official[8] language. In 2011, the population of Odisha was 4,19,74,218. The ratio of female and male is 978 females per 1000 males. The population density is 13.97 per cent and is 269 per sq km. The literacy rate is around 73 per cent in Odisha, of which around 82 per cent are males and 64 per cent females are literates. These figures are according to the 2011 census.

CUTTACK DISTRICT, RATILO VILLAGE[9]

Ratilo is a village in Salepur Tehsil in Cuttack district of Odisha. It is located 26 km towards the east from district headquarters in Cuttack; six km from Salepur; and 38 km from the state capital of Bhubaneswar. Cities near this village are Jagatsinghapur, Cuttack, Kendrapara and Bhubaneswar. Oriya is the local language spoken here. INC, BJD are the major political parties in this area[10].



STATUS OF HEALTH IN ODISHA: (National Family Health Survey)[11]

NO.	PARTICULARS	NFHS-I (1992-93)	NFHS-II (1998-99)	NFHS-III (2005-06)
1	Infant Mortality Rate (IMR)	112.1	81	65
2	Neonatal Mortality Rate (NNMR)	64.7	48.6	
3	Under-5 Mortality Rate	131.0	104.4	
4	Child Mortality Rate	21.3	25.5	

7. http://www.travelindia-guide.com/orissa_details.php
8. https://en.wikipedia.org/wiki/Odisha
9. http://www.mapsofindia.com/maps/orissa/tehsil/cuttack.html
10. http://www.onefivenine.com/india/villages/Cuttack/Salepur/Ratilo
11. http://health.odisha.gov.in/National_Family_Health_Survey.asp?GL=6

5	Total Fertility Rate	2.92	2.45	2.4
6	% currently using any method			
	Sterilization	31.6	35.6	8.1
	Spacing Method	10.0	4.7	6.9
7	% of mothers receiving ANC	61.0	79.2	60.9
8	Institutional Delivery (%)	14.1.	22.9	39
9	Safe Delivery (%)	20.5	33.7	
10	Children fully vaccinated	36.1	43.7	51.8
	BCG	63.3	84.7	83.6
	DPT	56.3	61.9	67.9
	Polio	56.7	68.4	65.1
	Measles	40.2	54.0	66.5

OBJECTIVES OF REPRODUCTIVE CHILD HEALTH (RCH-II)[12]

Despite the gradual improvement in health status over many years, preventable mortality and morbidity in Odisha are high. The government of Odisha has launched RCH-II programme in the state since April, 2005, with goals of reducing IMR from 87 per 1,000 live births to 50 per 1000, MMR from 367/100000 to 250/100000, Total Fertility Rate from 2.46 to 2.2 and couple protection rate from 46.8 per cent to 65 per cent by 2010. In terms of thematic focus, the major thrust of the programme is on IMR and MMR and that forms the preamble for the future. Component for child health has been designed as per the IMNCI protocol. Special emphasis has been made to initiate community level involvement on basic and comprehensive emergency obstetric care as regards maternal and child health. A separate component has been designed for Adolescent Reproductive Health to be implemented as a mainstream strategic component of RCH Programme. Efforts have been made to focus on providing health services to tribal communities (62 tribes, including 13 primitive tribes) with a population of 8.15 million constituting 22.3 per cent of the state's population. The goal of the Department of Health & Family Welfare, government of Odisha is to facilitate the incremental improvement in the health status of people of Odisha with their participation, and to make available health care in a socially equitable, accessible and affordable manner within a reasonable timeframe, creating partnerships between public, voluntary and private health sector and across other developmental sectors.

The overall objective of the RCH II is:

- To establish health care services with improved access and quality to respond to the needs of disadvantaged groups
- To ensure that no one is denied services due to inability to pay
- And to ensure better and equitable utilization of service

12. http://health.odisha.gov.in/Reproductive_Child_Health.asp?GL=8

Objectives

- To reduce Total Fertility Rate to 2.1 from 2.5 by 2010 in the state
- To reduce Infant Mortality Rate from the present level of 87 /1000 live births to 50/1000 live births by 2010 in the state
- To reduce Maternal Mortality Rate from the present level of 470/100,000 to 250/100, 000 by 2010 in the state

FACTS ABOUT THE INCIDENCT

A 22-year-old HIV positive pregnant woman in Ratilo Village from the OBC category was left to suffer labour pain for 30 hours that led to infant death. Her health and reproductive rights were denied at Community Health Center, Salepur, SCB Medical College and Hospital,and at private labs by doctors, nurses and other medical staff members. She faced severe harassment everywhere she went along with her husband, while she was in labour. This incident ultimately led to the death of the infant.

Interaction with the victim

When the fact-finding team members interacted with the victim at her house in Ratilo village, she described the hardships she faced in SCB Medical College and Hospital in Cuttack. She told the team that she enrolled her name as she conceived in MCTS (Mother Child Tracking System) card under Auxiliary Nurse Midwifery (ANM), Ratilo Sub Health Center. Her MCTS card number is 12100470225. She had got regular checkups done by ANMs and was counseled by counsellor Namita, ICTC, Salepur under Salepur CHC. Her LMP was on July 20, 2016, and Her Expected Date of Delivery (EDD) was on April 24, 2017. She was given Tetanus Toxoid (TT) on October 12, 2016, and November 9, 2016; her hemoglobin was 10gm and the heart beat of her fetus per minute was 125 on December 9, 2016; 130 per minute on February 1, 2017, and 109 per minute on March 9, 2017. Her ICTC number is 01810/29.11.2016; Pre ART PAS number is 6347/5.02.16; ART number is OR/CTC/4274; and CD4 is 594 on March 20, 2017. She is under TLE regimen of prophylaxis.

On April 16, 2017, she experienced labour pain around 9 pm and the next morning, with the assistance of an ASHA worker, an ambulance was called around 11am and they reached Salepur CHC. But medical staff here did not attend to the patient. At this time, Dr Chinmayee Nanda was in labour room and without even seeing the patient,she sent a message from the labour room to refer the patient to SCB Medical College and Hospital,Cuttack which is 30 kms away from Salepur CHC.

In such severe pain, she was forced to travel long distance to reach SCB hospital. Accompanied by ASHA worker, she entered the hospital labour room and was laid down on the floor. Upon learning that the patient was HIV-positive, the doctors and the staff members refused to touch her and warned her not to use the washrooms or touch anyone around. They abused and fought with the ASHA worker for bringing the patient to this hospital. At this point, her condition was getting serious but she was not allotted a bed and was not admitted in the labour room. Almost after 24 hours, the patient was sent to the regional diagnosis centre for a blood test but had to return empty-handed as the officials refused to examine the blood. When her husband requested the doctor to provide immediate medical treatment and care to his wife to relieve her of the pain, the latter misbehaved and drove the couple out. In the evening, a doctor came and advised her

to get ultrasound done. As she did not get the facility to get an ultrasound done in the hospital, she was advised by health care providers of the hospital to get it done from private labs, which she did. After seeing her ultrasound reports, the doctor scolded the couple and without informing them about the results of the report, he told them,"You go anywhere, here, delivery will not be conducted". She then lay on the floor in severe labour pain for the whole night and was ignored by the medical staff for almost 30 hours.

The next day, after the interference of an NGO, 'Utkal Sevak Samaj' which approached the superintendent of the hospital, she was given a bed around 12 pm. She was advised to get a blood test done but Anchhalika Seva Kendra refused to do it for her. She finally got a test from a lab. After several hours of appeal, a doctor began to attend to her and around 2 am, a stillbirth male child was delivered. On April 19, 2017, around 10 am, they discharged her and sent her to the village without providing referral transport service from facility to home. With gloomy eyes, the woman said that her child could have been saved with proper and timely medical care and treatment given to her.

Interaction with the victim's husband

He told our fact-finding team that he had been harassed by everyone right from the CHC to the SCB Medical College and Hospital. He also said that he lost his child due to the negligence and delay in providing immediate medical treatment to his wife at the CHC and at the SCB hospital. He said that his wife was not allowed to enter into the labour room when it came to the knowledge of medical staff that she was an HIV-positive woman. He said that he was ashamed to see such discrimination done to his wife in a hospital. The couple expressed that they felt severely discriminated against and harassed throughout.

Interview with ICTC counselor

The ICTC counselor told the team that the victim was regularly visiting her for counselling. No to that particular day, she came to CHC and she was referred to SCB Medical College and Hospital, Cuttack because the patient was earlier identified as red card holder which signifies high risk patient. On April 18, 2017, the counselor visited the patient in SCB Medical College in the afternoon and by that time, she was on the bed. Next day, the counselor heard that she had delivered a stillbirth child. The counselor denied any negligence or delay on the part of the authorities at CHC and SCB Medical College and said that every other admission process gets delayed by few minutes.

Interview with Amiya Biswal, chief functionary, Utkal Sevak Samaj

He informed the team that he visited urgently to the SCB Medical College and Hospital after being informed about the situation by his staff. At that time, the woman was lying on the floor in the labour room. A media team also reached the spot and with them, Biswalmet the superintendent of the SCB Medical College and Hospital and spoke to him about the urgency of the case and asked for immediate medical attention.

The couple claims that it was upon the organization's intervention that the doctors at the SCB finally admitted her and provided a bed. "After we contacted the SCB authorities in this regard, an initiative was taken for the treatment of the victim," said Biswal. However, the hospital has rejected any allegation of medical negligence. "The patient was allotted a bed in maternity ward

and treatment was on to ensure a normal delivery," said SCB emergency officer Dr Bhubanananda Moharana.

The team tried to meet Dr Chinmayee Nanda on May 6, 2017, but a CHC staff member said that she had been transferred to another location.

OBSERVATION

This appears to be a case of gross violation of the reproductive rights of an HIV-positive woman where she was left unattended by medical staff for almost 30 hours in severe labour pain, on the floor of the SCB medical college and hospital.

The ANMs of Ratilo village do not establish proper linkages with facilities like Salepur CHC, ART Center, Cuttack and SCB Medical College and Hospital, Cuttack for institutional delivery of the HIV positive pregnant women. And the Medical Officer in CHC, Salepur did not ensure safe and emergency delivery management and hence, violated the regulations of the Janani Shishu Suraksha Karyakram (JSSK) scheme. When the patient reached CHC in an emergency condition, the doctor referred her to SCB Medical College (which is 30 km from the CHC) without seeing her. No birth preparedness activities were previously planned by the Medical Officer, Salepur CHC and BPM of NHM Salepur block. District ICTC Supervisor, Cuttack did not ensure preparedness for activities conducting HIV-positive delivery at SCB Medical College. The Medical Officer In-charge, ICTC, Salepur did not ensure safe institutional deliveries either. District RCH officer, Cuttack, CHC medical officer, and ANM did not ensure a birth management plan of the victim. They did not even ensure PPTCT services at the time of her delivery. Non-availability of referral transport service for the victim at the SCB medical college & hospital (i.e from facility to home) and forcing her to get an ultrasound scan done from a private laboratory further shows violation of the JSSKs scheme. The patient and her husband faced stigma and discrimination by the doctors, nurses and other staff members. If the above functionaries had a proper birth management plan in place, the precious life of a child could have been saved. This is a case of gross discrimination by healthcare providers at SCB medical college & hospital, Cuttak to a HIV-positive pregnant woman, violating her Fundamental Rights enshrined in the Constitution under Articles 14 and 21, among others, basic human rights and also her rights ensured under different national and international guidelines, covenant and conventions.

HUMAN RIGHTS VIOLATIONS UNDER NATIONAL AND INTERNATIONAL LAW

Violations of Guarantees under Indian Constitution

The right to the highest attainable standard of health (referred to as ''right to health'') was first outlined in 1946 in the Constitution of the WHO. In the Indian context of the constitutional violations of "right to health care" are as follows:

Article 14: "The State shall not deny to any person equality before the law or the equal protectionof the laws within the territory of India."

Article 15 (1): "The State shall not discriminate against any citizen on grounds only of religion,race, caste, sex, place of birth of any of them."

Article 15 (3): "Nothing in this article shall prevent the State from making any special provisionfor women and children."

Article 21: "No person shall be deprived of his life or personal liberty except according to procedureestablished by law."

In the case of Munshi Singh Gautam v. State of M.P.[13], the Supreme Court held that,

Article 21: "[l]ife or personal liberty includes a right to live with human dignity. There is an inbuiltguarantee against torture or assault by the State and its functionaries."

Violation of basic human rights to a HIV-positive pregnant woman under international laws: The right to survive pregnancy and childbirth is a basic human right. These are some of the laws provided in support of maternal health by the international community which is also up held by India. These are the laws intact in order to provide these basic necessities but are violated by the State. These laws are as follows:

Universal Declaration of Human Rights, 1948

Article 16 (1), (3):

"Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State."

International Covenant on Civil and Political Rights (ICCPR)

Article 6:

"Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life"

International Convention on Economic, Social and Cultural Rights (ICESCR)

Article 10(1)-(3):

"States Parties to the present Covenant recognize that [t]he widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society. Special protection should be accorded to mothers during a reasonable period before and after childbirth. Special measures of protection and assistance should be taken on behalf of all children and young person's without any discrimination for reasons of parentage or other conditions."

Article 12:

"States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

13. (2005) 9 SCC 631 : AIR 2005 SC 402; Olga Tellis v. Bombay Corpn., AIR 1986 SC 180 (paras 33-34): (1985) 3 SCC 545; D.T.C. v. Mazdoor Congress Union D.T.C., AIR 1991 SC 101 (paras 223, 234, 259): 1991 Supp. (1) SCC 600; Consumer Education & Research Centre v. Union of India, (1995) 3 SCC 42 (para 22).

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Article 15:

"States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

CEDAW makes clear "the social significance of maternity and the role of both parents in the family and in the upbringing of children." The convention recognizes "that the role of women in procreation should not be a basis for discrimination."

Article 12(1), (2):

"States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure...access to health care services, including those related to family planning. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

Article 16:

"States parties shall take all appropriate measures to eliminate discrimination against women in all matters relating...family relations and in particular shall ensure...[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."

United Nations Convention on the Rights of the Child (UNCRC)

Article 24 (1), (3):

"States parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures [t]o ensure appropriate pre-natal and postnatal healthcare for mothers."

INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

Human rights standards and the nature of state obligations

The Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights in June 1993[14], affirmed that all human rights are universal, indivisible, interdependent and interrelated. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, states have the duty, regardless of their political, economic and cultural systems, to promote and protect universal human rights standards and fundamental freedoms.

A human rights approach to HIV is, therefore, based on these state obligations with regard to human rights protection. HIV demonstrates the indivisibility of human rights since the realization of economic, social and cultural rights, as well as civil and political rights, is essential to an effective response. Furthermore, a rights-based approach to HIV is grounded in concepts of human dignity and equality which can be found in all cultures and traditions.

The key human rights principles which are essential to effective state responses to HIV are to be found in existing international instruments, such as the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of the Child. Regional instruments, namely the American Convention on Human Rights, the European Convention for the Protection of Human Rights and Fundamental Freedoms and the African Charter on Human and Peoples' Rights also enshrine state obligations applicable to HIV. In addition, a number of conventions and recommendations of the International Labour Organization are particularly relevant to the problem of HIV, such as ILO instruments concerning discrimination in employment and occupation, termination of employment, protection of workers' privacy, and safety and health at work. Among the human rights principles relevant to HIV/AIDS are, inter alia:

- The right to non-discrimination, equal protection and equality before the law;
- The right to life;
- The right to the highest attainable standard of physical and mental health;
- The right to liberty and security of person;
- The right to freedom of movement;
- The right to seek and enjoy asylum;
- The right to privacy;
- The right to freedom of opinion and expression and the right to freely receive and impart information;
- The right to freedom of association;
- The right to work;

14. GwAQ7PeH7fJTFa4DXguurfn7GULq2pTs

- The right to marry and to found a family;
- The right to equal access to education;
- The right to an adequate standard of living; The right to social security, assistance and welfare;
- The right to share in scientific advancement and its benefits;
- The right to participate in public and cultural life;
- The right to be free from torture and cruel, inhuman or degrading treatment or punishment;
- Particular attention should be paid to human rights of children and women.

Discrimination against women, de facto and de jure, renders them disproportionately vulnerable to HIV and AIDS. Women's subordination in the family and in public life is one of the root causes of the rapidly increasing rate of infection among women. Systematic discrimination based on gender also impairs women's ability to deal with the consequences of their own infection and/or infection in the family, in social, economic and personal terms[15].

With regard to prevention of infection, the rights of women and girls to the highest attainable standard of physical and mental health, to education, to freedom of expression, to freely receive and impart information, should be applied to include equal access to HIV-related information, education, means of prevention and health services. However, even when such information and services are available, women and girls are often unable to negotiate safer sex or to avoid HIV-related consequences of the sexual practices of their husbands or partners as a result of social and sexual subordination, economic dependence on a relationship and cultural attitudes. The protection of the sexual and reproductive rights of women and girls is, therefore, critical. This includes the rights of women to have control over and to decide freely and responsibly, free of coercion, discrimination and violence, on matters related to their sexuality, including sexual and reproductive health[16]. Measures for the elimination of sexual violence and coercion against women in the family and in public life not only protect women from human rights violations but also from HIV infection that may result from such violations.

Violence against women in all its forms during peacetime and in conflict situations increases their vulnerability to HIV infection. Such violence includes, inter alia, sexual violence, rape (marital and other) and other forms of coerced sex, as well as traditional practices affecting the health of women and children. States have an obligation to protect women from sexual violence in both public and private life.

Furthermore, in order to empower women to leave relationships or employment which threaten them with HIV infection and to cope if they or their family members are infected with HIV, states should ensure women's rights to, inter alia, legal capacity and equality within the family, in matters such as divorce, inheritance, child custody, property and employment rights, in particular, equal remuneration of men and women for work of equal value, equal access to responsible positions, measures to reduce conflicts between professional and family responsibilities and protection against sexual harassment at the workplace. Women should also be enabled to enjoy equal

15. See report of the Expert Group Meeting on Women and HIV/AIDS and the Role of National Machinery for the Advancement of Women, convened by the Division for the Advancement of Women, Vienna, 24-28 September 1990 (EGM/AIDS/1990/1).

16. Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, 4/5 September 1995 (A/CONF.177/20).

access to economic resources, including credit, an adequate standard of living, participation in public and political life and to benefits of scientific and technological progress so as to minimize risk of HIV infection.

HIV prevention and care for women are often undermined by pervasive misconceptions about HIV transmission and epidemiology. There is a tendency to stigmatize women as "vectors of disease", irrespective of the source of infection. As International Guidelines on HIV/AIDS and Human Rights 87 a consequence, women who are or are perceived to be HIV-positive face violence and discrimination in both public and in private life. Sex workers often face mandatory testing with no support for prevention activities to encourage or require their clients to wear condoms and with little or no access to health-care services. Many HIV programmes targeting women are focused on pregnant women but these programmes often emphasize coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory pre- and post-natal testing followed by coerced abortion or sterilization. Such programmes seldom empower women to prevent prenatal transmission by prenatal prevention education and an available choice of health services and overlook the care needs of women. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obliges states parties to address all aspects of gender-based discrimination in law, policy and practice. States are also required to take appropriate measures to modify social and cultural patterns which are based on ideas of superiority/inferiority and stereotyped roles for men and women. The CEDAW, which monitors the Convention, has underscored the link between women's reproductive role, their subordinate social position and their increased vulnerability to HIV infection.

The human rights of HIV+ pregnant women in India

Overview

HIV+ pregnant women in India face constant threats to their fundamental rights to health, life, non-discrimination, privacy, and personal dignity. India has the third-highest HIV prevalence rate in the world[17]. HIV+ women have the same rights as women who do not have HIV. As a signatory to CEDAW, in accordance with various international legal standards, and based on the Constitution of India, the Union of India has an obligation to provide HIV+ pregnant women the highest attainable standards of health services and care. Further, India adopted the 2013 World Health Organization (WHO) Prevention of Parent to Child Transmission (PPTCT) Guidelines providing ART (triple drug regimen) for all pregnant and lactating women living with HIV in India.

However, the present stories of HIV+ women in India make clear that equal and non-discriminatory treatment for HIV+ pregnant women is far from reality. Regular reports of cases from across India demonstrate that HIV+ pregnant women are refused medical care (even while in stages of labor), are mocked, discriminated against, harassed, and neglected by medical professionals, are refused patient privacy rights, are charged exuberant amounts not charged from women without HIV, and are not given the state required PPTCT to avoid transmission to a child. As a result, women with HIV are more vulnerable to maternal and infant mortality. Further, many women do not disclose their HIV+ status to avoid discrimination putting the woman, child, and medical staff in more danger. The treatment of HIV+ pregnant women in India is a grave violation of a woman and her newborn child's right to health, life, non-discrimination, privacy, and personal dignity.

17. The Gap Report – Beginning of the End of the AIDS Epidemic, UNAIDS, 17 (2013) (UNAIDS defines the prevalence rate as adults (15-49 years) living with HIV/AIDS as of 2011).

Repeated cases show that the Union of India fails to ensure these rights for HIV+ pregnant women. It is crucial that the Indian government upholds these guidelines and ensures that schemes have adequate funding, monitoring, and implementation to guarantee the Article 21 rights of pregnant HIV+ women.

Factual Background: HIV

As of 2011, India has an estimated 2.1 million people living with HIV. Numbers of adults with new HIV infections have fallen (2.7 lakh in 2000 to 1.17 lakh in 2011)[18]. While the numbers related to prevalence have decreased, HIV+ women still face pervasive discrimination and barriers to adequate care. Those fundamental rights violations make vertical transmission (mother-to-child transmission) difficult to prevent. Women represent 39 per cent of people living with HIV and children under the age of 15 represent 7 per cent of all HIV infections in India. The risk of vertical transmission of HIV is equal during pregnancy, delivery, and breast-feeding. Without PPTCT intervention, the likelihood of transmission from child to mother can be from 20-45 per cent.

In India, there are 27 million pregnancies a year, 52.7 per cent "attend health services for skilled care during child birth in India, and of those services 8.83 million (62 per cent) received HIV testing." From those 8.83 million, 12,551 pregnant women with HIV were detected. A woman's ability to access PPTCT intervention throughout India is plagued by pervasive discrimination and human rights violations, often at the hands of government medical institutions. The Union of India has adopted international guidelines that guarantee each woman's access to PPTCT treatment. As noted in the studies and cases below, the Union of India has a long way to go to ensure that the human rights of HIV+ pregnant women are actively upheld and protected.

Overview of discrimination

HIV+ pregnant women continue to experience grave human rights offenses as a result of discrimination from government medical professionals and facilities. A 2006 UNDP study found that "25 per cent of people living with HIV in India have been refused medical and surgical treatment on the basis of their HIV-positive status"[19]. In an additional UN and NACO study, about "12 per cent of female PLWHA [Persons Living With HIV/AIDS] reported that they had faced discrimination at health facilities." Among the study participants, the large majority experienced discrimination at government facilities: '65 per cent of male PLWHA and more than 75 per cent of female PLWHA' faced discrimination at government facilities. Of the individuals who reported discrimination, 'about 25 per cent were either refused medical treatment or were referred to another health facility, nearly 40 per cent felt that they were neglected and isolated, about 30 per cent were abused and teased [and] [a]bout 4.5 per cent reported that they were denied admission at health facilities'. The study also found prevalent discrimination in the forms of refusing to treat HIV+ patients, refusing to touch HIV+ patients, disclosing HIV+ status to other patients and medical staff, and charging additional fees. In many cases, study participants self-reported that they stopped disclosing their HIV+ status at facilities to avoid the discrimination and ensure availability of treatment[20].

18. National AIDS Control Organization, Updated Guidelines: Prevention of Parent to Child Transmission (PPTCT) of HIV using Multi Drug Anti-Retroviral Regimen in India, Government of India, Ministry of Health & Family Welfare, Department of AIDS Control, New Delhi (December 2013).

19. Experiences of HIV Positive Mothers from Rural South India during Intra-Natal Period, US National Library of Medicine (Oct.2013)

20. Basanta K. Pradhan and Ramamani Sundar, Gender Impact of HIV and AIDS in India, NACO, NCAER, and UNDP (2006)

Discrimination is intensified for HIV+ pregnant women due to strong patriarchal standards in the Indian society. The patriarchal influence result in additional forms of discrimination that women face in their family units. While around "5.5 per cent of female PLWHA were asked to leave their home" after revealing an HIV+ status, only 1.9 per cent of males faced the same treatment. Women are also found to be more supportive of their HIV+ husbands (12.4 per cent) in comparison to men of their HIV+ wives (8.5 per cent). The gender gap in support of spouses demonstrate the extra levels of discrimination HIV+ women face in comparison to male counterparts[21]. It is clear, based on the institutional and familial discrimination faced by HIV+ pregnant women, that the Union of India has a long road ahead to provide funding, training, and implementation oversight to ensure that HIV+ pregnant women are protected against discrimination and guaranteed the right to health.

GUIDELINES AND CASES

National AIDS Control Program Guidelines

In 2013, the Government of India, under the National AIDS Control Organization (NACO), committed to work towards the Millennium Development Goal (MDP) of "elimination of new HIV infection among children" by 2015. At that time, the India Department of AIDS Control initiated the lifelong ART (triple drug regimen) for all pregnant and lactating women living with HIV (regardless of stage, CD4 count, or clinical stage) to prevent vertical HIV transmission. The lifelong ART guidelines were based on WHO guidelines of 2013. The ART guidelines are also referred to as the "National Guidelines for PPTCT (2013)."

Under these most recently adopted PPTCT guidelines (2013), all states are to strengthen convergence with the National AIDS Control Program (NACP) and the National Reproductive Health (RCH), including Sexually Transmitted Infections (STI), to improve access to HIV awareness counseling and screening/testing services to detect HIV infection amongst pregnant women on their very first contact with the health system. The PPTCT program also recognizes four elements that are integral to prevention of HIV transmission between women and children:

1) primary prevention of HIV, especially among women of child bearing age
2) preventing unintended pregnancies among women living with HIV
3) prevent HIV transmission from pregnant women with HIV to their children
4) provide care, support, and treatment to women living with HIV, their children and family

The guidelines outline classes of people who should be tested for HIV: women attending antenatal care (including women screened at all levels of the systems: hospitals, CHCs, PHCs, and other sub-centres), pregnant spouses of HIV+ men, and women presenting directly-in-labor (including un-booked cases and requiring screening even before delivery) with follow-up care at Integrated Counseling and Testing Centres (ICTCs). The adopted guidelines mandate that ICTCs are established at all medical colleges, district hospitals, CHCs and PHCs. Sub-centres are expected to have screening centres to conduct a whole blood finger prick test to screen for HIV.

The guidelines note that women detected to have HIV during ANC or during or soon after delivery should be treated as top priority for clinical management and monitored care. The guidelines

21. Ibid

also provide that treatment and medication should be free of cost. It is clear that the Indian government fails to protect the human rights to health and life of HIV+ pregnant women when considering the adopted guidelines and the various examples of discrimination and refusal of care described below[22].

National Rural Health Mission Guidelines

In July 2010, the National AIDS Control Programme (NACP) and the NRHM issued a joint directive for the convergence of the two programmes to ensure universal HIV screening as an integral part of all routine ANC check-ups under the NRHM. The purpose of the convergence was to ensure detection of HIV+ pregnant women and to provide the connection between HIV health and PPTCT services for the woman. The joint directive also included convergence of Integrated Counseling and Testing Centres and ART (triple drug regime) Centres into NRHM health centre systems.

International Law

In addition to guarantees and entitlements outlined in government schemes, international law obligates the Government of India to ensure HIV+ pregnant women's fundamental rights. Various international covenants and conventions ensure HIV+ pregnant women's rights to life, health, equality before the law, and privacy. Moreover, the government has an obligation to protect marginalized communities that have disproportionately high incidences of HIV including women, children, people experiencing poverty, and indigenous people[23].

Due to pervasive discrimination against HIV+ pregnant women, the protection of internationally recognized reproductive rights is imperative. Starting in the late 1980s the WHO Global AIDS Strategy was the first international entity to produce guiding documents for how countries should respond to HIV. The initial guidelines were comprehensive and included commentary about promoting non-discrimination but did not directly address the needs of HIV+ pregnant women. Comments to additional covenants have attempted to make more direct statements on HIV+ pregnant women's rights[24].

Case Law: The Supreme Court of India

Shanno Shagufta Khan v. State of Madhya Pradesh & Ors., High Court of Madhya Pradesh (2014)

Gitabai was denied care at a Government Hospital in Madhya Pradesh on the basis of her HIV+ status. The hospital egregiously denied her admission and basic emergency care despite the fact that she was going into labor. She left and delivered her baby in an auto-rickshaw. Both Gitabai and the baby eventually died as a result of the hospital staff's failure to ensure adequate care. Advocate Shanno Shagufta Khan filed a PIL in the High Court of Madhya Pradesh at Indore. The High Court found that the staff did act negligently and the family was awarded some minor

22. National AIDS Control Organization, Updated Guidelines: Prevention of Parent to Child Transmission (PPTCT) of HIV using Multi Drug Anti-Retroviral Regimen in India, Government of India, Ministry of Health & Family Welfare, Department of AIDS Control, New Delhi (December 2013)

23. The Right to Health – Fact Sheet No. 31, Office of the United Nations High Commissioner for Human Rights and the World Health Organization

24. Sofia Gruskin, Laura Ferguson, and Mindy Jane Roseman, Reproductive Health and HIV: Do International Human Rights Law and Policy Matter? The Program on International Health and Human Rights, Harvard School of Public Health

compensation. Petitioners appealed to the Supreme Court for orders directing the government to establish guidelines for proper treatment of pregnant women with HIV/AIDS.

Decision: The Supreme Court dismissed the case noting that the decision below was adequate and did not give further guidelines on behalf of HIV+ pregnant women. The court noted, "We do not find any reason to entertain this petition."

Sankalp Rehabilitation Trust v. Union of India (2008 & 1999)

Lawyer's Collective and the Sankalp Rehabilitation Trust of Mumbai filed this PIL in the Supreme Court seeking to address barriers preventing people living with HIV from accessing health care services and facilities. In 2008, the Sankalp Rehabilitation Trust filed its directions sought from the Court.

Decision: The Supreme Court ordered "rapid upscale of ART centres and Link ART centres;increasing the number of CD4 machines and ensuring their maintenance in a timely and efficient manner; ensuring adequate infrastructure in ART centres; creation of a grievance mechanism by the institution of a complaint box in every ART centre; provision of free treatment for opportunistic infections; ensuring non-discrimination of people with HIV in health care settings; and ensuring availability precautions and post exposure prophylaxis for health care providers in public hospitals". This was followed by an order in 2010, after NACO requested the Supreme Court to ensure that private doctors follow NACO protocols while prescribing ARVs and track how many patients they are supplying the medication to.

Voluntary Health Association of Punjab (VHAP) vs. The Union of India and Others (2003)

HRLN advocates filed a petition on behalf of VHAP to ask that the Union of India provide free ARV drugs to HIV-positive people. The petition was brought under the right to health and the right to life under Article 21 of the Constitution.

Decision: Soon after, and as a result of the pressure from the petition (not in the court order), thegovernment started free ARV drugs for 100,000 people in six high prevalence states: Maharashtra, Andhra Pradesh, Nagaland, Manipur, Tamil Nadu and Karnataka.

Mr. X vs. Hospital Z (1999)

This case is cited by multiple courts in cases involving various issues related to HIV/AIDS – usually cited by the courts in some form justifying a hospital or medical professional's discriminatory treatment of persons with HIV/AIDS. In this case, a doctor's marriage did not take place after the hospital publically revealed his HIV+ status. He filed for damages against the hospital for the violation of his privacy.

Decision: The Supreme Court held that there are exceptions to the right to privacy of an HIV+person when not disclosing the status could harm another person and that the fundamental right to marriage is not absolute.

Important Note: In the decision the Court described AIDS as the following: "AIDS is the product of indiscipline sexual impulse. This impulse, being the notorious human failing if not disciplined, can afflict and overtake anyone how high so ever or, for that matter, how low he may be in the social strata."

Such language contributes to and perpetuates the stigmatization of HIV+ persons in the courts systems and society at large.

The Central Information Commission

Mr Nitesh Kumar Tripathi vs. Employees State Insurance (2014)

Appellants included Mr Kumar of Uttar Pradesh, who sought information from the CPIO ESIC Hospital Okhla, Delhi. The appellant appealed an order after not receiving the information sought. The appellant sought the following information: 1) How many cases of HIV/AIDS had been diagnosed in the hospital in pregnant women and out them how many had delivered vaginal deliveries and how many aborted; and 2) How many blood units have been diagnosed with HIV and how has the infected blood has been managed since 2005.

Decision: Pending answer from the commission.

The Delhi High Court

Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors (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."

X vs. Govt. of Nct of Delhi & Anr (2013)

The 19-year-old petitioner had been forced into prostitution, and a raid conducted, she and three other girls were rescued. Soon after the raid, the petitioner was found to be HIV+ and 19 weeks pregnant. The child was conceived by rape. The petitioner was in protective custody by the state and was therefore not allowed to exercise her right to a medical termination of the pregnancy.

Decision: Under the MTP Act, the woman must be allowed to medically terminate the pregnancy and the Court ordered that the medical facility should continue to monitor the woman's health after the surgery was performed as well.

The Gawuhati High Court

Mr. Wahengbam Joykumar v. Union of India & Ors (2005)

The petition sought provision of antiretroviral drugs to people with HIV/AIDS in Manipur under the 'Free Antiretroviral Treatment Programme' established by NACO. The petitioner was the Programme Executive of Human Rights Alert, a human rights organization located in Manipur.

Decision: The High Court directed the government to provide CD4 machines in more districts.As a result of the case, the government set aside additional funds for people who couldn't afford treatment.

Gujarat High Court

Parents of Children v. Hospital Of The City of Junagadh (2014)

Parents of 23 different children brought suit for negligence against the Government Civil Hospital in Junagadh after their children became HIV+ through blood transfusions at the hospital. The hospital responded by arguing that the children did not receive HIV+ blood at the Government Hospital.

Decision: After a Court ordered CBI investigation, the Court ordered the State Government to create a high-level committee to investigate the functioning of the blood bank, and whether actions should be taken against a particular individual. The Court then dismissed the case with the ongoing CBI investigation.

Harshad J. Pabari v. State of Gujarat (2013)

The petitioner, a 25-year-old pregnant woman tested positive for HIV during her ANC at Guru Gobindsing Government Hospital Jamnagar. The medical staff at the hospital influenced the petitioner to have an abortion. On June 20, 2009, the petitioner arrived at the hospital for an abortion, which was performed by a student nurse after instruction from a medical officer, labelled with a sticker on her forehead by a student nurse (after instruction from a medical officer) noting her HIV+ status. A medical officer and the student nurse proceeded to parade the pregnant woman around the hospital to show other staff and patients. It was also reported that doctors refused to treat the pregnant woman. The woman's six-month-old daughter and mother-in-law were present and witnessed the events. The petitioner filed a suit for the failure to maintain confidentiality, and prayed for the Court to take action against the responsible parties, and to maintain confidentiality of HIV+ patients.

Decision: The High Court upheld the lower commission's decision that the hospital MedicalOfficer and nurse should be held responsible for the discrimination. The MO was transferred to another hospital as a result. The Court also issued additional suggestions that the identity of HIV+ patients should not be disclosed and that there should be proper schemes for rehabilitation of persons who are diagnosed with HIV.

Babublal vs. Directors (2012)

The Court cited the importance of the right to life and to safe blood, and ordered the Government of India's Ministry of Health and Family Welfare to create and oversee a body of experts to determine whether blood banks should use Polymerase Chain Reaction (PCR) tests along with the standard ELISA test to avoid the window period (the initial months after transmission before HIV can be detected) related to donations of blood and blood screening. The case was brought as a public interest litigation after 22 children were infected with HIV from blood transfusions at the Government Hospital in Gujarat.

Decision: The Court ordered the Ministry of Health and Family Welfare to form a team of expertsto look into the question further.

The Kerala State Consumer Dispute Redressal Commission

Managing Partner, Sri Kirshna Maternity Nursing Home, Chinmaya Mission Colony vs. Vijayan, Chodala P.O., Madipady Kasargod (2009)

A pregnant woman went to a maternity nursing home in Kerala, Chinmaya Mission, where she was tested for HIV. She and her husband were told at the facility that she had AIDS and were asked by the nursing staff, and again by the staff working at the front desk, to immediately leave the facility. The woman and her husband were devastated, they left at the instruction of facility staff. The woman and her husband went to the government hospital and were again tested. The results showed that the woman did not have HIV. The woman and her husband brought a suit for the emotional trauma and discrimination they faced from the medical facility. The forum below, the CDRF, found that the medical facility was liable to pay a compensation of Rs 20,000 for unfair trade practice and deficiency in service and a cost of Rs1,500 to the complainant. The opposing medical facility appealed.

Decision: The Kerala State Consumer Disputes Redressal Commission upheld the decision for the woman and her husband and ordered an increase in compensation finding the lower forum's award to be very lenient. The Commission increased the award Rs 20,000 to the complainant, Rs1,500 with a carried interest rate of 25 per centper annum for the entire amount from the date of 24.2.2000 (dating nine years back). The Commission also ordered the medical council of India to take appropriate disciplinary action against the appellant who violated professional ethical codes of conduct. The Commission also directed the Government to create laws and regulations to prohibit unauthorized clinics and pathological labs.

Important Note: The Commission took pity on the woman because, "she is a totally innocent human being who was demarked by a modern system of treatment as an AIDS patient" - insinuating that she was innocent because she didn't have HIV and that if she did have HIV, she would not be considered a completely 'innocent' human being. The language reinforces the social stigma of blaming the individual for their diagnosis. But the Commission also went on to note "that when AIDS is detected in any patient, proper counseling should be provided to them to adapt to that reality" and the health facilities response of telling the woman and her husband that she had AIDS and then demanding them to leave the facility was not tolerable.

Additional Public Health Related Cases

The Lawyer's Collective cases involving public health do not mention pregnant women but rather revolve more around ensuring access to health services and medical facilities and ensuring that government funds and oversight are being appropriately allocated to ART facilities.

Lucy R. D'Souza v. State of Goa (1990)

Dominic D'Souza had gone to donate blood where he was found to be HIV positive and as a result was quarantined in a TB hospital. The Goa, Daman and Diu Public Health Act, 1985 authorised the State of Goa to mandatorily test any person for HIV and to isolate persons found to be HIV-positive. The provision was challenged before the Goa Bench of the Bombay High Court by Dominic's mother, Lucy D'Souza, on the ground that it violated the fundamental rights of her son, guaranteed under Articles 14 (right to equality),19(1)(d) (right to move freely throughout the country) and 21 (right to life) of the Constitution.

Decision: The Court held that the matter essentially fell in the realm of policy and that expert public health authorities made the decision to test and isolate Dominic D'souza. Further, while recognizing the harmful effects of isolation of people living with HIV, the Court held that in case of a conflict between individual liberty and public health, considerations of public health would prevail. However after the judgment was passed, the Government has not taken further further actions under the impugned Act.

Shri Subodh Sarma & Anr. v. State of Assam & Ors. (2000)

A public interest litigation was filed, praying for the proper utilization of funds allocated by the Central Government to Assam for the HIV programme. Grievances of the Petitioners included a lack of systematized data, general awareness among the public and proper documentation, blood banks operating without licenses and control, misallocation of funds, discrimination against people living with HIV, amongst others.

Decision: The Court's order said: properly implement guidelines and strategiesformulated by NACO in letter and spirit; not divert funds released by the Union Government to any other heads of account except for the implementation of the programme as per guidelines and strategies formulated by NACO; inquire as to the irregularities in funding affairs, and take appropriate remedial measures; open AIDS Counselling Centres at different State Hospitals and ensure their effective functioning, and appoint trained and qualified persons; provide adequate equipment and other facilities in the three state Medical College; evolve monitoring system to supervise the implementation of the Programme; ensure persons suspected to be living with HIV/ AIDS are not refused treatment in the hospitals.

CONCLUSION

The fact-finding team was profoundly disturbed by the details surrounding the death of infant of the HIV-positive pregnant woman who was denied immediate medical care and treatment, PPTCT (Prevention of Parent to Child Transmission) services at CHC Salepur and at SCB medical college & Hospital, Cuttack. There is a system in place that is designed to provide adequate care for pregnant women in each of these villages, and yet they are not properly administered. This is a direct violation of Indian Constitutional Guarantees and multiple International Agreements, Conventions and Covenants that establish a right to survive pregnancy and childbirth in India. The Government of India has created multiple schemes to provide services that guarantee a pregnant woman these rights. In this particular instance, there was a breakdown in the referral mechanisms which prevented antenatal care from being distributed, prevented the doctor from being able to understand his patient's condition when she arrived, and a failure of CHC and DH, SCB Medical College and Hospital that could treat her in time. All of these resulted in a failure to avert a preventable infant mortality; a violation of her right to survive her child birth. Denial of referral transport service to the victim from facility to home is a gross violation of Janani Shishu Suraksha Karyakram scheme (JSSK).The events of this case also constitute violations of multiple rights provided by the Constitution, including the fundamental right to health, and guaranteed access to medical services regardless of status. The victim especially, and the state failed to hold its employees accountable, she did not receive the care she needed to remain healthy during her pregnancy. There is fear that other women similarly situated may face the same fate if the

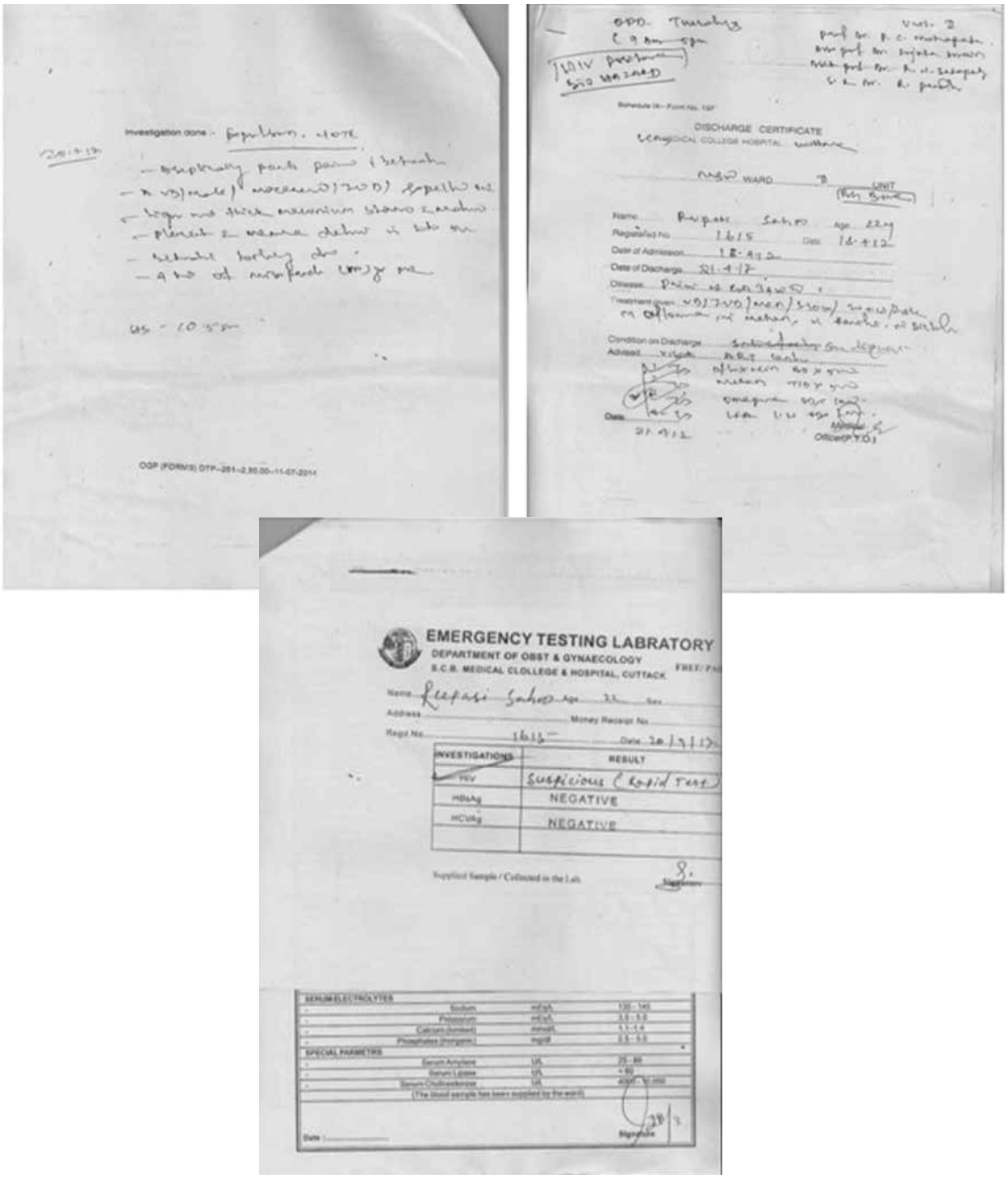
state does not address these egregious violations. The lack of oversight and accountability has created an environment rampant with failures that have finally resulted in infant death and severe stigma and discrimination in health care institution. The CHC, ambulance service and SCB Medical College and Hospital in Cuttack and ART Center in Cuttack all failed in their inability to respond quickly with services that could have saved the life of the child of the HIV positive pregnant woman. A fully functional public health system is not just about delivering services, it should also engage the community members and build the trust of the people by providing responsive and quality PPTCT services. Public health service should develop a culture of rights and accountability and strengthen infant death review and take these death review reports seriously to create and develop a strong and responsive public health system.

MAJOR FINDINGS FROM THE CASE STUDY

- The ANMs of Ratilo village failed to establish proper linkages with facilities like Salepur CHC, ART Center, Cuttack and SCB Medical College and Hospital, Cuttack for institutional delivery of the HIV positive pregnant women.
- Medical Officer in CHC, Salepur did not ensure safe delivery, and emergency delivery management and hence, violated the regulations under Janani Shishu Suraksha Karyakram scheme (JSSK).
- When the patient reached CHC in severe labour pain, the doctor without examining the patient from labour room asked the nurse to refer patient to SCB Medical College (which is 30 KM away from the CHC). Earlier, no birth preparedness activities were planned by the Medical Officer, Salepur CHC and BPM of NHM Salepur block.
- The HIV-positive pregnant woman was asked to get her ultrasound done from a private lab where she was denied several times. This was a violation of her reproductive rights under the Janani Shishu Suraksha Karyakram scheme (JSSK).
- District RCH Officer, Cuttack involving pregnant women, CHC medical officer, ANM did not ensure birth management plan of the victim. Also, they did not ensure PPTCT services at the time of her delivery.
- District ICTC Supervisor, Cuttack did not ensure preparedness for activities conducting HIV-positive delivery at SCB Medical College.
- The Medical Officer In-charge, ICTC, Salepur did not ensure timely referral and safe institutional deliveries.
- The patient and her husband faced stigma and discrimination for being an HIV-positive pregnant woman by the doctors, nurses and other staff members.
- If the above functionaries could have done proper birth management plan and timely risk management, the precious life of the child could have been saved.
- At SCB medical college & Hospital, Cuttack, the victim was denied immediate medical care and treatment, and she was left unattended for almost 30 hours in severe labour pain lying down on the floor of the hospital.
- Health care providers scolded the victim several times and discriminated against her by not allowing her to move to the labour room or admonishing her to not touch anybody there.

- She was denied an ultrasound scan at the hospital, which is a violation of the JSSK scheme.
- Non-availability of referral transport service to victim from facility to home at SCB medical college & hospital is a gross violation of JSSK scheme.

ANNEXURES 1, 2 and 3



DISCHARGE CERTIFICATE

EMERGENCY TESTING LABRATORY
DEPARTMENT OF OBST & GYNAECOLOGY
S.C.B. MEDICAL CLOLLEGE & HOSPITAL, CUTTACK

INVESTIGATIONS	RESULT
HIV	Suspicious (Rapid Test)
HBsAg	NEGATIVE
HCVAg	NEGATIVE

4

The Maternal Death of Runa Begum

HRLN
HUMAN RIGHTS LAW NETWORK
Reproductive Rights Initiative,
576, Masjid Road, Jangpura, New Delhi, India 110014

INTRODUCTION TO MATERNAL HEALTH AND MATERNAL MORTALITY

Access to healthcare is a basic human right. The right to health is considered a fundamental right and has been recognized as so in India under Article 21 of its Constitution. Reproductive health rights are an integral part of the right to health. The WHO refers to maternal health as the health of women during pregnancy, childbirth and the postpartum period[1].

High maternal mortality continues to plague many developing countries in the world. Maternal death has been defined by WHO as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes[2]. Maternal mortality has at many places reached epidemic proportions. Although the overall number of maternal deaths in the world is falling gradually, a lot of countries in the world are still languishing at the bottom of human development, with an alarming rate of maternal mortalities. A total of 73 out of 184 countries have an MMR of 100 or more with South Sudan having the worst MMR of 2054. Estonia has the lowest MMR, i.e. 2[3].

Maternal mortality is appraised through the Maternal Mortality Ratio (MMR) which is the number of maternal deaths per 1,00,000 live births.

In 2000, the United Nations (UN) Member States pledged to work towards a series of goals. They termed it as the Millennium Development Goals (MDGs). These goals were to be achieved by 2015. It included the target of a three-quarters reduction in the 1990 maternal mortality ratio (MMR). Though India's MMR has been decreasing, India was expected to reduce its MMR to 109 per 1,00,000 live births by 2015, but it failed to do so with its last recorded MMR standing at 174[4].

To build on the momentum generated by the MDGs, the Sustainable Development Goals (SDGs) were adopted. In July 2014, the UN General Assembly Open Working Group proposed a document containing 17 goals to be put forward for the General Assembly's approval in September 2015. This document set the ground for the new SDGs and the global development agenda spanning from 2015-2030. The SDGs adopted at the UN General Assembly in September 2015 came into effect from 1 January, 2016. The SDGs aim to establish a transformative new agenda for maternal health towards ending preventable maternal mortality and a target to reduce the global MMR to less than 70 per 1,00,000 live births by 2030 has been set[5].

MATERNAL HEALTH IN INDIA

Maternal health is a matter of serious concern in India. In 1990, the MMR in India was as high as 556. With advancement in health services and improved access to health facilities, MMR has been gradually declining and now stands at 174. We are still some distance away from an ideal situation. In numbers, there were approximately 45,000 maternal deaths in India in 2015 which is about 15% of total maternal deaths in the world in that year. In addition, India and Nigeria together are estimated to account for over one-third of all maternal deaths worldwide in 2015[6].

1. Quoted from WHO website; http://www.who.int/topics/maternal_health/en/
2. Quoted from WHO website; http://www.who.int/healthinfo/statistics/indmaternalmortality/en/
3. Country Comparison> Maternal Mortality Rate; https://www.indexmundi.com/g/r.aspx?v=2223
4. WHO 2015, Trends in Maternal Mortality: 1990 to 2015
5. Goal 3 Targets; Sustainable Development Goals
6. WHO 2015, Trends in Maternal Mortality: 1990 to 2015

A number of schemes have been introduced and implemented like the Janani Suraksha Yojana, National Maternity Benefit Scheme and the Janani Shishu Suraksha Karyakram under the overall umbrella of the National Health Mission to improve the maternal health situation in the country. But the seriousness of Government's efforts can be legitimately questioned, when we observe that only 4.7% of the country's GDP is spent on health. To compare, advanced countries like Germany and France spend more than 10 percent of their GDP on healthcare[7].

In this report, we will examine a particular case of maternal death in Assam and try to analyse the circumstances surrounding the death.

MATERNAL HEALTH IN ASSAM

Assam is a state in the northeast of India and is one of the largest tea-producing regions in the world. But it throws up some shocking numbers when we talk about maternal deaths. Even as we have mentioned the poor health situation of India, it is worse in Assam. As per Annual Health Survey Assam, the state has a MMR of 301. This is almost double the MMR of India and the highest amongst all Indian states.

While Assam produces some of the best quality tea in the world, ironically, 77 percent of maternal deaths take place in the tea garden areas[8]. This is reflective of the conditions in which the tea garden workers live.

Public health centres have been set up at various places, but these health centres lack in services and facilities. They lack quality and do not comply with the India Public Health Standards. Thus, the purpose for which they were set up remains unfulfilled.

Before analyzing the case in detail, let us look into some of the legal implications of the right to maternal health.

RIGHT TO MATERNAL HEALTH: LEGAL IMPLICATIONS

The right to maternal health is a part of the right to health and has been expounded upon by numerous court judgments. It is recognised not just by the Constitution of India, but this is legally enshrined by the international community through the adoption of numerous treaties. Furthermore, the Indian government has established schemes in an attempt to lower the maternal mortality ratio. These aspects will be discussed below.

PROVISIONS OF INTERNATIONAL TREATIES

India has ratified numerous treaties concerning the right to maternal health. The most relevant of these are the Universal Declaration of Human Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of all forms of Discrimination Against Women. The relevant articles of each of these treaties are reproduced below.

Universal Declaration of Human Rights (UDHR) adopted by the United Nations General Assembly, of which India is a member, provides that:

7. World Bank Data, Health Expenditure, total (% of GDP); http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

8. Sophie Cousins, Assam's Dying Mothers (2015)

Article 25 (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

International Covenant on Economic, Social and Cultural Rights (ICESCR) ratified by India on 19 April 1979 provides that:

Article 10(2): Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

Article 12(1): The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) which was ratified by India on 9 July 1993 provides that:

Article 12 (1): states Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. (2) Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

RELEVANT PROVISIONS OF THE CONSTITUTION OF INDIA

The right to maternal health is indirectly enshrined in the Constitution in terms of article 21 and article 47 which have been examined by the Courts in numerous cases as is discussed below.

Article 21 provides that:

No person shall be deprived of his life or personal liberty except according to procedure established by law.

Article 47 provides that:

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

RELEVANT CASE LAWS

The Supreme Court of India and various High Courts have issued orders and judgments establishing the right to maternal health and giving substance thereto by placing certain duties on the shoulders of the Government.

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

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

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

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

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 for pregnant women is essential to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India. The Court held, "…[w] e observe from the material on record that there is shortage not only of the infrastructure but of the man power also which has adversely affected the effective implementation of the [National Rural Health Mission] which in turn is costing the life of mothers in the course of mothering. It should be remembered that the inability of women to survive pregnancy and childbirth violates her fundamental rights as guaranteed under Article 21 of the Constitution of India. And it is primary duty of the government to ensure that every woman survives pregnancy and childbirth, for that, the State of Madhya Pradesh is under obligation to secure their life."

GOVERNMENT SCHEMES APPLICABLE IN ASSAM

The Government of India has tried to back its efforts of improving the maternal health situation with a series of schemes. They are the National Rural Health Mission; National Maternity Benefit Scheme; Janani Suraksha Yojana; Janani Shishu Suraksha Karyakram; National Family Benefit Scheme and the Indian Primary Health Standards. In addititon, the Government of Assam had introduced the Mamta and Mamoni schemes in support of the cause. These are briefly discussed below.

National Rural Health Mission (NRHM)

The preamble to the NRHM provides that: "Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition,

sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The goal of the mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

National Maternity Benefit Scheme (NMBS)

Under NMBS, there is a provision for payment of Rs 500 per pregnancy to women belonging to poor households for pre-natal and post-natal maternity care up to first two live births. The benefit is provided to eligible women of 19 years and above.

Janani Suraksha Yojana (JSY)

The Janani Suraksha Yojana (JSY), launched on 12 April, 2005, was implemented by the Central government to lure pregnant women to opt for institutional deliveries and in the process, improve the maternal health conditions in India.

It is a centrally sponsored scheme and provides cash assistance for pre- and post-delivery care. A pregnant woman from rural area is given Rs 1,400 and one from an urban area is given Rs 1,000 for delivery in government and government-accredited hospitals. Rs 500 is given for home-delivery by BPL women. Relevant ASHA workers also get Rs 600 for every delivery in govt and government-accredited hospitals.

Janani Suraksha Yojana (JSY), under the overall umbrella of National Rural Health Mission (NRHM), integrates cash assistance with antenatal care during the pregnancy, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health workers. Some other strategies of the scheme are:

- Early registration of pregnancies with the help of the village level health workers like ASHA or the equivalent;
- Early identification of complicated cases;
- Providing at least three antenatal care, and post delivery visits;
- Organizing appropriate referral mechanisms and providing referral transport to the pregnant mother;
- Convergence with Integrated Child Development Services (ICDS) worker by involving the Anganwadi worker (AWW);
- Ensuring transparent and timely disbursement of the cash assistance to the mother and the incentive to the Accredited Social Health Activist (ASHA) or an equivalent worker with fund available with ANM.

Janani Shishu Suraksha Karyakram (JSSK)

The Janani Shishu Suraksha Karyakram (JSSK) was launched by the Government of India on 1st June, 2011.

This scheme supplements the cash assistance given to a pregnant woman under Janani Suraksha Yojana (JSY) and is aimed at mitigating the burden of out of pocket expenses incurred by pregnant women on herself and sick newborns.

The following are the free entitlements for pregnant women:

- Free and cashless delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay

Further, the following are the free entitlements for sick newborns till 30 days after birth. This has now been expanded to cover sick infants:

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home

The National Food Security Act, 2013

The National Food Security Act, 2013 (also Right to Food Act) is an Act of the Indian Parliament which aims to provide subsidized food grains to approximately two thirds of India's 1.2 billion people.

Further, the NFSA 2013 recognizes maternity entitlements. The Midday Meal Scheme and the Integrated Child Development Services Scheme are universal in nature whereas the PDS will reach

about two-thirds of the population (75% in rural areas and 50% in urban areas).

Pregnant women, lactating mothers, and certain categories of children are eligible for daily free meals.

National Family Benefit Scheme (NFBS)

National Family Benefit Scheme (NFBS) is a component of National Social Assistance Programme (NSAP). Under the National Family Benefit Scheme assistance is given in the form of a lump sum family benefit for households below the poverty line on the death of the primary breadwinner in the bereaved family. The amount of benefit is Rs20,000 in case of death of primary breadwinner due to natural or accidental causes. The family benefit is paid to the surviving member of the household of the deceased who, after local inquiry is determined to be the head of the household.

Indian Primary Health Standards (IPHS)

Health care in India is provided by means of a tiered system as per Chart 1. In 2007, the Indian Public Health Standards (IPHS) were published to provide a set of uniform standards for the public health centres at different levels (Sub-Centres, Primary Heath Centres, Community Health Centres and District Hospitals) in an attempt to improve the quality of health care delivery in the country. The IPHS have since been updated in 2012.

In spite of this carefully crafted system, maternal mortality rates remain unacceptably high across India. Although the national average has shown a steady decrease over the past 25 years as discussed above, it is important to bear in mind that the mortality rates in certain states are far above the average and thus require specific attention.

FACT FINDING: MATERNAL DEATHS IN BARPETA DISTRICT

A team comprising social activists from HRLN conducted a fact-finding mission on maternal deaths and its causes in Barpeta district of Assam. At a village called Daisingari in Barpeta, we met the family of Runa Begum who had died hours after her childbirth on 10-04-2016 at Fakhruddin Ali Ahmed Medical College in Barpeta. The following lines contain a brief description of the events leading to Runa's death.

Case Study

Name	Runa Begum
Age	About 24 years
Husband	Nurej Ali
Address	Village - Daisingari, District: Barpeta, Assam

Runa Begum's Background

It is important to understand a little bit about Runa Begum's background before we delve into her pregnancy and death related information. Runa's husband, Nurej Ali, is serving a life sentence in jail on charges of murder for the past twelve years now. Runa and Nurej got married around two

years before Runa's death. Runa as informed to us by the ASHA worker of that area and by family members as well, was depressed as her husband could hardly spend any time with her. Especially after Runa's pregnancy, the ASHA worker informed that Runa felt a stronger need for her husband and his absence in that critical period depressed her more. She lived with her brother-in-law and mother-in-law. The brother-in-law, Ramij Ali, was the sole bread-earner in the family and the income arose from farming.

Medical History and Pregnancy-related information

Runa Begum had done her ante-natal check-ups at Daisingari sub-centre. Her pregnancy was registered on 09-10-2015 which fell on the third month since her Last Menstrual Period. Her Expected Date of Delivery was accurately determined as 10-04-2016. This was her first pregnancy. She received four Antenatal Checkups.

Information as recorded during her Antenatal Checkups is mentioned in the table below:

Date of ANC	Anaemia	Weight	Blood Pressure	Haemoglobin	Sugar/ Albumin	Referral
09-10-2015	Yes	50kgs	100/60	10 gmdl	Nil	No
15-12-2015	No	54 kgs	110/70	11 gmdl	Nil	No
24-02-2016	No	56 kgs	110/70	11 gmdl	Nil	No
08-04-2016	No	59 kgs	110/70	10.5 gmdl	Nil	No

Runa's ANCs reveal that her health was quite normal during the period of her pregnancy. Only during her first ANC, Runa was slightly anaemic but she received 100 IFA tablets and the level of haemoglobin recovered. She had also received two doses of Tetanus Toxoid injections each on 04-11-2015 and 02-12-2015 respectively.

Chronology of Events prior to death

In the early morning of 10th April, 2016, at around 3 am, Runa's labour pain started. She was nine months pregnant at the time and 10th april was also the pre-determined expected date of her delivery (EDD). At that time, only Runa's younger brother-in-law, Ramij Ali, and her mother-in-law, Hamsa Bibi, were residing with her. An ambulance was called but the ambulance did not come due to the poor condition of the road that leads to their house. Ramij Ali informed that ambulance usually does not come to that area. Finally, a private vehicle had to be hired for Rs. 500 and Runa, with her brother-in-law, mother-in-law and ASHA worker, left for Pathsala Sub-Divisional Hospital at about 6.30 am.

The Sub-Divisional Hospital was located about 10 kms away from their residence at Daisingari. They reached the hospital at about 8 am.

Runa was admitted and checked by a doctor who said that her delivery would be conducted at around 1.30 pm in the afternoon on the same day. Some medicines and injections were prescribed which had to be bought from a pharmacy outside. Saline was provided by the hospital free of cost. Thereon, Runa remained in the maternity ward and was attended by the staff of the hospital. She was kept company by her brother-in-law, mother-in-law and the ASHA worker. The ASHA worker informed us that on that particular day, Runa was distraught and was crying throughout. She terribly missed her husband.

At 1.20 pm, the doctor conducted Runa's delivery. It was a normal delivery. Runa gave birth to a female child who weighed about 3.1 kgs. After about an hour of delivery, Runa started getting severe convulsions. She was hypertensive throughout the period of delivery. While in her senses, Runa was extremely agitated and wanted to get up and leave. The doctors were called who came and said that they were not being able to correctly identify the disease. But after some further investigation, the doctors told that Runa was in some shock as she might have been expecting a boy instead of a girl. They told her she would recover within an hour.

An injection was given to Runa then after which she became semi-conscious and started vomiting. But even after an hour, Runa remained unstable and did not recover. The doctors told her family to get a blood test done immediately. After the test, it was found that her haemoglobin level had dropped to around 7 when it was around 10 at the time of delivery. The doctors immediately told the family to either take Runa to Guwahati or Barpeta. It was about 4.30 pm then. The 102 ambulance service was called and it took about 45 minutes for an ambulance to arrive. Runa was then taken to Fakhruddin Ali Ahmed Medical College and Hospital (FAAMCH) in Barpeta.

The bunch reached FAAMCH shortly after 6.30 pm. Runa's newborn child was also taken along. The doctors there rebuked the family for not bringing Runa earlier. They said that Runa was suffering from high pressure and that blood had stocked up in her brain. There were little chances of her survival. The doctors told Ramij to fetch blood from the blood bank as Runa was also suffering from severe anaemia. They also prescribed some medicines. By the time Ramij could arrange the blood and get the medicines, he was informed that Runa had died.

Post Death

An ambulance was not available to bring back Runa's body. Two vehicles were hired, one in which Runa's body was brought and the other in which the newborn was brought. Both the vehicles cost Rs 4,500.

Analysis

Ramij Ali claimed that he had to spend almost Rs 20,000 on the delivery date. He incurred expenses on travel and medicines. Ambulances were not available when required. Medicines had to be bought from private pharmacies. Also, some amount had to be paid to the nurses at Pathsala SDH. He also treated everyone at Pathsala SDH to tea and biscuits after the delivery. It shows how even the poorest of people still have to incur high out-of-pocket expenditure on healthcare. This is a setback to government's efforts to eliminate out of pocket expenditure through schemes like the Janani Shishu Suraksha Karyakram. Out-of-pocket expenditure is a major deterrent for the poorer sections in availing professional healthcare.

Further, in Runa's case, her hypertension was triggered by the absence of her husband throughout the critical period of her pregnancy and especially on her date of delivery. The hypertension was the likely cause that had led to Postpartum Eclampsia. Further, in her Maternal Death Review Report, there is a reference to Postpartum Haemorrhage (PPH) as one of the causes of referral to FAAMCH. Although, the interviewee family didnot mention it, PPH is the likely cause that had led to the depletion of blood and anemia in Runa Begum. Runa was referred to FAAMCH after around five hours of her delivery with repeated convulsions and severe anemia in an unconscious state. She died about 30 minutes after reaching FAAMCH.

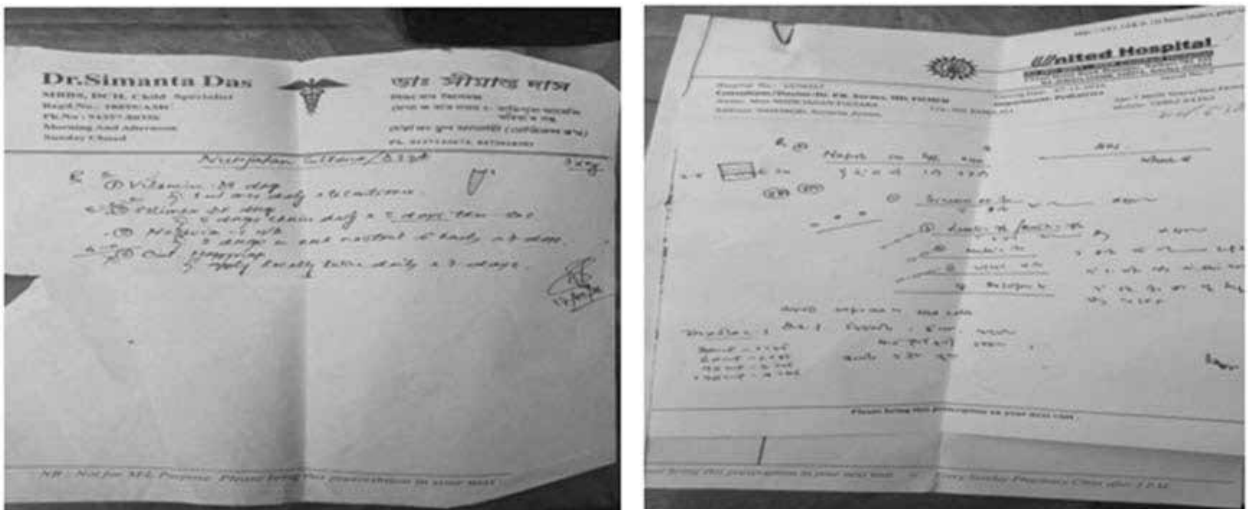
The direct obstetric cause of Runa's death has been stated as Postpartum Eclampsia in her maternal death review report. The indirect obstetric cause of death has been stated as Cerebrovascular Accident (CVA) with severe anemia.

CVA is commonly known as stroke and occurs when some brain cells die due to lack of blood supply to the brain. An article says that the lack of blood supply causes oxygen deficiency in the brain.[9] This may be caused by a blockage or rupture of an artery to the brain.

Eclampsia is a serious condition that causes seizures during pregnancy. The article says that Eclampsia often follows Preeclampsia, which is characterized by high blood pressure after the 20th week of pregnancy. If preeclampsia worsens and affects the brain, causing seizures or coma, then one has developed eclampsia. These are all serious conditions and require urgent medical treatment[10].

Apart from the above causes, there is also a lack of proficiency in the Pathsala SDH to treat these diseases. Referral was not immediate and it was after many hours of delivery and the onset of the problem and this delay was acknowledged by the doctors at FAAMCH who said that Runa should have been brought earlier. An ambulance was also not available on time. The 102 ambulance that brought Runa to FAAMCH arrived after 45 minutes of being summoned which led to valuable loss of time.

Now after Runa's death, her mother-in-law and brother-in-law are taking care of her child. The little girl is deprived of the love and care of her mother. Especially she lacks access to the most nutritious breastfeeding of her mother. Consequently, she has already been suffering from several ailments even before she has completed a year after birth. Ramij Ali, being the sole bread-earner in the family has extreme financial constrainsand difficult for him to attend his niece's health needs. It adds to the general needs of a motherless child like nutrition, clothing, etc.



Two of Noorjahan Sultana's many prescriptions

9. Definition of Cerebrovascular accident" on Medicinenet.com

10. 'Eclampsia', Brindles Lee Macon and Marijane Leonard (2017)

CONCLUSIONS AND RECOMMENDATIONS

Despite the alarm bells ringing on the health conditions in India and the maternal health scenario in Assam, public health service has still not been brought to the best of standards. As mentioned earlier, the health expenditure component of GDP constitutes only 4.7%.

- There is urgent need to increase the investment in health. There is a higher level of proficiency expected in the health centres of the state.
- In Runa's case, the staff at Pathsala had to be paid through unofficially for their services. Medicines had to be bought from private pharmacies leading to significant out-of-pocket expenditure for Runa's brother-in-law.
- There was delay in Runa's referral to a better equipped medical institution. And even after delay, an ambulance took a long time to arrive. The delay was such that ultimately Runa's life could not be saved even in a higher health facility and she died soon after.
- Though the Government has been trying to improve access to professional healthcare through ambulance services like the 102 and 108 in Assam, financial assistance through the Janani Suraksha Yojana and eliminating out-of-pocket expenditure in pregnancy cases through the Janani Shishu Suraksha Karyakram, the implementation of these schemes has been irregular.
- Accessibility of ambulances is impeded by poor infrastructure. Free services for pregnant women still remain a myth as has been observed in most cases that medicines have to be purchased from private pharmacies and staffs in health institutes often charge money for their services though unofficially.
- There has to be greater awareness creation and better investment in general infrastructure as well as in health infrastructure. Health centres at the lower levels lack specialist services and there is a high rate of dependency on the district hospitals and medical colleges in Assam.

As a suggestion, a compensation scheme for maternal deaths can be formulated. (Ramij Ali, Runa's brother-in-law, is now unfairly burdened with the entire care and upbringing of his niece. Already, his income certificate says that he has an annual income of only Rs 20,000 per annum, and now on top of that, he has to take care of all the requirements of a sick child. Consequently, one would fear about the future of this little girl. Her health specially is in constant jeopardy. Some aid and intervention from the government would be a major help. After all, its instrumentalities had a role to play in the situation that exists today. The maximum financial assistance that can be availed is through the National Family Benefit Scheme which provides for assistance of Rs 20,000. But such a meager amount cannot compensate for the death of a woman).

5

Visit to Howly Community Health Centre in Barpeta District, Assam

HUMAN RIGHTS LAW NETWORK
Reproductive Rights Initiative,
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INTRODUCTION

A large sector of India's population lives in poverty and consequent to this, there is a big demand for public health services. But how efficient are these public health services? India's public health expenditure is one of the lowest in the world accounting to about 1.4% in the year 2014[1]. 70% of the people pay the medical expenses from their own pockets. This draws a picture as a whole that the public health is being neglected.

Public Health Centres have earned a reputation of being low in quality and hygiene and the staffs are known to be uncouth. People who are financially strong mostly prefer private health institutes as there is a lack of faith in the public health sector because of the aforementioned reasons. Especially in the rural areas, public health centres are often the only option available.

Health is held as a fundamental right under the Constitution of India. This creates a responsibility on the State to provide services that cater to the health requirements of the citizens to the best of its ability. But how well is the Government doing its job when it comes to health services?

The Ministry of Health and Family Welfare of the Government of India had introduced the Indian Public Health Standards (IPHS) in 2007 to set benchmarks for services to be provided by a public health centre. The IPHS, although is not statutorily enforceable, they provide a guiding light for the public health centres and are expected to be complied with, so as to deliver an acceptable standard of services in the public health centres of India. But how far these standards are met is a question to ponder upon to understand the poor reputation that has been imputed to the public healthcare sector.

In this report, we will study about the facilities available at Howly Community Health Centre in the Barpeta district of Assam and try to analyse the ability of its service delivery system. Our primary focus would be on reproductive health services.

Community Health Centres are at the secondary level of healthcare and provide referral as well as first-point health services. They are expected to provide specialist services to patients being referred from Primary Health Centres (PHCs) as well as to those who approach the CHC directly. They cater to a population ranging from 80,000 to 1,20,000. In all, there were 214 CHCs in Assam[2].

METHODOLOGY

A group of activists and lawyers visited the Howly CHC to assess the hygienic conditions and health facilities available at the CHC. Data was collected through a physical recce of the CHC as well as through an interaction with staff members. Secondary data was also collected from NRHM Assam website, HMIS and the Annual Health Survey Assam 2012-13.

The IPHS were used for comparative purposes to determine any lacunae and locals were also consulted to understand their view of what they felt was lacking in the CHC and how services could be improved to provide greater utility.

1. Quoted from the official website of World Bank (http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS)
2. District Level Household and Facility Survey (2012-13); Assam

MATERNAL HEALTH SITUATION IN BARPETA

Barpeta has a population of 1,789,085[3] and a dismal sex-ratio of 917[4]. The district has a female literacy rate of 71.6 per cent as compared to the male literacy rate of 85.1 per cent. The overall literacy rate of 78.6 per cent is lower than the state average of 81.6 per cent. The mean age of women at marriage in the district is a low 21.7 years. The district has a fertility rate of 2.4 which is same as the overall fertility rate of the state. 74.1 per cent women (currently married women 15-49 years) in the district have reportedly used some family planning method, though only 39 per cent have used a modern method of family planning[5].

The district has 264 sub-centres, 51 Primary Health Centres (PHCs), six Community Health Centres (CHCs), one sub-district hospital, one district hospital and one medical college. Fakhruddin Ali Ahmed Medical College and Hospital is the premier health institute of the district catering to the largest number of patients in comparison to other health institutes of the district. A very high rate (89.6 per cent) of mothers in Barpeta received their ANC from a Government source. As of institutional deliveries, 45 per cent of all deliveries were at government institutions as compared to only 7.3 per cent at private institutions. This reflects a strong dependence on the public healthcare system.

Barpeta is lagging behind in maternal health when compared to the overall statistics of the state. Some maternal health indicators as compared to the overall statistics of Assam are presented below:

Key Indicators	Assam	Barpeta
Mothers registered in the first trimester (%)	54.8	35.7
Mothers who had at least 3 ANC check ups (%)	66.2	55.6
Mothers who got TT1 injection (to total ANC regd.) %	94.5	94
Mothers who received post natal care within 48 hrs of delivery(%)	66.2	50.1
Mothers whose blood was taken for Hb (%)	63.4	44.7
Mothers who underwent ultrasound (%)	38.9	29.8
Institutional deliveries (%)	65.9	52.3
Children with birth weight less than 2.5kg (%)	23.3	22.5
Children (aged 6-35 months) exclusively breastfed for at least six months (%)	40.4	36.1
Women who are aware of HIV/AIDS	78.1	64.8
Women who are aware of RTI/STI	67.1	30.3
Infant Mortality Rate (IMR)	55	43

Source: Annual Health Survey Assam 2012-13

3. District Factsheet: Maternal and Child Health Indicator (2014-15 & 2015-16); Provisional HMIS data for (Apr 15 - Mar 16)

4. District Factsheet: Maternal and Child Health Indicator (2014-15 & 2015-16); Provisional HMIS data for (Apr 15 - Mar 16)

5. Annual Health Survey Assam 2012-13

MATERNAL DEATHS IN BARPETA

Assam has a notorious reputation of being the state with the highest Maternal Mortality Ratio (MMR) in the country.[6] Assam has an MMR of 301 whereas Barpeta has an MMR of 254[7]. Surprisingly, Barpeta witnessed an increase in the reported number of maternal deaths unlike the overall decreasing trend in Assam. Where the total reported maternal deaths in Barpeta was 42 during 2014-15, it increased to 67 during 2015-16. The estimated number of maternal deaths in the district was 107 during 2014-15 and 117 during 2015-16[8]. The cause of maternal deaths in Barpeta during 2014-15 and 2015-16 are as follows:

Cause of maternal death	2014-15	2015-16
Due to abortion	1	3
Due to obstructed/prolonged labour	1	3
Due to severe hypertension/fits	5	10
Due to bleeding	8	9
Due to high fever	2	-
Due to other causes	25	42
Total reported deaths	42	67
Estimated Maternal deaths	107	117

Source: District Factsheet: Maternal and Child Health Indicator (2014-15 & 2015-16); Provisional HMIS data for (Apr 15 - Mar 16)

FINDINGS AT HOWLY COMMUNITY HEALTH CENTRE

Howly CHC is one of the six CHCs of Barpeta District of Assam. Situated on Hospital-Amtal Road in Howly, Barpeta, a few hundred metres off National Highway 27, the CHC caters to a population of about 83,000 people according to hospital authorities.

OPD/IPD patient load: The significance of a health centre, its importance and role in society isoften determined by the number of patients it serves. This part can be assessed by looking into the OPD/IPD patient load of a health institute. As mentioned earlier, catering to a population of about 83000, Howly CHC is one of the busiest health centres of Barpeta. It is one of the health centres with some of the highest patient load in numbers. This is reflected by the number of OPD/IPD patients it handles every year. A year-wise comparison, starting from 2012-13, of the patient load of Howly CHC both in terms of OPD and IPD is presented in the tables below:

Year	2012-13	2013-14	2014-15	2015-16
OPD patient load	43694	47470	21979	37366
Year	**2012-13**	**2013-14**	**2014-15**	**2015-16**
IPD patient load	934	1297	754	775

Source: NRHM Assam website

6. NITI Aayog Data, Maternal Mortality Ratio (MMR) (per 100000 live births); http://niti.gov.in/content/maternal-mortality-ratio-mmr-100000-live-births

7. Annual Health Survey, 2012-13,

8. District Factsheet: Maternal and Child Health Indicator (2014-15 & 2015-16); Provisional HMIS data for (Apr 15 - Mar 16)

Institutional deliveries: Institutional deliveries in Assam have been witnessing an upward trend. The credit for this goes to increased awareness amongst the public though the community level health workers and propelling schemes like the Janani Suraksha Yojana (JSY) which provides financial assistance for institutional deliveries to Below Poverty Line women. Although as per the scheme, financial assistance is provided even for home deliveries, the amount of assistance is higher for institutional deliveries. Also, a scheme like the Janani Shishu Suraksha Karyakram (JSSK) is aimed at removing the burden of out-of-pocket expenditures by providing for free services to pregnant women. These efforts of the State have borne fruit as we witness an increasing number of institutional deliveries in the state with a decreasing trend of maternal mortalities.

The trend of institutional deliveries in Howly CHC does not replicate the trend of institutional deliveries in the State. Though the trend on an average has been on a rise there has been a fluctuating trend since 2012-13 with the number of deliveries at the CHC falling in the year as compared to 2011-12. Since then, the number of deliveries has both increased and decreased from year to year. The year-wise distribution of the number of deliveries conducted at Howly CHC is presented in the table below:

Year	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
No. of deliveries	83	310	370	NA	602	396	NA	465	368	473

Source: NRHM Assam website

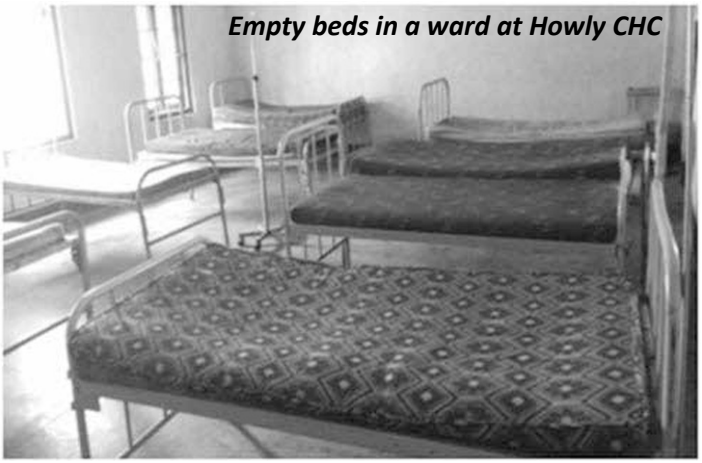
Janani Suraksha Yojana: The Janani Suraksha Yojana is a scheme which has the objective to reduce maternal and neo-natal mortality by promoting institutional deliveries. Under the scheme, financial assistance of Rs 1,400 to women in rural areas and Rs 1,000 to women in urban areas is provided for delivery in Government and accredited hospitals. Rs 500 is provided to BPL women for home deliveries.

The staff at the hospital informed that funds under the Janani Suraksha Yojana (JSY) have always been available and eligible candidates were provided with appropriate amount under the scheme. At the time of the interview too, adequate funds were at the disposal of the hospital.

Antenatal Care: Antenatal care is an important tool for ensuring safe passage of the pregnancy period. It is proper supervision of women during pregnancy to monitor the progress of foetal growth and to ascertain the well-being of the mother and the foetus. Proper antenatal care provides necessary care to the mother and supervises her health condition during the period of pregnancy, and it also helps in identifying any complications arising during pregnancy and averting any dangers to the life of the child and the mother and also in preventing the complications from aggravating any further.

In 2015-16, 92 women had visited Howly CHC for antenatal checkups, whereas in 2016-17, 91 women had visited for antenatal checkups. The staff at the hospital informed that necessary provisions for antenatal checkups like weight-tracking devices, blood-pressure measuring devices, blood sugar test, urine test, etc. were available at the CHC and proper antenatal check-ups were done there. Further, the staff informed that there was increasing awareness amongst the public about the importance of antenatal check-ups, especially due to the awareness done by the Accredited Social Health Activists (ASHA) working at the ground level.

HIV tests are also a part of the Antenatal Empty beds in a ward at Howly CHC checkups done at the hospital. HIV counseling is done by the General Nursing and Midwifery (GNM) staff of the hospital.



Empty beds in a ward at Howly CHC

Bed Availability: The Howly CHC has 30-beds. There is also a maternity ward at the hospital consisting of six beds. The labour room at the CHC has two beds. This aspect of the CHC is in compliance with the IPHS which prescribes for an equivalent number of beds for a CHC. The staff at the hospital also informed that there were adequate numbers of beds at the hospital to accommodate the patients who visit. On a physical recce of the wards at the hospital, it was observed that there were many beds lying vacant. So it can be safely assumed that shortage of beds is not an issue at Howly CHC.

Transport service: The CHC has one ambulance of its own and its services are supplemented by three 102 ambulances provided by the Government of Assam which ply in the vicinity. It can be said that the CHC has adequate transport services and is in conformity with the Indian Public Health Standards (IPHS). The nearest superior health facility is the Fakhruddin Ali Ahmed Medical College located about 12 kms from Howly CHC.

Laboratory and radiology services: Howly CHC provides basic laboratory services. Two lab technicians are employed there. Tests like Haemoglobin, Blood Sugar, Urine and HIV are done at the laboratory.

The CHC has an X-ray machine and x-ray services are made available to the public.

Ultrasound: There is no ultrasound facility at the CHC. Ultrasound has one of the basic services used in gynecology and is helpful in tracking the development of the fetus and in identifying any risks to the mother or the child. The staff at the hospital acknowledged the fact that the provision of ultrasound facility would help in significantly improving their maternal health services.

Blood Bank/Blood Storage Facility: Availability of blood is an important characteristic of goodmaternal health services in a hospital. There is high prevalence of anaemia in India and in Assam. Haemorrhage or bleeding is also a major cause of maternal deaths. Thus under the circumstances, it is important for a Community Health Centre to have a blood storage facility, as it functions as a First Referral Unit. Unavailability of blood can lead to severe delays in providing necessary treatment and is often the cause of maternal deaths.

Howly CHC does not have a blood storage unit. Under the IPHS too, it has been made essential for a CHC to have a blood storage unit. Thus, the CHC fails to comply with the IPHS in respect of blood availability.

Infrastructure: The Howly CHC had been set up in 1990 and is a single-storeyed structure. The present edifice of the hospital was constructed back then and hardly any significant additions or repairs have been made to the building since. The structure is not attractive to the eyes and is in dire need of repairs.

- The walls and floors of the hospital look worn out. There are little ditches on various parts of the floor.
- In multiple places in the hospital, windows were found with broken panes.
- Furniture was found to be lying haphazardly at different places.

Broken window panes and worn out wall

- Beds at the hospital though adequate in number appeared to be in need of repairs or replacements and exuded a worn out look.
- Parts of walls at the hospital were found to be leaking water.
- One toilet had become engulfed in plants and was rendered unusable.
- The staff informed that there is a shortage of rooms in the hospital. Two doctors would usually sit in one room to attend to patients during OPD hours.
- On the contrary, the medicine storage room was found to be well-maintained and arranged though a little congested. The Deputy Superintendent himself acknowledged the need of more rooms and a bigger storage facility.

Diet and Kitchen facilities:

There is a kitchen in the CHC but it is in a pitiable condition.

- The entire kitchen has been cramped into a tiny room with few utensils and a stove. There is only one staff for the kitchen. Proper dietary provisions are required for patients who are admitted at the CHC as well as for relatives accompanying the patients. Moreover, when new mothers have been prescribed at least 48 hours of post-delivery stay at the hospital, it is important that they are provided proper diet.
- There is a shortage of staff dedicated to the kitchen at the hospital. Also, the kitchen area is too small and inadequately equipped.
- The kitchen staff informed the team that it was not possible to make adequate dietary provisions for patients at the hospital. Firstly, she was the only staff member employed in the kitchen, and secondly, there was not enough space and equipments to cook on a bigger scale.

The IPHS prescribes that diet may either be outsourced or adequate space for cooking should be provided in a separate space.

Hygiene and toilets: The CHC as mentioned earlier is physically inadequate. The physical structure of the CHC is in need of repairs, additions and improvements. Hygienically too, the

hospital has shortcomings. There was garbage found to have been dumped and disposed haphazardly right next to the hospital building within its premises. Also, all dustbins in the campus were found to be uncovered.

Uncovered waste bins

There is just one toilet space for use by all patients at the hospital. Earlier, there were two, but as mentioned earlier, the other toilet has been rendered useless by the engulfing shrubs and creepers that uncovered waste bins have grown around it. Now there is just one toilet at the hospital for use by patients. Though the toilet has directions specifying that it is for use only by males, but as there is no separate toilet for females, it is used both by males and females. the toilet is unhygienic and poorly maintained. It is not regularly cleaned and smells bad.

Operation Theatre: There is no operation theatre at Howly CHC. There is a labour room with two beds for normal deliveries. The IPHS prescribes there should be one Operation Theatre at a CHC. Thus, the lack of an operation theatre reflects the deviation from the IPHS. Cases requiring minor operations also have to be referred to better equipped health institutes adding on the burden of these superior institutes.

Maternal Health and Delivery services: At Howly CHC, only normal deliveries are conducted.There is no provision for conducting caesarean deliveries. This is a serious lacuna of the hospital. Being one of the busiest hospitals of Barpeta district, it is important that Howly CHC provide proper maternal health services. Even the IPHS provides that a CHC should provide '24 hour delivery services including normal and assisted deliveries'. Further, the IPHS states that 'all referred cases of complications in pregnancy, labour and post-natal period must be adequately treated', and that there should be 'proficiency in identification and management of all complications including PPH, Eclampsia, Sepsis etc. during PNC'. Caesarean deliveries have been brought under the purview of essential services to be provided by a CHC. The essential services section of maternal health services of the IPHS for CHCs includes: 'Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions'. But it was learnt that if any complications arise during pregnancy, the patient has to be referred from Howly CHC. Already 113 referrals of pregnant women had been made from Howly CHC during the period 2016-17.

Manpower details: The fact-finding team was able to access the list of staffs. As the CHC provides 24 hour service, the staffs have been divided into three duty schedules, each batch working for 8 hours. There are in total 54 staff members assigned at the CHC including doctors. 37 of them are regular employees of the hospital, 16 are assigned under the National Health Mission (NHM) and one under the Revised National Tuberculosis Control Program (RNTCP).

There are eight doctors at the hospital, including two AYUSH and one Homeopathic. There is no specialist at the hospital.

The Community Health Centres are designed to provide specialist healthcare to the rural population. A CHC is expected to provide routine and emergency care in Surgery, Medicine, Obstetrics

and Gynecology, Pediatrics, Dental and AYUSH. But amongst the list of essential manpower requirements of a CHC, the missing ones at Howly CHC are one Public Health Specialist, one General Surgeon, one Physician, one Obstetrician & Gynecologist, one Pediatrician, one Anesthetist and one Dental Surgeon. An Obstetrician & Gynecologist and a Pediatrician are especially important in providing proper maternal health services. Dentistry services are completely missing at the CHC.

Also, there is a shortage of nurses at the hospital. As the CHC provides 24-hour services, 16 nurses have been placed as a requirement at Howly CHC, but at present only 10 nurses have been appointed at the hospital.

Other staff includes two pharmacists, one radiographer, one dietician, four lab technicians, one Accountant, one cook, two sweepers and four Grade-IV staff amongst others.

Others: The CHC provides immunization services to newborns. Necessary vaccines were reported to be available at the CHC.

The staff also informed that essential drugs were available at the CHC. Requisition for drugs were placed every month and the supply is also monthly. A list of essential drugs has been put up at a conspicuous spot at the CHC.

Contraceptives like condoms are available at the CHC. Sterilization operations were not performed at the CHC but there was provision for inserting Intra-uterine Devices for contraceptive purposes.

Power back up and drinking water facility is available at the CHC.

RECOMMENDATIONS AND CONCLUSION

The visit to the Howly CHC, which is one of the important public health institutes in the district of Barpeta, was a revelation with regard to the standard of health services available in Barpeta district, especially to the poor. A much better standard of services is expected from a Community Health Centre as compared to what was observed at Howly CHC. The IPHS too states that a CHC is designed to provide referral as well as specialist services. It is to act as a Block level health administrative unit and a gatekeeper for referral to higher level of facilities.

Despite being functional for over 25 years, Howly CHC still fails to provide specialist services with the total absence of any specialist doctors. Furthermore, its maternal health services are poor as there is no provision for caesarean deliveries and any complications arising during pregnancy require referrals to a superior health institute. There is no operation theatre at the CHC and neither is there a blood storage unit at the CHC. The infrastructure of the hospital requires serious repairs, renovations and additions. The hygienic conditions at the hospital require special attention with special focus on the toilets and garbage management. Dietary provisions require an uplift. Finally, we can conclude this report by making the following recommendations for Howly CHC:

- Provision of caesarean section facilities at the hospital. Caesarean sections are recommended as an essential service to be provided by a CHC under the IPHS. It would also significantly reduce the number of referrals from the hospital to higher health facilities unless absolute emergency calls for it.

- Provision of a blood storage unit. Blood availability is important in a CHC as blood transfusion often becomes necessary in obstetrics and gynecology cases as well as in other emergencies like accidents. This will also help in preventing major delays in receiving life-saving treatment.
- Provision of an Operation Theatre at Howly CHC. The IPHS provides that a CHC should have one Operation Theatre. An Operation Theatre would again help in capacity building of the CHC and reduce referrals.
- The provision of specialists at the CHC, especially obstetrics, gynaecologist and a pediatrician. These two specialists can help in significantly improving the maternal health services at Howly CHC. Maternal health as known is a matter of serious concern in Assam and across India.
- Assessing the viability of providing ultrasound facilities at the CHC.
- Provision of better kitchen and dietary facilities. The kitchen space requires urgent expansion and there is a need for providing more utensils to cook for more patients. Also, the kitchen requires additional staff to serve the needs of all patients and their relatives who stay at the CHC.
- Infrastructure development of the CHC-The CHC has been functioning since 1990 and has the potential to significantly ease the load on the higher health institutes of the district. There is sufficient space to expand the edifice of the hospital. Issues like two doctors sitting in one room to check patients could be mitigated through infrastructure development. This will prevent a chaotic situation from arising at the hospital and also help in building on the capacity of the hospital.
- The walls of the hospital look worn out and repairs can do wonders to the appearance of the hospital. Broken windows require repairs and haphazardly kept furniture should be managed better.
- There is a need to improve the hygienic conditions at the hospital. A separate toilet for women is essential and the existing toilet should be kept clean. Garbage bins should be kept covered and garbage should not be allowed to collect on the premises. Any leakages in walls should be plugged.
- Functioning on a 24-hour basis, there is a need to increase the number of nurses appointed at the hospital. A particular number could be arrived at after a proper assessment of the requirement.

6

Abortion Services in Holambi Kalan, New Delhi

HRLN
HUMAN RIGHTS LAW NETWORK

GLOSSARY

Abortion	Termination of pregnancy. An abortion can occur either spontaneously (called a spontaneous abortion or miscarriage), or it can be brought about by intervention (called an induced abortion). It is with this last meaning that the word is generally used.
Antenatal care	Health care given to women during pregnancy, also referred to as Prenatal care.
Birth control	Birth control is the use of any practice, method, or device to prevent Pregnancy from occurring in a sexually active woman. Also referred to as family planning, pregnancy prevention, fertility control, or contraception; birth control methods are designed either to prevent fertilization of an egg or implantation of a fertilized egg in the uterus. Birth control may be irreversible or reversible. Birth control methods include hormonal, barrier, natural family planning, abstinence and abortion.
Conception/Conceive	The moment at which a sperm fertilizes an egg released from the ovaries.
Convention on the Rights of the Child (1989)	International treaty upholding the human rights of children. It is the most widely ratified treaty in the world.
Convention on the Rights of the Persons with Disabilities	International treaty to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)	International treaty codifying states' duties to eliminate discrimination against women. It has provisions related to reproductive health and rights.
Dilation and Curettage (D&C)	Most common abortion procedure. Also used for completing or checking miscarriage, it consists of scraping the walls of the uterus with a knife-edged, spoon-shaped instrument.
Embryo	Preborn baby in the early stages of development that are characterized by the laying down of fundamental tissues, cleavage, and the initial formation of organs and organ systems. Usually taken to mean the preborn child before eight weeks.
Fetus	The term referring to the preborn baby after eight weeks' gestation.
Gynecology	The branch of medicine dealing with diseases of the female reproductive system. Specialists in this field are referred to as gynecologists.
Hysterectomy	The surgical removal of the uterus.

INTRODUCTION

Context and Overview

Healthcare is an integral component of the functioning of a society. However, in India it can be seen that to many sections of the population, it remains out of reach despite several mechanisms in place with respect to healthcare.Following the target set by the 2000 Millennium Development Goals to reduce its Maternal Mortality Ratio by three quarters by 2015, India put maternal health at the centre of its healthcare policies and attempted to reach that goal. Implementation, however, was severely lacking; a few factors included a vastly diverse social demographic, lack of accessibility to information and facilities, and the healthcare providers themselves being unaware and in some cases, apathetic of the services they are to provide. As a result, India's position as one of the worst performing countries in terms of maternal health has remained relatively unchanged. As subsequent data will show, the State has failed in its duty to provide accessible healthcare for all regardless of social status, as there still exists a wide gap between the urban and rural access to healthcare, as well as between castes and classes.One of the largest measures undertaken by the government to improve healthcare, such as the National Rural Health Mission, though in place,is not effectively implemented in practice: non-functioning health facilities, sub-standard treatment, denial of care and medical negligence are a few examples of these.

With respect to maternal healthcare, though, in theory, there are several mechanisms through which women can register grievances and stake their claim to their entitlements under various government schemes, in reality it is seen that most of them are not aware of what to do, where to go, and to whom they can address their problems, as human rights reports show(Human Rights Watch, 2010). In addition, there are reports of rural women in India stating that they are too scared to complain against doctors or nurses for fear of reprisals. On the other end of the spectrum, government officials and doctors report that they do not have the facilities to meet the demands for institutional delivery that have been put in place by Janani Suraksha Yojana (JSY) (Human Rights Watch, 2009)[1].

Gap Between Theory and Practice

India has signed several international treaties such as the CEDAW, ICPD, Beijing Platform for Action, ICCPR, ICSCR, and as a member of the United Nations, has adopted the Sustainable Development Goals of which Goal 3 is related to good health, specifically maternal health.

In addition, the Constitution, specifically Article 21, guarantees the citizens the Right to Life. However, the social divide between various sections of society results in many being deprived of this fundamental right, owing to the mistreatment and negligence at the hands of the authorities institututed to protect them at any cost. Many other obligations, required to produce

1. 'Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis,' USAID

an egalitarian society, are enshrined in the Constitution and are listed under Directive Principles of State Policy. These include Article 47, 39 and 38, which argue for the need to raise the level of nutrition, enhance standards of living and improve public health. They also make a case for social justice and sustainable livelihoods.Indeed, the Supreme Court has, on many occasions, cited the Constitution having read many of these principles into the fundamental rights guaranteed to all its citizens. For example, such a reading of Directive Principles, which deal with improving the health, into Article 21, adds a completely new dimension to the ideal[2].

This too, while available in theory, does not exist in practice. Poverty does not allow for access to adequate nutrition and standards of living and healthcare which is supposed to be free to a large extent to certain sections of people, is failing. Several reports show that women do not receive, nor are they aware of many of their entitlements under the JSY, JSSY, etc such as free deliveries, cash incentives for institutional deliveries, ambulance services, specific medicinal care, access to ultrasound facilities, prenatal and antenatal checkups, and much more. Doctors and nurses themselves have been known to mistreat and in some cases, turn away patients who come to them even in emergencies. Private hospitals are the other option to turn to, but since they are often costly, remain a difficult option to resort to for many women from poor families. Further, trained ASHA workers and Anganwadi workers who are supposed to provide guidance, help and counselling in villages regarding healthcare and maternal and childcare, do not perform their duties and in many cases do not even show up to their designated villages. PHCs and CHCs which are included in the structural implementation of the NRHM and NHM are very often lacking in basic facilites and resources, contrary to what they are supposed to have under the various policies. Therefore, not only do overarching social factors, but also poor implementation, apathy and negligence on the part of the State play a role in the high rate of maternal complications and deaths in the country and India's reputation as a poor provider of basic and accessible healthcare.

Current Status Quo: Disproportionately Inadequate Care

General

The maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given period per 100,000 live births during the same period. For 2010–12, India's MMR was estimated at 178 maternal deaths per 100,000 live births (RGI 2013). In 2010, 19 per cent of the 287,000 maternal deaths estimated worldwide took place in India (WHO 2012). In addition, there are critical equity concerns, as studies have noted significant inter- and intra-state disparities, with a disproportionately higher burden of maternal deaths among marginalised communities and tribal populations[3].

It is therefore evident that one significant barrier to implementation is that health is a state subject, therefore wide disparities exist in delivery and access between states, rural and urban population according to the state resources and conditions. However, almost everywhere, the poor of India are disproportionately deprived of health care in India. The plight of the families from marginalized backgrounds underscore human apathy and a basic failure — the breakdown of public healthcare in India. Some of the recent incidents prove the same:

"A man in Odisha's Malkangiri district walked 6 km with his seven-year-old daughter's body

2. http://www.thehindu.com/opinion/op-ed/Health-care-for-all/article13380789.ece

3. 'Maternal Mortality in India: A Review of Trends and Patterns' IEG Working Paper No. 353, 2015

as the ambulance transporting them to the hospital left them midway after learning that the girl has died."

"Denied stretcher, woman drags husband on hospital rampat the Government Regional Hospital in Guntakal, Anantapuramu district, Vijaywada"

"Woman Denied Ambulance by Hospital For Daughter's Body in UP. The woman ran from one hospital to another with her daughter's body and was forced to spend a night outside the emergency wing of the district hospital with the dead child after ambulance drivers allegedly refused to take them to their village as it was in another district".

As is evident from the above, the prevailing status quo shows a wide disparity in conditions according to the social demographic. It can be seen that many women have little or no access to proper reproductive health services, nor are they aware of their entitlements under various schemes and are therefore not beneficiaries to them. Very often it is the case that the implementation of these schemes are not carried out adequately, resulting in marginalized women whom it was intended for, suffering the burden of their social inequities. These result in a number of health complications and sometimes, even death, as underprivileged women do not have the means or the resources to access and avail of healthcare facilities properly. Indeed, India accounts for about 20 per cent of the total maternal deaths worldwide, with the maternal mortality rate averaging about 240. Along the same lines, it follows that safe abortion following proper guidelines is the right of every woman. The argument can be made for the right to self-determination of women, where they have the right to choose with respect to their bodies, including their reproductive capacities.

Delhi

Delhi, being the national capital holds the distinction of having good health care facilities to cater to its huge clientele. However, on the outskirts of this very 'advanced' city, dwell the slums or the less privileged areas of Delhi. These underprivileged people are devoid of basic rights that they are entitled to even under the Indian Constitution and under various schemes as well implemented under the National Rural Health Mission. The sad reality is that even after so many years of Independence, there remains a wide gap between the rich and the poor and the haves and the have-nots of the society. There is no equitable distribution of wealth or resources, of which these poor people have to pay a very heavy price. Healthcare is one of the very basic requirements of every human being irrespective of his/her financial status. According to 2011 census, the total population of Delhi is 1,6787,941. The total figure of population living in urban areas is 16,368,899 of which 8,761,005 are males and while remaining 7,607,894 are females. The urban population in the last 10 years has increased by 97.50 percent. The total population growth in this decade was 21.21 percent while in previous decade it was 46.31 percent. The population of Delhi forms 1.39 percent of India in 2011. In 2001, the figure was 1.35 percent[4]. As of 2003, Delhi's Maternal Mortality Rate was 172; and there were 15 PHCs instituted across the area. It comprises of health centers covering the population of 50,000 instead of 30,000.Maternal Mortality Rate (MMR): Existing 104 per lakh live births (CRS 2012).[5]

4. http://www.census2011.co.in/census/state/delhi.html

5. SAMPLE REGISTRATION SYSTEM: BASELINE SURVEY 2014

A1.9 : PERCENTAGE DISTRIBUTION OF SAMPLE UNITS BY TYPE OF MEDICAL FACILITY AVAILABLE FOR DELIVERY, INDIA AND STATES (RURAL)- 2014*

India and States	Institutional											ANM/ LHV / ASHA	Traditional Dai	Others	Rural Sample Unit (No.)
	Government							Private							
	Sub-Centre	Primary Health Centre	Community Health Centre	UHC/ HHP/ UFWC	Dispensary/Clinic	Hospital	AYUSH Hospital/Clinic	Dispensary/Clinic	Hospital	AYUSH Hospital/Clinic	NGO or Trust Hospital/Clinic				
INDIA	**43.0**	**25.1**	**10.3**	**6.7**	**12.9**	**11.2**	**6.2**	**25.2**	**12.8**	**6.0**	**5.4**	**49.5**	**31.3**	**18.9**	**4963**
Bigger States															
Andhra Pradesh	62.5	42.3	21.2	20.2	21.2	21.2	17.3	48.1	22.1	14.4	12.0	50.5	23.6	23.6	199
Assam	48.9	36.7	11.1	3.3	11.1	15.6	3.3	32.2	12.2	3.3	6.7	31.1	30.0	20.0	90
Bihar	50.0	16.0	3.5	2.0	15.0	3.0	2.5	52.5	4.0	2.0	1.5	63.5	35.0	12.5	200
Chhattisgarh	24.7	13.7	1.4	1.4	1.4	5.5	4.1	11.0	2.7	5.5	1.4	35.6	52.1	50.7	73
Delhi	20.0	10.0	10.0	10.0	30.0	10.0	0.0	20.0	10.0	10.0	0.0	30.0	30.0	30.0	10

A1.11: PERCENTAGE DISTRIBUTION OF SAMPLE UNITS BY TYPE OF HEALTH FACILITIES(URBAN), INDIA AND STATES - 2014*

India and States	Availability of health facilities in the sample unit												If No health facility available except Others, distance from nearest health facility (in kms.)		Urban Sample Unit (No.)
	Government							Private				Others			
	Sub-Centre	Primary Health Centre	Community Health Centre	UHC/ HHP/ UFWC	Dispensary/ Clinic	Hospital	AYUSH Hospital/Clinic	Dispensary/ Clinic	Hospital	AYUSH Hospital/Clinic	NGO or Trust Hospital/Clinic		Below 2	2 & above	
INDIA	**57.9**	**49.5**	**43.2**	**37.1**	**49.8**	**53.9**	**34.7**	**67.3**	**58.1**	**36.5**	**37.4**	**42.5**	**93.5**	**6.3**	**3895**
Bigger States															
Andhra Pradesh	88.7	69.5	66.0	68.1	81.6	93.6	44.7	80.9	89.4	43.3	45.4	63.1	99.3	0.0	128
Assam	67.1	49.0	34.3	21.4	42.9	51.0	19.5	61.9	47.6	32.4	38.1	43.8	97.6	2.4	210
Bihar	66.2	88.5	83.1	68.5	88.5	84.6	53.8	96.2	90.0	56.9	57.7	57.7	99.2	0.8	130
Chhattisgarh	90.6	84.7	87.1	44.7	64.7	83.5	64.7	92.9	89.4	68.2	56.5	85.9	98.8	1.2	85
Delhi	15.3	10.0	8.9	3.2	20.5	11.1	8.9	60.5	15.3	6.8	6.3	8.4	85.3	14.7	190

This fact finding focuses on the various healthcare facilities provided to the urban poor (special emphasis on pregnant women) in India, especially Delhi (where the organization conducted field work). The report further narrows down to one disturbing incident reflecting hospital apathy in Government Hospitals where a woman was denied her right to proper and adequate medical services despite the fact that there is a system in place.

HOLAMBI KALAN: DEMOGRAPHY

Holambi Kalan is located in the Narela Tehsil of the district of North West Delhi. As of the 2011 Census, the village has a population of 42,392 people of which 22,933 are males and 19,495 are females. The average sex ratio is 903, and the literacy rate is 67.50 per cent of this, the male literacy rate stands at 76.09 per cent while the female literacy rate is 57.27 per cent.

The government healthcare dispensary under the Directorate of Health Services in Holambi Kalan is the DGD-Allopathic Holambi Kalan[6].

METHODOLOGY

A fact-finding team from SLIC visited Holambi Kalan in May 2017. Upon reaching the site, several cases of negligence with respect to maternal healthcare were discovered, the most prominent one being that of Kamini Devi. An urgent petition was filed and the case was heard before the Delhi high court, due to her alarmingly dangerous and painful condition. The report thus throws light upon the nature of care that was denied to Kamini Devi, and the events that took place during her visit to the Satyawadi Harish Chandra hospital.

CASE STUDY

The fact-finding team from HRLN met Kamini Devi at Holambi Kalan on 2nd May 2017 during the course of interaction with pregnant and lactating mothers. Kamini Devi was in a lot of pain and had somehow managed to walk to the Anganwadi centre where all the other women had gathered.

6. Citizen Charter, GOVT. OF NATIONAL CAPITAL TERRITORY OF DELHI: DIRECTORATE OF HEALTH SERVICES

Kamini Devi is about 32-years-old and is the wife of Shri Chotelal. She is a housewife and her husband who works as a halwai in a sweets shop is the only breadwinner. He earns approximately Rs 6,000 per month. They have four children and live in a one-room rented house. Kamini Devi and her husband come from the backward and underprivileged section of our society and were deprived of the basic fundamental and reproductive rights that she is entitled to.

Kamini Devi informed that she was pregnant with her fifth child. Two-and-a-half months into her pregnancy, she started bleeding heavily on 25th April 2017 since 4am in the morning. Since there was no one at home to take her to a doctor, Kamini waited the whole day. Chotelal took Kamini to the OPD of a nearby district-level government-run hospital Satyawadi Raja Harish Chandra Hospital, Narela, on 26th April 2017.From here, he was sent to emergency department at around 11 am. Kamini, while bleeding, was not provided any proper medical assistance or comprehensive abortion care[7]. The husband and wife were made to go from one counter to another, one floor to another without any treatment or any proper guidance. Kamini Devi was made to stand in queue for OPD card and other formalities. Throughout the day, she kept pleading and crying to be admitted in the hospital for immediate treatment. The couple struggled for the whole day but did not receive any medical care. The medical staff instead of admitting her, simply handed over three Misoprostol tablets and asked her to get an ultrasound examination done from a private lab because the district level hospital did not have an ultrasound machine (according to the doctor.) The doctor wrote on the prescription to come for follow up after 15 days but did not give any instructions to Kamini. Kamini and her husband being illiterate did not know what was happening and what were they supposed to do. Kamini informed the team that she was not given any counseling or directions about abortion procedures and follow up visit/checkups.

Kamini Devi got her ultrasound done from Smt. Kaushalya Jain Memorial Healthcare Centre, Bawana Road, Narela, aprivate health centre, and ended up spending Rs. 600 which was a big amount for her. Kamini went back to the same hospital on 27th April 2017 with her ultrasound report. The doctor barely looked at the report or took it seriously even though it clearly showed incomplete abortion and sent her back home asking her to continue taking Misoprostol. Kamini Devi took three tablets in one and a half days. Soon after taking the medicine, her bleeding stopped completely. However, Kamini Devi was experiencing excruciating pain in her abdomen and her back. She started suffering from constant dizziness, light-headedness and pain after receiving three Misoprostol tablets for her abortion.

The team visited Holambi Kalan on 2nd May and met with Kamini. Kamini could barely sit, was in lot of discomfort and pain. The team insisted that she must see a doctor right away. Kamini's husband owing to the disrespectful behaviour and denial of services at the government hospital did not want to take Kamini back to the same hospital. He had decided to take her to a private hospital instead. However, due to the fact that he could not leave Kamini alone and someone had to take care of children too, Chote could not go to work hence he did not have enough money for treatment in private hospital. The team convinced Chote to take Kamini to Satyawadi Hospital because she needed instant medical attention because infection could have set in.

Chote took Kamini to the hospital for the third time on 3rd May 2017. This time, again the medical staff told Chote and Kamini to come back after 15 days. When Kamini out of frustration and

7. According to National Health Mission Guidelines on Comprehensive Abortion Care
"Every women who seek medical termination of pregnancy should be given counseling during pre and post abortion." Further, the guideline suggests that Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA) is safe and simple technique for termination of pregnancies up to 12 weeks of gestation.

agitation due to denial of services began crying, the doctor yelled at her. Kamini shared that instead of receiving proper care and services, she was given 12 tablets of voveran 50 mg with rantac 150 mg[8] and sent back home.

Legal Intervention

The SLIC team filed an urgent application on 3rd May 2017 for an early hearing and interim order. The matter was heard by a single bench judge who passed an interim relief directing the respondents to provide adequate and immediate medical care and attention to the petitioner (Kamini). The court accepted that Kamini was in a critical condition and required immediate medical attention and that she has been denied admission and treatment at Satyawadi Harish Chandra Hospital.

The court issued notices to the Hospital, the government of the NCT of Delhi and the department of Health and Family Welfare. Kamini was asked to immediately report to Dr Puneeta, Regional Director at Dr Baba Saheb Ambedkar Hospital, Rohini. Dr Puneeta was instructed to take immediate care of Kamini, and provide her with the necessary medical treatment.

Kamini was admitted in Ambedkar Hospital on 5th May 2017 and a proper dilation and evacuation was done. She had to be hospitalized for four days and was discharged on 8th May, 2017.

Violations

1. Kamini Devi was sent back home from the Satyawadi Raja Harish Chandra Hospital, Narela, Delhi without any proper medical assistance or comprehensive abortion care services, which is in complete disregard of a bundle of government guidelines on Comprehensive Abortion Care; WHO guideline on Safe Abortion and other international guidelines ensuring provisions for maternal health care and comprehensive abortion care services. These guidelines cater to the proper diagnosis and adequate care for pre and post abortion care of women. However, the hospital has failed to ensure a safe and conducive environment for women's experience of labour and their subsequent emotional well-being. There have been lapses in abortion care services, providing assistance and counselling post abortion, disrespectful behaviour which amounts to a negligence by the state before, during and after the abortion.
2. The doctor, without any check-up or ultrasound examination, prescribed three Misoprostol tablets. The doctor also failed to take Kamini through the entire procedure of abortion. Patients undergoing miscarriage can go in shock. However the doctor did not think it was important to address this issue.
3. The website of Satyavadi Raja Harish Chandra hospital shows availability of an ultrasound lab since 2014, however, the hospital staff regularly sends people for ultrasound to a private lab and claims that the ultrasound facility is not available. Kamini was forced to spend Rs 600 on her ultrasound examination. This is violation of her rights as per JSSK scheme.
4. The medical prescription shows that Kamini was prescribed 'Misoprostol' (600 mg) tablet to be taken at night. On the contrary, she was misguided and asked to take one tablet in the morning and one in the evening. Hence, the petitioner ended up taking three tablets in one and a half days.

8. Voveran is a non-steroidal anti-inflammatory drug and Rentac is a medicine to reduce the amount of acid produced in the stomach.

5. The prescription shows that counseling was provided regarding bleeding and that patient has been asked to come after 15 days. However, this was not the case. Kamini was not provided any counseling nor was she informed about the follow up visit.
6. Kamini informed that after taking three Misoprostol tablets in one and half days her bleeding stopped completely and as a consequence she has been suffering from excruciating abdominal and back pain along with dizziness. The hospital took it very lightly and kept denying her services.
7. On 3rd May, 2017 Kamini Devi went back to the hospital owing to her deteriorating health condition. She shared that the hospital authority instead of providing proper care and services, further gave her 12 tablets of voveran 50 mg with rantac 150 mg and sent her back home.
8. The medical staff at Satyawadi Raja Harish Chandra Hospital, Narela, Delhi denied the necessary medical care and services and has discriminated against Kamini Devi at the very outset.
9. Kamini was not given counseling or directions about abortion procedures and follow up visit/ checkups.
10. After taking Misoprostol tablet, within 48 hours the retained products of conception should flush out from birth canal. But in case of Kamini no such products were flushed out and it had been seven days since she took the tablets.

Constitutional Articles, International Laws, and Case Laws

Article 21 (Indian Constitution)

States that "No person shall be deprived of his life or personal liberty except according to procedure established by law."

a. 'Right to Health' has been encapsulated as a fundamental, Constitutional guarantee in the numerous cases. The social justice objectives that the Supreme Court has read into Article 21 that includes the Right to Health and sets out a clear requirement of qualitative standards for the provision of healthcare facilities. Besides natural justice principles and legal precedent, international law places obligations on States to provide for quality healthcare. These international obligations have also been affirmed by the Supreme Court's Constitutional Benches over the years; further, the Supreme Court has recognized that International treaty obligations can well be enforced (unless in direct conflict with national legislation) as held by the apex court Vishaka & Ors.v State of Rajasthan (1997) 6 SCC 241.

b. 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."

c. In the case of Pashchim Banga Khet Mazdoor Samity v. State of West Bengal [1996 (4) S.C.C. 37], Hakim Sheikh, a member of the Paschim Banga Khet Mazdoor Samity, fell off a train and suffered serious head injuries. He was brought to a number of state hospitals, including

both primary healthcare centers and specialist clinics, for treatment of his injuries. Seven state hospitals were unable to provide emergency treatment for his injuries because of a lack of bed space and trauma and neurological services. The Supreme Court held that Article 21 of the Constitution casts an obligation on the state to take every measure to preserve life. The Court found that it is the primary duty of a welfare state to ensure that medical facilities are adequate and available to provide treatment and due to the violation of the right to life of the petitioner, compensation was awarded to him.

d. The landmark case of Bandhua Mukti Morcha v. Union of India [AIR 1984 SC 802]: held that "It is the fundamental right of every one in this Country, assured under the interpretation given to Article 21 by this Court in Francis Mullen's case, to live with human dignity, free from exploitation. This right to live with human dignity, enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Article 39 and Article 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers, men and women, and of children of tender age..."

c. The case of Thangapandi v The Director of Primary Health Service, DMS Teynampet, Chennai and Ors (2011(1) MLJ 1329) is crucial in this regard. In this case owing to medical staff and doctors refusing timely medical services to a pregnant woman in labour, the woman lost her life. The Hon'ble Madras High Court held that her family be paid compensation and that:

i) "Article 21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government Hospitals run by the State and the medical officers and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21"

ii) "Article 21 of the constitution of India guarantees right to life, which includes right to get meaning full health care, especially during maternity/delivery period."

Articles 14 and 15 (Indian Constitution)

Article 14 states that "The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India." Article 15 provides for the "Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth. "

Arbitrary denial of health care services is illegal and amounts to violation of the petitioner's fundamental rights to equality under 14 & 15 of the Constitution of India. It was held in Maneka Gandhi vs. UOI (1978) 1 SCC 248 that it isn't enough that our provision under a legislative act be constitutionally valid-if, in the implementation of the provision, a state action is infringing on a person's fundamental right, that the state action is ultra vires. In the present case, the denial of comprehensive abortion care and services is a violation of petitioner's right to life and right to equality.

The International Covenant on Economic, Social and Cultural Rights (ICESCR)

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

General Comment No. 14 adopted by the Committee on Economic, Social and Cultural Rights

This comment elucidates the contents and nature of the Right to Health. It examines the correlation between the Rights to Health and associated rights such as Right to food, sanitation, safe drinking water etc. It also analyses the freedoms and non-discrimination inherently implied in the way Right to Health must be enforced.

The Convention on Elimination of All Forms of Discrimination Against Women

Article 12 (1)

Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. (2) Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Universal Declaration of Human Rights (UDHR)

Article 25 (1)

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

ANNEXURES

ANNEXURE I: Procedures for Safe Abortions

1. Medical Abortion- to be provided by a trained and certified healthcare provider
2. Surgical Abortion- a minor surgery is performed by an experienced, trained and certified doctor, conducted in a certified and registered facilities.
3. Pre-abortion counseling- on options in abortion methods, pre-operative investigations,consent, procedure details, complications with warning signals, referral facilities, follow-up schedule and need, importance of follow-up, time of admission and discharge.
4. Post-abortion counseling- on the procedure done, signs of normal recovery, post-procedure care and hygiene, medicine dosage and schedule, warning signs of complications, resumption of sexual activity, routine follow-up and for delayed menstruation, contraceptives, and other clarifications. Emotional support is provided to the woman and her partner, if applicable. Women suffer from low-self esteem and guilt at the apparent stigma, so they need empathetic advice.[9] (Family Planning Association of India)

Women being prescribed Medical Methods of Abortion (MMA)[10] should ideally be screened for the following common contraindications:

– Anaemia (haemoglobin<8 gm %)

– Confirmed or suspected ectopic pregnancy/undiagnosed adnexal mass

– Uncontrolled hypertension or BP

– Known cases of:

- Heart problems such as angina, valvular disease, arrhythmia which can lead to sudden cardiovascular collapse
- Renal, liver or respiratory disease (Bronchial asthma is not a contraindication since Misoprostol is a bronchodilator)
- Current long-term systemic corticosteroid therapy
- Uncontrolled seizure disorder
- Chronic adrenal failure
- Hypersensitivity to Mifepristone/Misoprostol[11] or other prostaglandins

9. Family Planning Association of India . “Safe Abortion .”

10. In December 2008, Combipack with Mifepristone+ Misoprostol (1 tablet of Mifepristone 200mg and 4 tablets of Misoprostol 200mcg each) was approved by the Central Drugs Standard Control Organization, Directorate General of Health Services, India, for the termination of intra-uterine pregnancy for up to 63 days/9 weeks gestation. CAC Training & Service Delivery Guidelines, 2010 by MoHFW, GoI recommends its use up to 49 days in public sector sites, in line with the MTP Rules 2003. A proposed amendment to the MTP Act, 1971, to increase the gestation limit for MMA to 9 weeks in public sector sites is under process. Till the proposal is approved, MMA in public health facility would be allowed only up to 7 weeks.

11. Mifepristone is an antiprogestin, which blocks the progesterone receptors in the endometrium, causing the necrosis of uterine lining and detachment of implanted embryo. It causes cervical softening and an increased production of prostaglandins, causing uterine contractions. A small percentage of women (3%) may expel products of conception (POC) with Mifepristone alone.

Timeline and procedure to be followed for MMA

Visit	Day	Drugs used
First	One	• 200 mg Mifepristone oral; • Anti D 50 mcg, if Rh negative (give 300 mcg if 50mcg not available
Second	Three	• 400 mcg Misoprostol (two tablets of 200 mcg each) *sublingual/ buccal/ vaginal /oral;* • Analgesics (Ibuprofen) ; • Antiemetic; • Offer contraception
Third	Fifteen	• Confirm and ensure completion of abortion; • Offer contraception, if not already done so

Procedure to be followed on day 1

Provider's task	Instructions to the woman
• Detailed history, rule out contraindications and note special precautions • General counselling • MMA specific counselling • Discuss contraceptive options with her • Complete physical and pelvic examination • Obtain informed consent in Form-C. • Fill in Form I. • Record investigations • Tablet Mifepristone 200 mg, to be taken orally • Complete MMA follow-up card • Give contact address and phone number for any emergency • Give 180 tablets of Iron and Folic Acid • Give 2 packets of sanitary napkins • Record details in Admission Register	• Explain what to expect after taking tablet Mifepristone • She must return for Misoprostol administration after two days (unless the service provider decides for home administration of Misoprostol) • She may have pain and bleeding during these two days • Take tablet Ibuprofen to relieve the pain • Avoid intercourse or use barrier method, such as condoms • Report to the center/provider in case of excessive bleeding/acute abdominal pain • Record any experience of side effects on the MMA follow-up card

Procedure to be followed on day 3

Provider's task	Instructions to the woman
• Note history of bleeding/pain in abdomen/ expulsion of POC • Pelvic examination to rule out continuation of pregnancy. USG, if indicated • Reiterate contraceptive counselling and services	• Contraceptive advice as per the method chosen • Report back if there are no periods within six weeks of the completion of the abortion process

Misoprostol is a synthetic prostaglandin E1 analogue. It binds to the myometrial cells, causing strong uterine contractions, cervical softening and dilatation. This leads to the expulsion of POC from the uterus.

Procedure to be followed on day 15[12] (Welfare, 2016)

ANNEXURE II: Health Effects of Unsafe Abortions

About a third of women with unsafe abortions experience life-threatening complications as a result of it. Unsafe procedures include insertion of a root, twig, catheter or traditional concoction in the uterus; dilation and cutterage performed incorrectly; ingestion of harmful substances; and external force. Complications include:

- Sepsis, haemorrhage, uterine perforation- fatal if untreated
- Acute renal failure, leading to death as a secondary complication
- Chronic pelvic pain, pelvic inflammatory disease, high risk of ectopic pregnancy, premature delivery, future spontaneous abortions
- Reproductive tract infections, of which 20-40% lead to pelvic inflammatory disease and consequent infertility.
- Incomplete abortion, excessive blood loss and infection.[13] (Guttmacher Institute , 2012)

ANNEXURE III: Relevant Guidelines

National Health Mission Guidelines on Comprehensive Abortion Care:

"Every women who seek medical termination of pregnancy should be given counseling during pre and post abortion."

Further, the guideline suggests that Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA) is safe and simple technique for termination of pregnancies up to 12 weeks of gestation.

WHO guideline on Safe Abortion:

Technical and Policy Guidance for Health System:

- For pregnancies of gestational age between 9 and 12 weeks (63–84 days)- The recommended method for medical abortion is 200 mg mifepristone administered orally followed 36 to 48 hours later by 800 µg misoprostol administered vaginally. Subsequent misoprostol doses should be 400 µg, administered either vaginally or sublingually every 3 hours up to four further doses, until expulsion of the products of conception.
- Information about abortion procedure: At a minimum, a woman must be given information on:

What will be done during and after the procedure;

1. What she is likely to experience (e.g. menstrual like cramps, pain and bleeding);
2. How long the process is likely to take;
3. What pain management will be made available to her;

12. Ministry of Health and Family Welfare. "Comprehensive Abortion Care: Training and Service Delivery Guidelines." 2010.
13. Guttmacher Institute . "Facts on Abortion in Asia ." 2012.

4. Risks and complications associated with the abortion method;
5. When she will be able to resume her normal activities, including sexual intercourse;
6. Any follow-up care

International Women's Health Coalition Guideline on Abortion with Self Administered Misoprostol: A Guide for Women

For pregnancies up to 12 weeks:

Step 1: Insert four 200-mcg tablets (or their equivalent) deeply into the vagina OR in the mouth under the tongue or in the cheek pouch. If tables are placed under the tongue or in the cheek pouch, hold in the mouth for 20-30 minutes to allow them to dissolve, and then swallow the remaining fragments.

Bleeding and uterine contractions (cramping) may begin half an hour following this first step and will almost always start within the first 12 hours. Bleeding itself does not mean that an abortion has occurred. Close inspection of the sanitary pad or other receptacle may reveal whether the pregnancy has been terminated. This will be difficult to detect in very early stages of pregnancy, however, because the embryonic tissue is indistinguishable from the normal clotting of menstrual blood. For example, six weeks into pregnancy (that is, six weeks from the first day of the last menstrual period), the embryonic sac is only about the size of a short grain of rice. By the eighth week it is more visible, about the size of a kidney bean. For terminations from 10-12 weeks, the fetus is 30 mm to 8 cm in length (1+ to 3+ inches) and it will be very clear when it has passed.

Step 2: If tablets were administered vaginally in Step 1, insert four more 200-mcg tablets of misoprostol deep into the vagina three to 12 hours after the first administration. If tablets were administered by mouth in Step 1, place four more 200-mcg tablets under the tongue or in the cheek pouch three hours after the first administration and hold them there for 20-30 minutes until they dissolve. The shorter time interval between steps for tablets in the mouth is needed to achieve the same effectiveness as vaginal administration at longer intervals but may cause more side effects.

Step 3: If the pregnancy has not been terminated after using the second set of pills and bleeding,insert four more 200 mcg tablets of misoprostol 3 to 12 hours after the second vaginal administration or three hours after the second administration by mouth. The majority of pregnancies up to 12 weeks duration are terminated within hours of the first administration of misoprostol. Generally, more than three-quarters of women experience an abortion within the first 24 hours, although it sometimes takes longer. If unsuccessful, the entire process may be repeated.

According to the same guideline women should seek medical attention if they experience any of the side effects after taking misoprostol such as- bleeding that stops but is followed two weeks or later by a sudden onset of extremely heavy bleeding, which may require manual vacuum aspiration or D&C. A true copy of the abstract of the guideline is annexed and marked as Annexure P5.

FOGSI Good Clinical Recommendation on Medical Termination of Pregnancy:

Vacuum aspiration, manual or electric is the preferred method of choice for the first trimester

surgical termination. Also, it is vital that consumer be educated regarding the abortion procedure and there need to be follow up once after 7 days or in the event of a problem. Further:

"Medical Methods for Early Abortions:

- FOGSI recognises the universal evidence on the effectiveness and safety of combining mifepristone - misoprostol for inducing abortion up to 63 days as approved for use by the Drug Controller of India.
- Under existing laws medical methods can only be administered by Gynecologists and Registered Medical Practitioners recognized for performing MTPs by the MTP Act of 1971.
- FOGSI recommends that the medical profession and the pharmaceutical industry exercise due diligence in their promotion and use.
- It is vital that consumers be educated regarding this recently introduced method its advantages, drawbacks, risks and limitations.
- The current recommendations for medical methods for early abortions are 200 mg mifepristone followed after 36 – 48 hours by 400 micrograms of oral or vaginal misoprostol up to 7 weeks or 800 micrograms of oral or vaginal misoprostol over 7 weeks.

7

Fact-finding Mission in Muskani village, Deogarh District, Odisha

Maternal Death in Deogarh District

From 20th May, 2017 to 24th May, 2017

HRLN
HUMAN RIGHTS LAW NETWORK
Reproductive Rights Initiative
1390/B, Sector-6, C.D.A, Cuttack, Odisha

ABBREVIATIONS

ADMO	:	Assistant District Medical Officer
ANC	:	Antenatal Checkup
ANM	:	Auxiliary Nurse Midwife
ASHA	:	Accredited Social Health Activist
AWC	:	Anganwadi Centre
AWW	:	Anganwadi Worker
BPL	:	Below Poverty Line
CDMO	:	Chief District Medical Officer
CDPO	:	Child Development Project Officer
CHC	:	Community Health Centre
DHH	:	District Headquarter Hospital
EAG	:	Empowered Action Group (States)
IPHS	:	Indian Public Health Standards
JSSK	:	Janani Shishu Suraksha Karyakram
JSY	:	Janani Surakhya Yojana
MCP	:	Mother and Child Protection (Card)
MCTS	:	Mother and Child Tracking System
MMR	:	Maternal Mortality Rate
MO	:	Medical Officer
NHM	:	National Health Mission
NRHM	:	National Rural Health Mission
OBGYN	:	Obstetrician/Gynecologist
OT	:	Operational Theatre
PHC	:	Primary Health Centre
PPH	:	Postpartum Hemorrhaging
SC	:	Scheduled cast
ST	:	Scheduled tribe
TT	:	Tetanus Toxoid
UNICEF	:	United Nations Children's Fund
VHND	:	Village Health and Nutrition Day ("Mamata Diwas")
WHO	:	World Health Organization

INTRODUCTION

Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth. Almost 99 per cent of those deaths occur in developing countries. India has a high Maternal Mortality Rate at 167 maternal deaths per 100,000 live births[1]. With ingenious initiatives implemented by the Indian Government, such as the Janani Surakhya Yojana project under the National Rural Health Mission, it is clear that some steps are being taken to counter maternal deaths. However, with these new proposals, not only is the implementation and enforcement flawed but in some cases fatal. Taking the case of Padmini Nahak, who died ten days after childbirth due to puerperal sepsis and lack of advanced and effective medical care, it is clear that there is a long road ahead towards attaining the Sustainable Development Goal of 70 maternal deaths per 100,000 live births worldwide.

The purpose of this fact-finding mission was to ascertain possible explanations for the death of Padmini Nahak. Her death fits into the internationally accepted definition of maternal death in terms of the period of death and the cause of death. 4 days after childbirth, Padmini was diagnosed with puerperal sepsis. She was ultimately treated at VSS Medical College, Burla, Sambalpur, where she died. The following day, her newborn baby also died in the Intensive Care Unit.

Maternal death is defined as the death of a woman while pregnant, during childbirth, or within 42 days of termination of pregnancy from any cause related to or exacerbated by the pregnancy[2].

The vast majority of maternal deaths are wholly preventable. Maternal health experts have determined the three avoidable problems that result in maternal death:

1. An initial delay in obtaining quality antenatal care;
2. A delay in reaching care (e.g., poor infrastructure, unavailable or costly transportation, continual referrals);
3. A delay in receiving quality care at a medical facility (e.g., inadequate staff, facilities, supplies, hygiene). These might be considered the social and governmental causes of death, which inevitably precede the direct medical causes of death.

CONTEXT

Maternal health is an area of prime concern in India. The National Rural Health Mission (NRHM) has fast-forwarded the progress in improving maternal health through initiatives such as promoting institutional deliveries and improving access to reproductive health services. However, glaring differences exist between different states and among districts. In Odisha, even though the overall picture indicates that the state is on the road to achieving its target for institutional deliveries, a lot more is desired in some of its most backward districts like Kalahandi, Balangir, and Koraput (KBK).

Some of the challenges include geographical inaccessibility, poor quality of care, female illiteracy, and large tribal population. However, central and state sponsored initiatives are contributing significantly to improving this situation. Initiatives of policy makers need to be supplemented with need-based research and critical analysis of district-level data. Here, academic institutes,

1. http://www.who.int/mediacentre/factsheets/fs348/en/
2. https://www.ucc.ie/en/mde/definitionandclassificationofmaternaldeath/

through active collaborations, can assume leadership roles. Besides focusing on achieving the targets for institutional deliveries, there is a need to improve the quality of care, particularly in remote areas.

METHODOLOGY

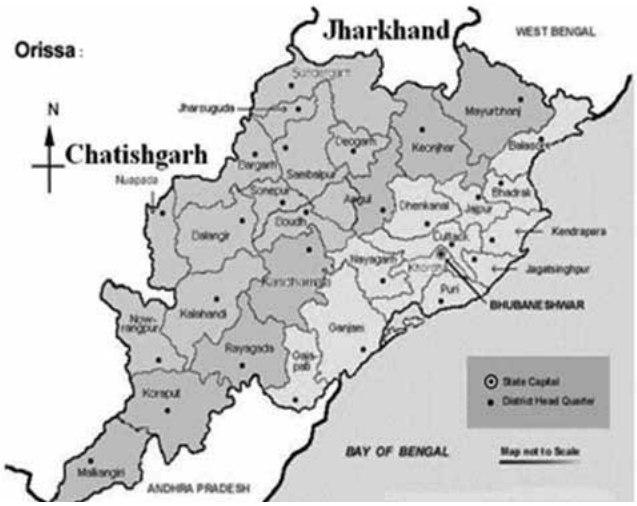
On 24th May 2017, a team consisting of three members (one health rights activist, HRLN, Odisha unit, one health rights activist, Deogarh, Odisha unit, and one Advocate of HRLN, Odisha Unit) conducted a fact-finding mission in Reamal Block under the Deogarh District of Odisha following the death of Padmini Nahak, a tribal, scheduled caste, pregnant women who died 10 days after childbirth.

The fact-finding team conducted in-depth research into the matter, with detailed interviews with the victim's husband, her family members, community people, the village leader, AWW, and ASHA. The team followed an open-ended questionnaire with the victim's family and triangulated the matter with the interviews from different health care providers on the same.

DISTRICT PROFILE: Deogarh

Deogarh District, also known as Debagarh District, was newly created on 1st January 1994, after being bifurcated from the Sambalpur District. Deogarh is surrounded by Angul District on its east and south, Sambalpur District on its west, and Sundergarh District on its north. It is a district of the Koshal region and is situated in the western region of the state, having its headquarters at Deogarh town.[3]

Deogarh's history dates back to the 5th century A.D. when the Mathara Royal Family was at the helm of the administration. After them, the Ganga Rulers came into power and established their capital at Deogarh. The British rule of Deogarh was one of the darkest periods in its history with no major developments to show.[4]



The District, covering a geographical area of 2940 square kilometers, is located between 21 degrees 31' 53" North Latitude and 84 degrees 43' 2" East Longitude. The total population of the District is 2,74,108 comprising of 1,38,408 male population (50.62 per cent) and 1,35,700 female population (49.38 per cent) as per the 2001 census. Total SC population of the District is 42,117 and ST population is 92,103.

3. State Map: http://www.visitorissa.in/orissa-map.html

4. District Map: https://cdn.shopify.com/s/files/1/1657/2397/files/Map-Deogarh-A-494x360_large.jpg?v=1493977199

As for the administrative setup, Deogarh district has one subdivision named Deogarh. There are 2 Tahasils, 3 Blocks, 60 Gram Panchayat, and 4 Police Stations functioning in the District.

The Deogarh district experiences hot summer from March to May, heavy monsoon from June to September, and winter from October to February. The average annual rainfall of the District is 1142.3 mm. The highest temperature of the District is 43 degree Celsius and lowest temperature is 8 degree Celsius.

The literacy rate of Deogarh District is well over seventy percent, higher than the national average literacy rate[5].

BENEFITS UNDER JSSK and JSY

The Government of India launched the Janani Shishu Suraksha Karyakaram initiative on 1st June 2011, under the umbrella of the National Rural Health Mission. Estimated to benefit more than 12 million pregnant women, this scheme will motivate those who still choose to deliver at their homes to opt for institutional deliveries. All States and Union Territories have initiated the implementation of JSSK.

Every needy pregnant woman is entitled to the following:

A. Free delivery (and C-Section),

B. Free drugs and consumables,

C. Free diagnostic,

D. Free diet during stay in the health institutions,

E. Free provision of blood,

F. Exemption from user charges,

G. Free transportation from home to health institutions,

H. Free transportation between facilities in case of referral,

I. Free transportation from medical facility to home after 48 hours stay;

All sick newborns, and now sick infants, are entitled to the following:

A. Free treatment,

B. Free drugs and consumables,

C. Free diagnostic,

D. Free provision of blood,

E. Exemption from user charges,

F. Free Transportation from home to medical facility,

I. Free Transportation between facilities in case of referral[6];

5. http://www.ordistricts.nic.in/district_profile/dist_glance.php

6. http://nhm.gov.in/janani-shishu-suraksha-karyakram.html

Also under the umbrella of the National Rural Health Mission, the Janani Surakhya Yojana also benefits pregnant women living in Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir. Launched on 12th April 2005, this scheme is being implemented in all states and union territories[7]. The initiative provides for financial assistance of Rs 500 per birth up to two live births to the pregnant women who have attained 19 years of age and belong to the below poverty line (BPL) households[8].

FINDINGS OF NATIONAL FAMILY HEALTH SURVEY 4 (ODISHA)

Conducted by the Institute of Health Management Research (IIHMR University), the NFHS-4 was held in Odisha from 21 January 2016 to 4 July 2016. This is the fourth edition of the survey and for the first time, conducted an in-depth analysis of districts, as well as states. The survey measured each region with four different lenses: Household, Woman's, Man's and Biomarker. For the Household aspect, information such as usual members of the household, visitors, socio-economic characteristics, water, and sanitation was recorded. Information on marriage, fertility, childcare, reproductive health, sexual behaviour, domestic violence was investigated in the Woman's aspect. The Man's aspect covered marriage, contraception, nutrition, attitudes towards gender roles, and HIV/AIDS. The Biomarker aspect focused on measurements of height, weight, haemoglobin levels, blood pressure, and random blood glucose level tests[9] [10].

Odisha - Key Indicators

Indicators	NFHS-4 (2015-16)			NFHS-3 (2005-06)
Maternal and Child Health	**Urban**	**Rural**	**Total**	**Total**
Maternity Care (for last birth in the 5 years before the survey)				
32. Mothers who had antenatal check-up in the first trimester (%)	69.6	63.1	64.1	48.3
33. Mothers who had at least 4 antenatal care visits (%)	69.7	60.6	62.0	36.9
34. Mothers whose last birth was protected against neonatal tetanus[7] (%)	96.5	94.1	94.5	83.3
35. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	40.8	35.8	36.5	22.5
36. Mothers who had full antenatal care[8] (%)	27.1	22.3	23.1	12.3
37. Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	97.2	97.2	97.2	na
38. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	73.6	73.3	73.3	31.7
39. Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution (%)	57.6	75.5	72.6	na
40. Average out of pocket expenditure per delivery in public health facility (Rs.)	4,900	4,125	4,225	na
41. Children born at home who were taken to a health facility for check-up within 24 hours of birth (%)	4.0	7.3	6.9	0.2
42. Children who received a health check after birth from a doctor/nurse/LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	25.0	30.3	29.5	na
Delivery Care (for births in the 5 years before the survey)				
43. Institutional births (%)	89.7	84.7	85.4	35.6
44. Institutional births in public facility (%)	66.9	77.4	75.9	28.8
45. Home delivery conducted by skilled health personnel (out of total deliveries) (%)	1.3	3.6	3.3	8.3
46. Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	89.7	86.1	86.6	44.0
47. Births delivered by caesarean section (%)	24.1	12.1	13.8	5.1
48. Births in a private health facility delivered by caesarean section (%)	49.5	56.0	53.7	32.4
49. Births in a public health facility delivered by caesarean section (%)	19.1	10.4	11.5	10.0

7. https://www.nhp.gov.in/janani-suraksha-yojana-jsy-_pg#
8. http://nhm.gov.in/nrhm-components/rmnch-a/maternal-health/janani-suraksha-yojana/background.html
9. http://rchiips.org/nfhs/FCTS/OR/OR_FactSheet_373_Debagarh.pdf
10. http://rchiips.org/nfhs/pdf/NFHS4/OR_FactSheet.pdf

Debagarh, Odisha - Key Indicators

Indicators	NFHS-4 (2015-16)	
Maternal and Child Health	**Rural**	**Total**
Maternity Care (for last birth in the 5 years before the survey)		
29. Mothers who had antenatal check-up in the first trimester (%)	49.5	49.9
30. Mothers who had at least 4 antenatal care visits (%)	58.1	58.4
31. Mothers whose last birth was protected against neonatal tetanus[7] (%)	93.1	93.4
32. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	34.1	34.0
33. Mothers who had full antenatal care[8] (%)	19.5	19.9
34. Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	96.8	96.9
35. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	70.3	71.2
36. Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution (%)	71.4	70.2
37. Average out of pocket expenditure per delivery in public health facility (Rs.)	4,363	4,263
38. Children born at home who were taken to a health facility for check-up within 24 hours of birth (%)	(14.6)	(14.6)
39. Children who received a health check after birth from a doctor/nurse/LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	24.5	24.6
Delivery Care (for births in the 5 years before the survey)		
40. Institutional births (%)	84.7	85.3
41. Institutional births in public facility (%)	78.7	78.5
42. Home delivery conducted by skilled health personnel (out of total deliveries) (%)	2.9	2.8
43. Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	86.2	86.7
44. Births delivered by caesarean section (%)	7.7	8.5
45. Births in a private health facility delivered by caesarean section (%)	*	*
46. Births in a public health facility delivered by caesarean section (%)	5.8	6.3

FINDINGS OF CAG REPORT IN ODISHA (2014)[11]

Following Article 151 of the Indian Constitution, the Comptroller and Auditor-General of India published a report regarding the National Rural Health Mission in Odisha. The following are two tables displaying relevant information to this incident. In Table 2.6, Maternal Mortality Rates and Infant Mortality rates in Odisha are outlined. In Table 2.7, JSY and the effectiveness of the scheme are outlined.

Table 2.6: Maternal Mortality Rate and Infant Mortality Rate in the state

Year	MMR of the state	IMR of the State			MMR in India	IMR in India
		Total	Rural	Urban		
2007-08	303	71	73	52	254	55
2008-09	NA	69	71	49	NA	53
2009-10	258	65	68	46	212	50
2010-11	277	61	63	43	NA	47
2011-12	237	57	58	40	NA	44
2012-13	NA	NA	NA	NA	NA	NA

Source- Data furnished by the Mission Director, HMIS, SRS Bulletin and Annual Health Survey

11. http://www.cag.gov.in/sites/default/files/audit_report_files/Odisha_Report_2_2014_chap_2.pdf

FACTORS ASSOCIATED WITH INSTITUTIONAL DELIVERY

Institutional deliveries are childbirths that take place in hospitals, with the help of medical professionals. The need for institutional deliveries cannot be understated. These deliveries provide hygienic equipment and potentially life-saving practices that reduce the risk of contracting prenatal or postpartum illnesses[12].

A. **Tribal population:** In districts with higher ratios of tribal populations, the proportions of institutional deliveries are lower.

B. **Female Literacy:** In the districts with lower female literacy, the proportions of institutional deliveries are lower as well.

C. **Standard of Living:** Districts with higher ratios of populations with a lower standard of living have lower proportions of institutional deliveries.

D. **Age at Marriage (girls):** Districts with higher ratios of marriages in which the woman is under the age of 18 have lower proportions of institutional deliveries.

E. **Antenatal care:** Data from most districts except KBK districts indicate that mothers registering early during pregnancy for ANC are more likely to come for at least 3 ANC visits and undergo institutional deliveries. Further research may be required to identify reasons for contrary findings in some of the KBK districts.

Universal coverage of institutional delivery in Odisha incorporates a large tribal population in the south and west, which are mostly rural and backward regions. As per the 2001 census, about 38.41 per cent people of these districts belong to the scheduled tribes. Female literacy in this region is only 24.72 per cent. During the 2009-10 National Sample Survey, 61.1 per cent people were categorized as below poverty line. More specifically, 49 community development (CD) blocks of the KBK districts are regarded as “very backward” and 28 CD blocks are considered as “backward.” To improve coverage of institutional delivery in this region is a daunting task and requires a multipronged approach from the government such as poverty alleviation schemes, generating employment opportunities, and improving health care infrastructure.

The adequacy of health care infrastructure includes the availability of a right number of health care institutions, proper equipment for conducting safe deliveries and managing complications, sufficiently trained and motivated health personnel, uninterrupted supply of essential medicines, and transport services for prompt referral. Even though there is improved funding through NRHM, the situations in many parts of south and west Odisha are far from desirable. The adequacy of health care infrastructure in this region needs to be studied and factors for its current status has to be identified to guide the action of policy makers.

DISTRICT WISE INSTITUTIONAL DELIVERIES IN ODISHA

The poorly performing districts of Odisha with regards to institutional deliveries include Rayagada, Nabarangpur, Koraput, Malkangiri, and Gajapati. The best performing districts include Jagatsinghpur, Khordha, Cuttack, Jharsuguda, and Puri; as per district level household facility survey-3 data [DLHS 3: 2007- 2008 (11)]. Thus, there is wide variation in progress among the 30 districts of the state of Odisha (Table 1).

12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2898676/

Table 1: Rank wise distribution for institutional deliveries in 30 districts of Odisha[13]

SR No.	Districts	Institutional Births (%)
1	Jagatsinghpur	79.7
2	Khordha	70.8
3	Cuttack	68.3
4	Jharsuguda	64.9
5	Puri	63.6
6	Jajpur	61.6
7	Sambalpur	56.6
8	Ganjam	55.4
9	Baleswar	52.6
10	Balangir	51.7
11	Kendrapoda	46.9
12	Dhenkanal	46.9
13	Sundergarh	45.3
14	Deogarh	44.5
15	Nayagarha	44.1
16	Bargarh	43.7
17	Mayurbhanja	43.1
18	Bhadrak	42.7
19	Sonpur	40.9
20	Anugul	40.7
21	Kendujhar	34.3
22	Boudh	28.8
23	Nuapoda	28.8
24	Kalahandi	27.5
25	Kandhamal	25.3
26	Gajapati	19.7
27	Koraput	18.9
28	Rayagada	18.3
29	Nabarangpur	25.9
30	Malkangiri	14.8

13. Extract from the Health agenda volume.1.issue 3, July, 2013

FACTS OF THE INCIDENT

Background

Padmini Nahak, about 20-years-old, lived in the Musakani village, Reamal block. She was the newly married wife of Mohadev Nahak. On 27.09.2015 she experienced labor pain around 8 am after suffering the entire day and night. On the next morning (28.09.2015) around 9 am, she was rushed to CHC Chhendipoda, and delivered a female baby weighing 3.200 gms. According to Mohadev Nahak, her last menstruation period was around 17.12.2014 and expected date of delivery was 21.09.2015. Following the delivery, both Padmini and her baby returned home. Four days after delivery, she felt tired, weightless, and suffered from fever. She went to the District Hospital Deogarh, where she did not receive a hospital bed, causing her to lie down on the floor of the gynecology ward and use a urinal to urinate. After a few hours, she suffered more vaginal pain, forcing her to stay and be treated at the District Hospital for two days. Dr Nayak referred her to the VSS Burla Medical, diagnosing her with puerperal sepsis. At that time she was not provided with 102 or 108 ambalance to reach VSS Burla, 65 kilometers away. Travelling in an autorickshaw, she reached the medical center and was admitted to the gynecology ward. Dr U Bodran, in pathology, also diagnosed Padmini with puerperal sepsis. Her newborn child was then admitted to the Intensive Care Unit. After four days, Padmini was declared dead and her child died the following day.

Mohadev Nahak had incurred expenditure approximating Rs 40,000 for the treatment and a funeral ceremony. Even though he is categorised below the poverty line, he did not receive any financial help and was not covered under Harishandra Yoshina scheme for their cremation ceremony. He informed the team that he was not satisfied with the service provided for his wife by DHH Deogarha. He believes that if DHH and DM RCH and ADMO F&W were prompt in taking action, her precious life could have been saved. He demanded Rs 3 lakhs from the State for their role in his wife's death.

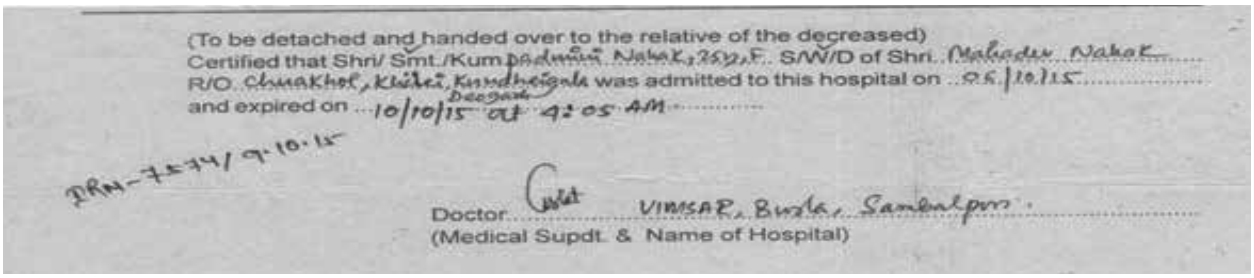
Meeting with AWW and ASHA

The fact finding team met with AWW, as they were the first point of contact by the Nahak family. AWWs are the key stakeholder of ICDS programme. They are meant to administer minimal care to pregnant village women with Maternal and Child Protection Cards, or "Mamta cards." They also provide nutritional supplements during pregnancy.

The team was able to verify the AWW register and found that all columns were filled in with a pencil, making it easier to manipulate the documents. CDPO of Reamal block did not visit the Nahak household. After Padmini's death, her baby was not provided emergency care and therefore died.

The HRLN team noticed that Padmini lived in a remote area, explaining the lack of health care providers. Accordingly, no prompt action was taken by ASHA, ANM, CHC, DHH, or at NRHM level.

The team has noticed that even though CHC and DHH are meant to provide medical services 24/7, patients are left without emergency care at night and noon. Additionally, patients being treated laid down on the floor, causing further risk of infections, such as sepsis.


(To be detached and handed over to the relative of the decreased)
Certified that Shri/ Smt./Kum Padmini Nahak, 25y, F. S/W/D of Shri Mahadev Nahak
R/O Chuakhol, Kulei, Kundheigola was admitted to this hospital on 05/10/15
and expired on 10/10/15 at 4:05 AM
IPRN-75734/9.10.15
Doctor
(Medical Supdt. & Name of Hospital)
VIMSAR, Burla, Sambalpur.

FINDINGS

A. Padmini Nahak came from a very poor family and lived in a remote area. After delivery, the ANM did not conduct a visit within 7 days, as is protocol to avoid the risk of sepsis and fever.

B. IPHS guideline was not followed up by subcenter, CHC, SDH or DHH.

C. Lack of oversight and punishment for services was not rendered.

D. The Nahak family incurred expenses of Rs 40,000 for treatment and lack of access to 102 and 108 Ambulance service, forcing her to hire a private vehicle.

F. Pregnant women are referred to VSS Burla Medical, at a distance of 65 kilometers from DHH Deogarh, as doctors are not always present.

Due to a shortage of hospital beds, patients are forced to lie down on the floor, increasing the risk of contracting serious infections. An investigation at a high level is necessary to identify and ensure follow up action accordingly.

HUMAN RIGHTS VIOLATIONS UNDER NATIONAL & INTERNATIONAL LAW

Violation of Guarantees under Indian Constitution

The right to the highest attainable standard of health is outlined in the Constitution of the WHO. The passage in the Indian context of the constitutional violations of "right to health care" is as follows:

Article 14: "The State shall not deny to any person equality before the law or the equal protectionof the laws within the territory of India."

Article 15 (1): "The State shall not discriminate against any citizen on grounds only of religion,race, caste, sex, place of birth of any of them."

Article 15 (3): "Nothing in this article shall prevent the State from making any special provisionfor women and children."

Article 21: "No person shall be deprived of his life or personal liberty except according to procedureestablished by law."[14]

14. http://lawmin.nic.in/olwing/coi/coi-english/coi-4March2016.pdf

Violation of Basic Human Rights To A Pregnant Woman Under International Law

The right to survive pregnancy and childbirth is a basic human right. The following are some of the laws provided in support of maternal health by the International Community, which is also upheld in India.

Universal Declaration of Human Rights, 1948

Article 16 (1), (3): "Men and women of full age, without any limitation due to race, nationality orreligion, have the right to marry and to found a family. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State."[15]

International Covenant on Civil and Political Rights (ICCPR)

Article 6: "Every human being has the inherent right to life. This right shall be protected by law.No one shall be arbitrarily deprived of his life".[16]

International Convention on Economic, Social and Cultural Rights (ICESCR)

Article 10(1)-(3): "[T]he widest possible protection and assistance should be accorded to the family […] Special protection should be accorded to mothers during a reasonable period before and after childbirth. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions."

Article 12: "[R]ecognize the right of everyone to the enjoyment of the highest attainable standardof physical and mental health. The steps to be taken […] to achieve the full realization of this right shall include those necessary for:

a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

b) The improvement of all aspects of environmental and industrial hygiene; […]

c) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."[17]

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

CEDAW makes clear "the social significance of maternity and the role of both parents in the family and in the upbringing of children." The convention recognizes "that the role of women in procreation should not be a basis for discrimination."

Article 12(1), (2): "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure [...] access to health care services, including those related to family planning. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement, and the post-natal period,

15. http://www.un.org/en/universal-declaration-human-rights/
16. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx
17. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[18]

United Nations Convention on the Rights of the Child (UNCRC)

Article 24 (1), (3): "States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures [t]o ensure appropriate pre-natal and postnatal healthcare for mothers."[19]

United Nations Sustainable Development Goal #3

Article 3.1: "By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 livebirths."

Article 3.2: "By 2030, end preventable deaths of newborns and children under 5 years of age,with all countries aiming to 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."[20]

18. http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf
19. http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf
20. http://www.who.int/sdg/targets/en/

CONCLUSION

The fact-finding team was profoundly disturbed by the details surrounding the death of Padmini Nahak. There is a system in place designed to provide adequate care for pregnant women in each of these villages, yet it is not properly administered. This is a direct violation of multiple international agreements that India is a party to establish a right to survive pregnancy and childbirth. Furthermore, the government of India has created multiple schemes to provide services that guarantee a pregnant woman the right to survive her pregnancy. In this particular instance, there was a breakdown in the referral mechanisms which prevented antenatal care from being distributed, causing Padmini to not receive 102 or 108 ambulance in a fatal condition. It is a failure of the CHC and DHH Deogarh for they could not provide adequate care. All of these resulted in failure to avert a preventable maternal mortality.

The events of this case also pose as violations of multiple rights provided by the Constitution, including the fundamental right to health and guaranteed access to medical services regardless of status. Padmini especially, when the State failed to hold its employees accountable, did not receive the care she needed to remain healthy during her pregnancy. Onset Anemia and other infections were not detected early in the antenatal period and after delivery. Additionally, there were no visits or care given by ANM.

There is a high probability that other women in similar situations may face the same fate if the state does not address these egregious violations. The lack of oversight and accountability has created an environment rampant with failures that have resulted in maternal death. The CHC, ambulance services, and District Headquarter Hospital all failed with their inability to respond quickly with services that could have saved Padmini's life. If the ANM had regularly visited the pregnant women at the time of the 3rd trimester and within seven days after delivery, this tragedy could have been prevented. The need for corrective action in this district is blatantly obvious and needs to be taken immediately. DHH and CHC also need to review their system and implement corrective action promptly.

RECOMMENDATIONS AND SUGGESTIONS

Padmini Nahak's death has clearly demonstrated the factors that contribute to maternal deaths in India. This means corrective measures also need to probe deep into the medical system. There is a clustering of maternal deaths around socially vulnerable groups: Dalits, tribals, migrants, and impoverished labourers. In the broader perspective of seeking social justice for the vulnerable, it is imperative to take action to enable the poor to avail services and seek them as their right. Within this framework, obeying the medical practitioner's code of ethics will strengthen the health system.

According to medical council of India updated December 2010, the duties and responsibilities of a physician, in general, are as follows:

The Principal objective of the medical profession is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

The Patient must not be neglected: A physician is free to choose whom he will serve. He should,

however, respond to any request for his assistance in an emergency. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. Provisionally or fully registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients of necessary medical care[21].

Improving Facilities and Services for Maternity Care

The Government of Odisha has issued many policy statements indicating its commitment to promoting safe and institutional deliveries by skilled personnel. To enforce the implementation of this policy, the following major actions are required:

a) Increasing the number of hospital beds at all levels immediately.

b) Initiate a rational management of maternity services at different levels of the health system.

c) In District Hospitals, services such as emergency, newborn, and maternity care should be strengthened with equipped staff and equipment.

   The current functioning of the most district hospitals in the public sector are not up to expectations, especially in relation to availability, accessibility, and quality. The main aim of DHH is to provide comprehensive secondary health care (specialist and referral services) to patients.

d) The ANMs and the ASHAs also need to identify and categorize patients based on risk level. The specialist intervention required would reduce the workload on medical professionals and allow them to provide more time and attention to those in high-risk situations.

   Resources and equipment will be used more efficiently. This method of screening of women throughout their pregnancy will also establish smooth functioning and ensure that high-risk pregnancy services are provided with immediate attention.

e) The objective of a Community Health Centre (CHC) is twofold: making modern health care services accessible to the rural poor and easing the overcrowding in district hospitals.

The CHC is the third tier of the network of rural health care institutions. It's primary role is to act as a referral centre (for the neighboring PHCs) for patients requiring specialized health care services. The CHCs are designed to be staffed with four specialists in the areas of medicine, surgery, pediatrics, and gynecology. The CHC is also equipped with 30 beds for indoor patients, an operation theatre, labour room, X-Ray Machine, Pathological Laboratory, Standby Generator along with complementary medical and paramedical staff.

The visit suggests that the Community Health Centre and DHH have an acute shortage of medical specialists, as well as a mismatch of facilities and specialists implying sub-optimal utilization and a thin spread of available resources.

Rational Use of Community Health Centres and First Referral Units

It was observed that the Obstetric and Gynecology specialists, along with fully trained nurses were not available in the CHC or DHH. The CHC and DHH could be more fully used to cater to larger numbers with the following measures:

21. http://www.dmetorissa.gov.in/files/Code%20of_conduct.pdf

a) Increase in staffs and facilities

b) Quality monitoring of work

c) Stronger linkages with periphery organizations – ASHA, AWW, and ANM

d) Training of ASHA and ANM to identify high-risk pregnancies

e) Have referral support and functional emergency transport

f) Proper treatment for prenatal and postpartum illnesses

g) Patient friendly behavior by which patient will be interested and comfortable in seeking health care

h) Proper monitoring of workload in CHC and DHH to accordingly arrange staff and specialists

Improvement in Peripheral Maternity Services

The Anganwadi Centre and the CHC were visited and interviews were held with the health care providers. It was clear that monitoring of peripheral health services needs improvement. Antenatal care tracking and maternal death auditing in a non-threatening atmosphere must become a priority of all PHCs and CHCs. There are no maternity huts established to provide services to at-risk pregnant women. Monitoring and reporting system need to be strengthened, as well as the maintenance of a high-risk pregnancy should be registered and reported to PHC.

Regular monitoring and guidance should be provided to the front line medical specialists like the ASHA and Anganwadi Workers.

8

Chimonger Primary Health Centre

HRLN

HUMAN RIGHTS LAW NETWORK

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
CDPO	Child Development Project Officer
CHC	Community Health Centre
FFFM	Followup Fact Finding Mission
GDP	Gross Domestic Product
IFA	Iron and Folic Acid (tablets or capsules)
IGMSY	Indira Gandhi Matritva Sahyog Yojana
JSY	Janani Suraksha Yojana
JSSK	Janani Shishu Suraksha Karyakram
LM	Lactating Mothers
MO	Medical Officer
NRHM	National Rural Health Mission
NHM	National Health Mission
OoPE	Out of Pocket Expenditure
PHC	Primary Health Centre
PM	Pregnant Mothers
PM & LM	Pregnant Mother & Lactating Mother
VC	Village Council
VHC	Village Health Committee

INTRODUCTION

A team from HRLN Nagaland conducted a fact-finding mission in October, 2016, in Chimonger Village under Tuensang District. The team, with an objective to evaluate the accessibility and facilities provided in the Health Centre, as well as the effectiveness of IPHS guidelines, initiated group discussions with the villagers. They also interviewed pregnant and lactating mothers, the staff of the PHC, the Village Council, the Village Health Committee, ASHAS, and Anganwadi Workers. The purpose of this follow-up fact-finding mission report is to shed light on the status of the PHC since the last visit that was conducted on October 11, 2016.

Chimonger Village, Tuensang District

Tuensang is a district that lies on the Eastern fringe of Nagaland, sharing an international border with Myanmar on the eastern side of the district. It is one of the original three districts, along with Mokokchung and Kohima formed at the time the Nagaland state was created. Over the decades, the district has gradually diminished in size with the carving out of Mon, Longleng and Kiphire districts. Tuensang encompasses an area of 1,728 square kilometers, and is the largest district of Nagaland.

According to the 2011 census, Tuensang has a population of 196,801 – roughly equal to the nation of Samoa. This makes it the 590th most populous district in India, out of a total of 640. Tuensang has a sex ratio of 930 females for every 1000 males, and a literacy rate of 73.7 per cent. Changs, Sangtams, Yimchunger and Khiamniugans are the main indigenous tribes of this district, although the Ao and Sema tribes also form a significant part of the population.

According to a press release, "Chimonger village is the largest village amongst the Sangtam tribe, with over 6000 populations and having 647 households"[1]. Chimonger has a lower literacy rate as compared to the Nagaland state average. In 2011, the literacy rate of Chimonger was 68 per cent, compared to the state average of 79.5 per cent, and this rate went down to 64.32 per cent when only considering females.

1. The Morung Express dated April 4 2016, retrieved on April 20th 2016: http://morungexpress.com/rohbi-jinger-becomes-first-eac-from-chimonger-village

METHODOLOGY

The team conducted formal and informal interviews and interactions with the PHC staff, the Village Council, Village Health Committee, ASHAs and Anganwadi workers along with some of the community members. This report is based on open ended interview schedules, as well as secondary sources including newspapers, reports, IPHS guidelines and the 2011 Census.

Primary Health Centre and IPHS[2]

In 1946, the Bhore Committee created the concept of a PHC as a basic health unit to be situated as close to the public as possible, providing integrated curative and preventative health care to rural populations with an emphasis on preventive and promotive aspects of health care. PHCs are the cornerstone of rural health services. When implemented correctly, they are the first port of call to a qualified doctor of the public sector in rural areas for the sick, and for those who are directly referred from sub-centres in order to receive treatment. It acts both as a referral unit for six sub-centres, as refers out cases to CHCs and higher order hospitals at the district and sub-district level.

PHCs are not spared from issues such as the inability to perform up to the expectation due to

(i) non-availability of doctors at PHCs; (ii) even if posted, doctors do not stay at the PHC HQ; (iii) inadequate physical infrastructure and facilities; (iv) insufficient quantities of drugs; (v) lack of accountability to the public and lack of community participation; (vi) lack of set standards for monitoring quality care etc.

From a service delivery angle, PHCs come under two categories, depending upon the delivery case load – Type A and Type B. Type A PHC is a PHC with a delivery load of less than 20 deliveries in a month. Type B PHC is a PHC with a delivery load of 20 or more deliveries in a month.

Chimonger PHC is a Type A PHC, as per the record of deliveries until March 2017.

Referral Services

- Appropriate and prompt referral of cases needing specialist care including:
- Stabilization of patient.
- Appropriate support to patient during transport.
- Providing transport facilities either by PHC vehicle or other available referral transport.
- Drop back home for patients as mandated under JSSK

Basic Laboratory and Diagnostic Services

- Essential Laboratory services including routine urine, stool and blood tests (Hb per cent, platelets count, total RBC, WBC, bleeding and clotting me)
- Diagnosis of RTI/STDs with wet mounting, Grams stain, etc

2. Indian Public Health Standards Guidelines for Primary Health Centres, Revised 2012

- Sputum testing for mycobacterium (as per guidelines of RNTCP)
- Blood smear examination malarial
- Blood for grouping and Rh typing
- RDK for Pf malaria in endemic districts
- Rapid tests for pregnancy
- RPR test for Syphilis/yAWS surveillance (endemic districts)
- Rapid test kit for fecal contamination of water
- Estimation of chlorine level of water using orthotoludine reagent
- Blood Sugar

Operation Theatre/ Minor OT

To facilitate conducting selected surgical procedures (e.g. vasectomy, tubectomy, hydrocelectomy etc.):

- It should have a changing room, sterilization area operation area and washing area
- Separate facilities for storing of sterile and unsterile equipment/instruments should be available in the OT
- It would be ideal to have a patient preparation area and post-operative area. However, in view of the existing situation, the OT should be well connected to the wards
- The OT should be well-equipped with all the necessary accessories and equipment
- Surgeries like laparoscopy/cataract/tubectomy/vasectomy should be able to be carried out in these OTs
- OT shall be fumigated at regular intervals. One of the hospital staff shall be trained Autoclaving and PHC shall have standard Operative procedure for autoclaving
- OT shall have power back up (generator/Invertor/ UPS). OT should have restricted entry. Separate foot wear should be used.

Labour Room (3.8 m x 4.2 m)

Essential

A. Configuration on of new-born care corner

- Clear pool area shall be provided in the room for newborn corner. It is a space within the labour room, 20-30 sq in size, where a radiant warmer (functional) will be kept.
- Oxygen, suction machine and simultaneously accessible electrical outlets shall be provided for the newborn infant in addition to the facilities required for the mother. Both the oxygen cylinder and suction machine should be functional with their tips cleaned and

covered with sterile gauze etc for ready to use condition. They must be cleaned after use and kept in the same way for next use

- The labour room shall be provided with a good source of light, preferably shadow-less
- Resuscitation kit including Ambu Bag (Paediatric size) should be placed in the radiant warmer
- Provision of hand washing and containment of infection control if it is not a part of the delivery room
- The area should be away from draught of air, and should have power connection for plugging in the radiant warmer

B. There should be separate areas for septic and aseptic deliveries.

C. The labour room should be well-lit and ventilated with an a ached toilet and drinking water facilities. Facilities for hot water shall be available.

D. Separate areas for dirty linen, baby wash, toilet, sterilization.

E. Standard Treatment Protocols for common problems during labour and for newborns to be provided in the labour room.

F. Labour room should have restricted entry. Separate foot wear should be used.

G. All the essential drugs and equipment (functional) should be available.

H. Cleanliness shall always be maintained in labour room by regular washing and mopping with disinfectants.

Janani Suraksha Yojana[3]

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. This scheme integrates cash assistance with delivery and post-delivery care. While the scheme would create demand for institutional delivery, it would be necessary to have adequate number of 24x7 delivery services centre, doctors, mid-wives, drugs etc. at appropriate places. Mainly, this will entail:

- Linking each habitation (village or a ward in an urban area) to a functional health centre-public or accredited private institution where 24x7 delivery service would be available
- Associate an ASHA or a health link worker to each of these functional health centre
- It should be ensured that ASHA keeps track of all expectant mothers and newborn. All expectant mother and newborn should avail ANC and immunisation services, if not in health centres, at least on the monthly health and nutrition day, to be organised in the Anganwadi or sub-centre
- Each pregnant women is registered and a micro-birth plan is prepared
- Each pregnant woman is tracked for ANC

3. Janani Suraksha Yojana, Guidelines for implementation, Ministry of Health and Family Welfare

- For each of the expectant mother, a place of delivery is pre-determined at the me of registration and the expectant mother is informed
- A referral centre is identified and expectant mother is informed
- ASHA and ANM to ensure that adequate fund is available for disbursement to expectant mother
- ASHA takes adequate steps to organise transport for taking the women to the pre-determined health institution for delivery
- ASHA assures availability of cash for disbursement at the health centre and she escorts pregnant women to the pre-determined health centre
- ASHA package in the form of cash assistance for referral transport, cash incentive and transactional cost to be provided as per guidelines

The financial package for the beneficiaries is as mentioned below (Press Information Bureau 2015).

Category	Rural Area		Urban Area	
	Mother's package	ASHA's package*	Mother's package	ASHA's package**
LPS	1400	600	1000	400
HPS	700	600	600	400

**ASHA package of Rs 600 in rural areas include Rs 300 for ANC component and Rs 300 for facilitating institutional delivery*
***ASHA package of Rs 400 in urban areas include Rs 200 for ANC component and Rs 200 for facilitating institutional delivery*

Cash assistance for home delivery

BPL pregnant women, who prefer to deliver at home, are entitled to a cash assistance of Rs 500 per delivery regardless of the age of pregnant women and number of children (Press Information Bureau 2015).

Janani Shishu Suraksha Karyakram (JSSK)

JSSK launched on June 1, 2011, is an initiative to assure free services to all pregnant women and sick neonates accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries, caesarian section operations and also treatment of sick newborn (up to 30 days after birth) in all government health institutions across States/UTs. This initiative supplements the cash assistance given to pregnant women under the JSY and is aimed at mitigating the burden of out of pocket expenditure incurred by pregnant women and sick newborns.

Entitlements for Pregnant Women

- Free and zero expense delivery and caesarian section
- Free drugs and consumables
- Free diagnostics (blood, urine tests and ultrasonography, etc, as required.)
- Free diet during stay in the health institutions (up to 3 days for normal deliveries and up to 7 days for caesarian deliveries)
- Free provision of blood
- Free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home.
- Exemption from all kinds of user charges

Entitlements for sick newborn until 30 days after birth

- Free and zero expense treatment
- Free Drugs and Consumables
- Free diagnostics

Primary Health Centre, Chimonger Village

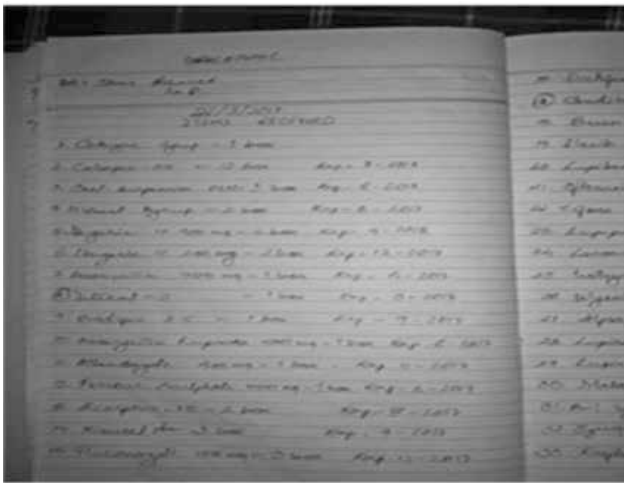
- Free provision of the Blood
- Free transport from home to institutions, between facilities in case of referrals and drop back from institutions to home.
- Exemption from all kinds of user charges

With a total 790 families residing, Chimonger has a population of 4996 of which 2607 are males while 2389 are females as per Population Census 2011. There are 7 Khels and 9 Anganwadi Centres in the village. The old Chimonger PHC, which has since been abandoned, was established during the 1980s and was functioning as a Subsidiary Health Centre since its establishment. It has been 9 years that the present Health centre was upgraded to

the level of a PHC. Due to difficulties in accessing medical support, and the distant road connectivity (it was approximately five kilometers away from the village, which was isolated and had extremely poor road conditions), it was moved to the village area, its current location. The present new PHC is functioning with only two rooms in a granary, constructed under the GIA Granary 2009-2010. For nearly 5 years, the PHC has been dysfunctional, and the PHC currently only provides immunization services and basic medications/treatments during the immunization. The new PHC is in pathetic condition, with just two rooms and a total absence of toilet facilities. There is no boundary for the PHC as such and it is also adjacent to the road.

During the field visit conducted by the HRLN team, there was not a single staff member present at the PHC. It was only upon being called by the village chairman that one chowkidar, three male health attendants, one LDA, one sweeper and one ANM turned up. There was no doctor present at the PHC; the doctor in question was said to have been on leave for weeks. The team tried to track down the doctor's leave application, but this was not available in the office registers of the PHC.

In terms of the facilities available in the PHC, it was found that even the most basic and essential facilities were unavailable in the health centre. Alarmingly, there was no electricity or water supply available – two of the most important and essential features of any functioning health care centre. There was no delivery facility available, just a worn-out labour bed. There were only two beds in total, one for the OPD and the aforementioned worn out labour bed in the room, which was also being used as a stock room for medicine, a pharmacy, for administrative purposes and all other general services at the PHC. Additionally,



of the two weighing machines found, only one was functional. Upon enquiring with the Village Heath Chairman as to whether there had been any maintenance or development funding supplied to the PHC, he stated that the only time a development fund was received for repairing the PHC was in 2015 where approximately Rs 4 lakh was received. He demonstrated a lack of awareness regarding how this fund was spent. "It was difficult to ascertain any developmental activities initiated in the PHC through the fund," he said.

When interacting with the staff members who turned up when called upon by the village chairman, the staff informed the team that the designated doctor visited the PHC for one day in January, one day in February and for three days in November 2016. They stated that the doctor usually comes once or twice a month, thus the immunizations in the village are undertaken once in a month when the doctor attends the PHC.

Upon enquiry regarding medical supplies in the PHC, it was found that there were always shortages of medicine. When checking the stock, a staff member informed the team that two different drugs delivered from the department in March 2017 were already expired.

In cases of emergencies, the villagers usually go to the Longkhim CHC, which is approximately a one-hour drive from the village (there is no public transport available) or to Tuensang DH, which is approximately a three-hour drive away. In order to travel to the other health centres, there are no ambulances (referral transport) being provided. Villagers therefore, have no choice but to hire private taxis at a cost of Rs 1,000 -1,500. There are no ambulances in the PHC, and there is no record of reimbursement of the cost of hiring private taxis to any of the villagers in Chimonger. These instances are very clearviolations of the JSSK Scheme.



On checking the sites around the PHC, it was found that only one small temporary wooden construction was available for urinal purpose alone (annex. 7), located outside adjacent to the PHC. Additionally, there was no proper bio-medical waste management. All of the bio-medical waste was thrown into the community open drainage system (annex. 8 and 8.1) and burnt in the open, which is dangerous for the villagers and highly unsanitary. Finally, there is no proper and concrete boundary or wall for the PHC.

When asked about the benefits and entitlements under the JSY and JSSK schemes, the staff demonstrated a lack of awareness of such rights and entitlements to PMs & LMs. Lack of awareness of health accessibilities, schemes, entitlements was highly prevalent in the village, and there was no strong awareness mechanism initiated by the department in the village.

Interactions

During the fact-finding mission, the team interacted with a number of villagers in order to extract primary data on the matters of health accessibility and services provided at the PHC. The team also interacted with ASHAs, Anganwadi workers, pregnant women and lactating mothers, the village health care committee and the village council. These interactions are documented below.

ASHA

Limala (ASHA, since 2012).

Limala attended ASHA training once for malaria immunization and was made aware about the duties, roles and responsibilities of an ASHA. On asking about the referral transport system, she said that in most cases, patients have to hire private taxis to go to the hospitals/health centres which cost around Rs 1,500 for a Tata Sumo, and Rs 1,000 for a Maruti Van. Some patients have to take their own vehicle. According to her, there was only one case of an operating referral transport service that she witnessed in 2014, for which the pregnant mother was incorrectly charged for using the ambulance and was not given any reimbursement from the hospital. When asked how the ASHAs maintain records, she stated that they send text messages about the registration of pregnant women to the compounder of the PHC. She informed the team that pregnant women received only Rs 250 for home delivery under the JSY scheme up until May 2015. After this date, no cash assistance or entitlements were given to pregnant women and lactating mothers under the JSY and JSSK schemes until date (March 2017).

According to the ASHAs, there were maternal and infant deaths in the village in the recent years. One case was of maternal death after one month of delivery, and the other was of infant death after birth due to the infant being underweight and malnourished, as well as the absence of a diagnosis and access to healthcare facilities.

According to ASHA workers, the only incentive that they receive during immunization was of recording +ve Malaria patients. It was said that, if the ASHA identify a +ve malaria patients the only incentive was Rs 5 and incase of a person identified -ve, the cash assistance was zero. On top of this, to even submit the list of infected patients, they have to incur Rs 1,000 to hire a taxi or Rs 100 in a shared passenger taxi to reach Longkhim town and submit the list to the doctor. They were never given any reimbursement for the travel expenses and have to incur the cost of the taxi from their own pocket. Which cost them more than the returns for their services. On asking about the present statistics about registration of pregnancy, these were the data provided:

PREGNANCY REGISTRATION STATISTICS		
	No. of Deliveries	6
2017	Registered PM for ANC	12
2016	No. of Deliveries	34
	Registered PM for ANC	21

'Every year ASHAs were to be provided with drug kits consisting of 15 sets of basic medicine and contraceptives for maternal and child health care services in rural areas. Scrutiny of records of four sampled DHs revealed that the ASHA drug kits worth 0.34 crore issued for replenishment during 2009-14 were not received in the four sampled districts. Thus, 71488[4] ASHAs in four test checked districts performed their duties without any drug kits in rural areas[5].'

4. Mon(227), Kohima (120), Tuensang(176) and Zunheboto(191) = 714 ASHAs.

5. CAG Report no. 1 of 2015, Page no. 38

Lactating Mother

Ayola (27 years)

Ayola is the mother of two children, whose last delivery was in February, 2015.On interviewing her, it was found that there were no records of assistance by the ASHA during her last pregnancy. The treatment taken during her pregnancy was all out of her own pocket. During her pregnancy, she visited Tuensang town twice for ANC. On asking of her delivery, it was said that she hired a taxi for Rs 1,500 and went to CHC Longkhim, for an institutional delivery. On asking of the medications she said, there were no free medicines and consumables provided to her during and after delivery in the CHC. The expenses incurred for medication were more than Rs 2,000. She did not receive any reimbursement for transportation and medicine expenses. The total expense was around Rs 5,000. She was not provided any assistance under JSY and JSSK schemes. However, she was taken by the ASHA for the institutional delivery for which the ASHA didn't even receive the cash entitlements despite asking of their entitlements. On asking why she never visited the PHC in the Village, she said that the PHC is dysfunctional and there is no staff present and available in the PHC almost all the time, the PHC is perpetually closed except during immunization drive.

Anganwadi Worker

There are nine AWC in the village as mentioned by the Health Committee Chairman.

Thringlongla (55-year-old)

She is the Anganwadi worker for the AWC. As per the AWW a total of 14 pregnant women were registered at the AWC. She was not quite sure about the registered number of children from 0-6 years as all her files/registers were being submitted to the department on December 2016. On asking about the IGMSY scheme, she was not aware about IGMSY scheme nor any one else present in the kitchen during the interaction. There is no register maintained and no records of IGMSY scheme in any of the AWCs in the village. On enquiring about the sanitation and toilet accessibilities, she said there is no toilet and kitchen facility available at this AWC. The food items are cooked at the village chairman's kitchen, which is adjacent to the centre. Also, there are no basic nutritional items, IFA tablets and vitamin supplements supply in the AWCs. The only handful of medicine supplies in a year, in the AWCs are for basic treatments like headache, stomachache and deworming

tablets. On asking about the last supply of items till March 2017, she said that, the last food items supply for her AWC was in the month of December, 2016 from the CDPO, Longkhim office. She said that the supply of food items is received quarterly or once in 3-4 months. The AWW also said that, in order to collect food items from the CDPO office, Longkhim all AWWs of Chimonger village collectively hire a private taxi for which they share the total fare among themselves. They have to spend OoPE since there were no reimbursements provided to them from the CDPO office, Longkhim. On asking of the charges and expenses incurred for picking up the food items, she said, to hire a taxi they usually incur Rs 1,000 or in a shared taxi of Rs 100. On asking of the list of food items received in December 2016, these are the following items:

Last food items received	
A.	1 carton of Balbhog
B.	2 bags of Rice
C.	1 carton of Biscuits
D.	1 carton of chow noodles
E.	1 carton of cornflakes

Human Rights Violations

(United Nations and International Conventions)

The right to survive pregnancy and childbirth is a basic human right. These are some of the laws provided in support of maternal health by the International Community, which is also up held by India. These are the laws intact in order to provide these basic necessities but violated by the State. These laws are as follows:

Universal Declaration of Human Rights, 1948

Article 16 (1), (3):

"Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State."

International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)

Article 5:

"States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment...the right to public health, medical care, social security and social services"

International Covenant on Civil and Political Rights (ICCPR)

Article 6:

"Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life"

International Convention on Economic, Social and Cultural Rights (ICESCR)

Article 10(1)-(3) :

"States Parties to the present Covenant recognize that [t]he widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society… Special protection should be accorded to mothers during a reasonable period before and after childbirth… Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions."

Article 12:

"States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

b) The improvement of all aspects of environmental and industrial hygiene;

c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Article 15:

"States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

CEDAW makes clear "the social significance of maternity and the role of both parents in the family and in the upbringing of children." The convention recognizeses "that the role of women in procreation should not be a basis for discrimination."

Article 12(1), (2):

"States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure...access to health care services, including those related

to family planning. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

Article 16:

"States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating...family relations and in particular shall ensure...the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."

United Nations Convention on the Rights of the Child (UNCRC)

Article 24 (1), (3):

"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures to ensure appropriate pre-natal and postnatal healthcare for mothers."

Violations of Indian Constitutional Guarantees

The right to the highest attainable standard of health (referred to as ''right to health'') was first outlined in 1946 in the Constitution of the WHO. In the Indian context of the constitutional violations of "right to health care" witnessed in the field during the two day FFFM in the Chimonger PHC of Tuensang District are as follows:

Article 14: "The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India."

Article 15 (1): "The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth of any of them."

Article 15 (3): "Nothing in this article shall prevent the State from making any special provision for women and children."

Article 21: "No person shall be deprived of his life or personal liberty except according to procedure established by law."

In the case of Munshi Singh Gautam v. State of M.P., the Supreme Court held that Article 21 "life or personal liberty includes a right to live with human dignity. There is an inbuilt guarantee against torture or assault by the State and its functionaries."

Article 47: "Duty of the State to raise the level of nutrition and the standard of living and to improve public health"

FINDINGS AND ANALYSIS

Findings

1. One of the important findings apart from the health accessibilities was the Out-of-Pocket Expenditure (OoPE). There were many instances of OoPE in the Village in accessing the health services. The PM & LM in receiving health services, ASHAs in their services to the community and the AWW in picking up food items from the concern office.

   OoPEfor health care is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is part of health expenditure undertaken by the affected person.

2. Leaving alone the essential equipment to be available in a PHC, there is literally no equipment available in the Chimonger PHC. The PHC does not even have the basic of the essential. The one or two worn out and unused basic equipment found during the FFFM are seen in the photographs.

3. According to the PHC guidelines, there shall be a monthly review meeting chaired by MO (or in-charge), and attended by all the health workers (male and female) and health assistants (male and female). However, there is no such mechanism conducted in the Chimonger PHC, leaving aside the monitoring and evaluation reporting which do not take place. This has also been one of the reasons for the communication gap and improper functioning of the PHC.

4. There is hardly any staffs present in the PHC and the Doctor is in perpetual leave. When people are in dire need of medical attention in the village with a population of 6000 approx. and when it is the only source of health accessibility other then the Longkhim CHC, which is approx. 15 kms away from the village. This is a very serious concern and should be dealt with at the earliest.

5. There are said and witnessed accounts of maternal and infant deaths in the village. However, there is not even a single record of Maternal Death Review in the PHC. The PHC does not even have proper maintenance of files and registers.

6. There are no instances of JSY and JSSK schemes since 2015. Despite the ASHAs submitting the

records of PM & LM to the PHC and the ASHA coordinator. This is a very serious concern and should be dealt with accordingly.

7. Basic laboratory facilities for routine blood, urine and stool examination are also not available in the PHC.
8. There is no electricity and water supply in the PHC. The 24x7 health service delivery is a dream.
9. There is no proper and continuous supply of medicines in the PHC. The team also identified expired drugs during the FFFM. And also, there were two different drugs that came expired from the department on March 2017
10. The last Referral Transport Service provided was in 2014, for which the pregnant mother was charged for the usage of the ambulance without reimbursement from the hospital, which is a clear violation of the JSSK scheme.
11. The road connectivity to Chimonger PHC from the Longkhim town is a kacha road and in a deplorable condition. It takes around two hours to reach from the town and during rainy seasons, it is prone to accidents and even a bigger problem and challenge to travel in those roads during emergencies for the community.
12. There is no record of the IGMSY beneficiaries in the village despite the state implementing in all the districts since 2013. The AWW are not aware of the IGMSY scheme. It is the responsibility of the department of Social Welfare in Nagaland to conduct such awareness drive to the AWW and the villages. The flow of IGMSY funds should be streamlined.

13. The Chimonger PHC doctor is said to be allegedly on study leave for three years. However, it is said that doctor was seen at the PHC in November after the HRLN team conducted a fact-finding mission on October 2016 and filed a petition.

Analysis

Health has been declared as a fundamental human right. In fact health services are now seen as a part of basic social services of a country. In India, the Bhore Committee in 1946 gave the concept of a Primary Health Center (PHC) as a basic health unit to provide as close to the people as possible, an integrated preventive and curative health care to the rural population with emphasis on preventive and promotive aspects of health care.

In Nagaland, most of the rural areas and villages like Chimonger are isolated in terms of geographical location and developmental activities. The majority of population in the village are farmers, being an agro-based society and daily wagers. The mere income level is limited. In such situation, when the expenditure of certain households is higher then the level of income, it becomes difficult to be accessing health needs and services, OoPE.

JSY scheme, which was started by Central Government during 2005-06 and reached the State in 2007. It provides for monetary benefits to all pregnant women to the tune of Rs 700 to rural areas and Rs 600 to urban areas so as to increase the institutional deliveries in urban and rural areas (Eastern Mirror Network 2013)7. However, there were no instances and visible services of JSSK in the village and not a single mother interviewed was said to have received referral transport services and other entitlements from the PHC. The financial management is not streamlined and there are instances of financial commitments not being honored and delays in release of funds, which impacted in achieving the objectives of NHM.

The absence of doctor at PHC is a big drawback as this undermines the importance of the PHC and the basic Human Rights of an individual, who are in need of medical attentions. This is a complete violation of the Right to Health and the constitutional. Also, if the Health Department was to keep the alleged doctor on study leave, why has there been no replacement of doctors in the first place and secondly, in such a hugely populated village of approximately 6000, why did the department keep the alleged doctor on study leave for all these three years knowing the dire medical needs of the community?

RECOMMENDATIONS

1. To ensure the availability, adequacy, and functionality of health infrastructural facilities including the medical and paramedical staff in PHC, there is an urgent need to emphasize on the systemic mechanism of supervision, monitoring, and review of the functioning of the Chimonger PHC.
2. On the JSY and JSSK Schemes; women and children are severely affected due to the corruption that has maligned the scheme and deprived thousands of the benefits entitled to them especially in a backward district like Tuensang. The success rates of these schemes (JSY & JSSK) have been very low in Nagaland despite the state's claims in their annual PIPs, and India remains one of the countries with the lowest level of health coverage for those who need it the most.
3. Punitive action against to be taken against those involve in delaying or non release of funds

earmarked for medicines and consumables under the JSY and JSSK schemes and against those found guilty in the malpractices of funds utilization of the JSY and JSSK schemes for the Chimonger PHC.

4. Punitive action against the negligence of duties and failure to address the dire health needs of the villagers in the Chimonger PHC.
5. Punitive action against concern officer on the misuses of Untied Funds, RKS Grants and the Annual Maintenance Funds for the Chimonger PHC.
6. Eastern Mirror Network 2016, 'CM presents CAG report in Assembly', Eastern Mirror, Available from: http://www.easternmir-rornagaland.com/cm-presents-cag-report-in-assembly/[20 November 2016

CONCLUSION

There is a great deal of violation of the right to health in the Village. This FFFM report clearly shows a mismatch between the infrastructure and the manpower, as the PHC is rarely used, as doctors and other staff are irregular and of a very poor service delivery. This mismatch between manpower and essential facilities is a matter of serious concern. This would require not only infrastructural strengthening but also adequate human resource support and well-developed service delivery protocols. The Chimonger PHC failed to deliver even the basic health services to the poor in such a large village, which is a direct violation of the basic human rights.

9

Maternal Death in Kurtha Dih, Jehanabad

Conducted by: Prayas

ABBREVIATIONS

ANC	Antenatal Check up
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CMHO	Chief Medical & Health Officer
CHC	Community Health Centre
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MBBS	Bachelor of Medicine/Bachelor of Surge
PMCH	Patna Medical College Hospital

INTRODUCTION

Kurtha Dih is a small village of Dhonraha in Jehanabad district of Bihar with a total population of 1,374. The village has one Anganwadi centre. The main occupation of the people of this village is daily labour. The people of this village mostly belong to the BPL category. Patna is the capital and largest city of the state of Bihar in India. It is the second largest city in eastern India after Kolkata. It had an estimated population of 1.68 million in 2011, making it the 19th largest city in India. With over 2 million people, its urban agglomeration is the 18th largest in India. Patna also serves as the seat of Patna High Court. One of the oldest continuously inhabited places in the world. Patna was founded in 490 BCE by the king of Magadha. Ancient Patna, known as Pataliputra was a seat of learning and fine arts. Its population during the Maurya period (around 300 BCE) was about 400,000. The modern city of Patna is situated on the southern bank of river Ganges. The city also straddles the rivers Sone, Gandak and Punpun. The city is approximately 35 kilometres (22 mi) in length and 16 to 18 kilometres (9.9 to 11.2 mi) wide. In June 2009, the World Bank ranked Patna second in India (after Delhi) for ease of starting a business. As of 2011-12, Patna had the highest per capita gross district domestic product in Bihar, at 63,063. Using figures for assumed average annual growth, Patna is the 21st fastest growing city in the world and 5th fastest growing city in India according to a study by the City Mayors' Foundation. Patna registered an average annual growth of 3.72 per cent during 2006-2010.

Maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

The world mortality rate has declined by 45 per cent since 1990, but still 800 women die every day from pregnancy or childbirth related causes. According to the United Nations Population Fund (UNFPA) this is equivalent to "about one woman every two minutes and for every woman who dies, 20 or 30 encounter complications with serious or long-lasting consequences. Most of these deaths and injuries are entirely preventable.

UNFPA estimated that 289,000 women died of pregnancy or childbirth related causes in 2013. These causes range from severe bleeding to obstructed labour, all of which have highly effective interventions. As women have gained access to family planning and skilled birth attendance with backup emergency obstetric care, the global maternal mortality ratio has fallen from 380 maternal deaths per 100,000 live births in 1990 to 210 deaths per 100,000 live births in 2013, and many countries halved their maternal death rates in the last 10 years.

World-wide mortality rates have been decreasing in modern age. High rates still exist, particularly in impoverished communities with over 85per cent living in Africa and Southern Asia. The effect of a mother's death results in vulnerable families and their infants, if they survive childbirth, are more likely to die before reaching their second birthday.

The Total Fertility Rate of the State is 3.1. The Infant Mortality Rate is 55 and Maternal Mortality Ratio is 318 (SRS 2007 - 2009) which are higher than the National average. The Sex Ratio in the State is 926 (as compared to 940 for the country). Comparative figures of major health and demographic indicators are as follows[1]:

1. RHS Bulletin, March 2012, M/O Health & F.W., GOI)

Item	Bihar	India
Total Population (Census 2011) (In Crores)	6.86	121.01
Decadal Growth (%) (Census 2011)	21.44	17.64
Crude Birth Rate (SRS 2013)	25.6	21.4
Crude Death Rate (SRS 2013)	6.5	7
Natural Growth Rate (SRS 2013)	19.1	14.4
Infant Mortality Rate (SRS 2013)	47	40
Maternal Mortality Rate (SRS 2010-12)	255	178
Total Fertility Rate (SRS 2012)	2.9	2.4
Sex Ratio (Census 2011)	926	940
Child Sex Ratio (Census 2011)	883	914
Schedule Caste population (in crore) (Census 2001)	0.97	16.67
Schedule Tribe population (in crore) (Census 2001)	0.71	8.43
Total Literacy Rate (%) (Census 2011)	67.06	74.04
Male Literacy Rate (%) (Census 2011)	80.51	82.14
Female Literacy Rate (%) (Census 2011)	52.66	65.46

Health Infrastructure of Bihar

Particulars	Required	In position	Shortfall
Sub-centre	15172	11487	3685
Primary Health Centre	2326	1528	798
Community Health Centre	581	382	199
Health worker (Female)/ANM at Sub Centres & PHCs	13015	17638	*
Health Worker (Male) at Sub Centres	11487	1592	9895
Health Assistant (Female)/LHV at PHCs	1528	1420	108
Health Assistant (Male) at PHCs	1528	201	1327
Doctor at PHCs	1528	1755	*
Obstetricians & Gynaecologists at CHCs	382	14	368
Paediatricians at CHCs	382	11	371
Total specialists at CHCs	1528	148	1380
Radiographers at CHCs	382	260	122
Pharmacist at PHCs & CHCs	1910	551	1359
Laboratory Technicians at PHCs & CHCs	1910	2639	*
Nursing Staff at PHCs & CHCs	4202	11926	*

DETAILS OF THE VICTIM

- Name of the woman- Kanchan Dev Paswan
- Age- 19 years
- Education Status- upto class 10
- Resident of -Kurtha Dih, Post Kurtha Bajar, Dhonraha, District Jehanabad, Bihar
- Anganwadi Center- Kurtha Dih
- BPL card- Yes
- Victim's age at the time of marriage - 17 years
- Age at the time of first delivery- 19 years
- Date and time of Death- 22nd July 2017, 7 am
- Place of Death – Sadar hospital Jahanabad
- Name of victim's husband and age - Chandan Paswan (23 years)
- Education status – Studied upto class 8
- Occupation – Labourer
- AWC is 200 metres far from Kanchan's house
- Name of AWW- Sapna Kumari Paswan
- Name of ASHA Worker- Parmila Mahto
- District Hospital –Jahanabad 20 kms far from Kanchan's house

Fact finding team and respondents

To investigate into the case, Goverdhan Yadav from Prayas visited Kurtha Dih village in Jehanabad on 24th Aug and 26th Aug, 2017. The respondents are as follows:

1. Chandan Paswan (husband of the late Anita Devi)
2. Bakhori Paswan (her father-in-law)
3. Sapna kumara, ananganwadi worker
4. Urmiladevi(her mother-in-law)

METHODOLOGY

This is a case of maternal death. Goverdhan Yadav from Prayas contacted Prafful Raj, a journalist who published the news of Kanchan's death in the local newspaper. The purpose behind carrying out a fact-finding report is to flag various lapses in delivering maternal health services that led to Kanchan's death. On the day of the visit, Yadav reached Chandan's house which is in a small village called Kurtha Dih in Jehanabad, Bihar. At Chandan's house they interviewed Chandan and his parents. There were other family members present there but they didn't talk.

After the discussion, Yadav went to Sadar hospital Jehanabad. The investigator asked for clicking photographs but Kanchan's family refused as they wanted this to remain confidential. They didn't want media attention as well. They just want to seek justice for Kanchan; hence no photographs were taken to respect the wishes of the victim's family.

BACKGROUND

Kanchan was 17 when she was married to Chandan who was 22-year-old at that time. Kanchan was a homemaker. Their family is BPL and struggles to make ends meet. In the village where they live, daily wage labour is the only occupation. Hence, Chandan works as a laborer and he does not own any land. He lives in Kurtha Dih, which is in Jehanabad district (Bihar). Kanchan and Chandan lived in a mud house comprising one room. They have managed to occupy a little area outside the house where they have few chicken. They do not have a constant source of electricity. There is no running water available in their house. Kanchan used to get water from the nearby well and a hand pump in the courtyard of their house. They do not have any toilet facility inside their house. They defecate outside. Chandan's parents live with them in the same compound but in another room with Chandan's three younger brothers. They have one hearth where the food is being cooked for the whole family. When Kanchan got pregnant for the first time, the family was very happy because it was going to be a first child. Chandan's other siblings do not have children as they are not married.

THE CASE

It was Kanchan's first pregnancy at the age of 19. She got herself registered in at the Anganwadi centre in Kurtha Dih where she learned that she was already six months pregnant. She also had her first checkup at the Anganwadi centre in Kurtha Dih. She had not received any THR (Take Home Ration) from the centre. Her MAMTA card was prepared when she was going to hospital for delivery. Kanchan did not receive any further checkups. Chandan informed that she did not have any complications. On 21st July 12pm, 2017 as her labor pains started she was taken to the primary health centre at Makhdumpur in an auto rickshaw hired by Chandan. She was admitted at the PHC right away but her pain was unbearable. So she was referred to Sadar hospital in Jehanabad at 12:15 am on 22nd of July, 2017. Upon reaching Jehanabad hospital, she was admitted in the female ward, but there was no doctor at that time. After some time an ANM came and checked Kanchan up. Her condition was very critical by that time. After about half an hour, a female doctor came and gave Kanchan an injection. Right after the injection was given, Kanchan's labour pains increased and she went into labour. However, due to some complications, the delivery could not take place. Despite repeated requests, no doctor came to check on her. Around 2 am that night, Kanchan died due to excessive blood loss. The hospital staff asked Chandan to go home as there was nothing else they could do. Chandan had already spent an amount of Rs 5,000 in bringing his wife to the hospital.

FINDINGS

- Kanchan conceived for the first time and registered herself at the Anganwadi Centre after 6th month as per Mamta card (17/05/2017 first ANC)
- She was not provided with any further health check up

- Kanchan did not receive any nutrition supply from Anganwadi as per Mamta card
- They were provided ambulance service while she was referred to other hospitals.
- She was not checked by any doctor at Sadar hospital Jehanabad
- Kanchan died due to excessive blood loss and lack of medical attention and treatment when she required it the most

VIOLATIONS OF RIGHTS

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 to 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 arising during this period is attended by skilled doctors available at the government hospital.

In Kanchan's case, there was delay in her checkup. This violates her right to receive a proper medical attention when required. No ANC checkups were conducted previously. The main purpose of issuing MAMTA card for pregnant women is to monitor the checkups that are mandatory under the schemes of JSSK. If there is some risk related to pregnancy it must be mentioned in the MAMTA card so that it can be taken seriously before delivery.

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.

Kanchan was bleeding profusely and she didn't receive any immediate help from the doctors. She was being referred from one health facility to another health facility. In such a time, frequent travel also increases the risk as already there is high risk pregnancy. It was Kanchan and Chandan's first pregnancy.

GUIDELINES FOR ANTE-NATAL CARE

Antenatal care

Antenatal care is the systemic supervision of women during pregnancy to monitor the progress of fetal growth and to ascertain the well-being of the mother and the fetus. A proper antenatal check-up provides necessary care to the mother and helps identify any complications of pregnancy such as anemia, pre-eclampsia and hypertension etc. in the mother and slow/inadequate growth of the fetus. Antenatal care allows for the timely management of complications through referral to an appropriate facility for further treatment. It also provides opportunity to prepare a birth plan and identify the facility for delivery and referral in case of complications. As provider of ante natal care, you are involved in ensuring a healthy outcome both for the mother and her baby.

However, one must realize that even with the most effective screening tools, one cannot predict which woman will develop pregnancy-related complications during and immediately after child birth. Therefore following things must be ensured:

- Recognize that 'every pregnancy is special and every pregnant woman must receive special care'
- Complications being unpredictable may happen in any pregnancy/child birth and we should be ready to deal with them if and whenever they happen
- Ensure that ANC is used as an opportunity to detect and treat existing problems, e.g. essential hypertension
- Prepare the woman and her family for the eventuality of an emergency
- Make sure that services to manage obstetric emergencies are available on time.

Kanchan was not given a single ANC checkup. This is the first step in the course of ensuring safepregnancy for a woman. Her health has been neglected at each stage. To ensure safe institutional delivery the State has a lot of schemes and guidelines for health workers but in her case none of the guidelines have been followed.

Care during Pregnancy—antenatal care

Quality ANC has several components, which are described below:

1) A few primary steps:
    - Ensure early registration and see to it that the first check-up is conducted within 12 weeks (first three months of pregnancy)
    - Track every pregnancy for conducting at least four antenatal check-ups (including the first visit for registration), keeping in mind all the essential components listed under section B
    - Administer two doses of TT injection
    - Provide at least 100 tablets of IFA
2) Essential components of every antenatal check-up:
    - Take the patient's history
    - Conduct a physical examination–measure the weight, blood pressure and respiratory rate and check for pallor and edema
    - Conduct abdominal palpation for fetal growth, fetal lie and auscultation of Fetal Heart Sound (FHS) according to the stage of pregnancy
    - Carry out laboratory investigations, such as hemoglobin estimation and urine tests (for sugar and proteins)
3) Desirable components:
    - Determine the blood group, including the RH factor
    - Conduct the Venereal Disease Research Laboratory (VDRL)/Rapid Plasma Reagin (RPR) test to rule out syphilis
    - Test the woman for Human Immuno deficiency Virus (HIV)
    - Check blood sugar
    - Carry out the Hepatitis B Surface Antigen (HBsAg) test
4) Counseling:
    - Help the woman to plan and prepare for birth (birth preparedness/micro birth plan)
    - This should include deciding on the place of delivery and the presence of an attendant at the time of the delivery
    - Advantages of institutional deliveries and risks involved in home deliveries
    - Advise the woman on where to go if an emergency arises, and how to arrange for transportation, money and blood donors in case of an emergency
    - Educate the woman and her family members on signs of labour and danger signs of obstetric complications

- Emphasize on the importance of seeking ANC and PNC
- Advise on diet (nutrition) and rest
- Inform the woman about breastfeeding, including exclusive breastfeeding
- Provide information on sex during pregnancy
- Warn against domestic violence (explain the consequences of violence on a pregnant woman and her fetus)
- Promote family planning
- Inform the woman about the Janani Suraksha Yojana (JSY)/any other incentives offered by the state

Early registration

Timing of the first visit/registration

The first visit or registration of a pregnant woman for ANC should take place as soon as the pregnancy is suspected. Every woman in the reproductive age group should be encouraged to visit her health provider if she believes she is pregnant. Ideally, the first visit should take place within 12 weeks. However, even if a woman comes for registration later in her pregnancy, she should be registered and care should be provided to her according to the gestational age. Her husband and mother-in-law should be counseled to give her support during pregnancy, delivery, after an abortion and during the post-partum period. Early detection of pregnancy is important for the following reasons:

- It facilitates proper planning and allows for adequate care to be provided during pregnancy for both the mother and the fetus
- Record the date of the Last Menstrual Period (LMP), and calculate the Expected Date of Delivery (EDD)
- The health status of the mother can be assessed and any medical illness that she might be suffering from can be detected and also to obtain/record baseline information (on blood pressure, weight, hemoglobin, etc.)
- Helps in timely detection of complications at an early stage and manage them appropriately by referral as and where required
- This also helps in providing the woman the option of an early abortion. If so, then refer the woman at the earliest to a 24-hour PHC or First Referral Unit (FRU) (whichever is closer) that provides safe abortion services. It is important to find out as early as possible whether the woman wants to go in for an abortion so that the procedure can be done safely as per the legal provisions laid down under the Medical Termination of Pregnancy (MTP) Act, 1972.

The following duties of an ANM/ASHA/AWW of an Anganwadi:

- Register every pregnancy within 12 weeks Track every pregnancy by name for provision of quality ANC, skilled birth attendance and postnatal services

- Ensure four antenatal visits to monitor the progress of pregnancy. This includes the registration and 1st ANC in the first trimester
- Give every pregnant woman Tetanus Toxic (TT) injections and Iron Folic Acid (IFA) supplementation
- Test the blood for hemoglobin, urine for sugar and protein at EVERY VISIT
- Record blood pressure and weight at EVERY VISIT
- Advise and encourage the woman to opt for institutional delivery
- Maintain proper records for better case management and follow up
- Do not give a pregnant woman any medication during the first trimester unless advised by a physician

Since there has been no visit from any health worker from the Anganwadi, Kanchan didn't receive all the checkups and advices as mentioned above in the guidelines. It is imperative for the State to ensure that such visits take place. The onus to ensure safe pregnancy should not solely be on the ANM or ASHA because they are hardly being paid to carry out so many visits. They are only given incentives which are very less. Unless they are given salaries that ensure job security it won't encourage the workers to carry out so much work.

RECOMMENDATIONS

- Chandan should be given a cheque of Rs 1,400 as mandated under JSY scheme
- He should be provided with the compensation for medicines that he procured on his own since the hospital did not provide them
- Chandan must be provided with a compensation for the loss of his wife because of the negligence of government health providers
- Proper sign outside the health facility must be put so that the patients who come know where to seek medical help in case of emergency
- Monitoring of the hospital must be strengthened and the hospital should be provided with all the facilities according to the guidelines of IPHS
- Monitoring of the work of ANMs, ASHAs and AWWs of Kurtha Dih must take place as soon as possible

CONCLUSION

Kanchan was only 19 and for her husband and herself, this was her first delivery where their first infant died. Kanchan went to a PHC and was referred to Sadar hospital Jehanabad. The first delivery took place in Jehanabad hospital where she didn't receive any ANC by the ANM. She didn't receive any benefits from JSSK or JSY. The state failed to ensure the safety of the infant. There could have been a number of reasons for excessive blood loss. Had there been a gynaecologist at the Sadar hospital Jehanabad, Kanchan's excessive blood loss could have been prevented or her problem of delivery could have been identified on time. And when she went to the hospital there were no medical staff. The objective behind launching of schemes like Janani Shishu Suraksha Karyakram and Janani Shishu Yojana is to ensure a safe motherhood and safety of the infant but in this case it was not achieved. It is imperative to sensitize doctors, make specialized doctors available at Sadar hospital and have a robust system at the health facilities so that women look forward to going to health institutions for delivering of their child. It was wrong on the part of the doctors to not treat Kanchan because they discriminated against his poor background. But our government, through Janani Shishu Suraksha Karyakram makes delivery cashless for the pregnant women and the Health department also provides the JSY cheque. The reason given by doctors for not helping Kanchan further was in utter violation of her human rights. This talks volumes about how they lack empathy and are negligent towards lives of others. It is utterly shameful that the most important service providers are so negligent. Strict monitoring needs to be done in all government health institutions.

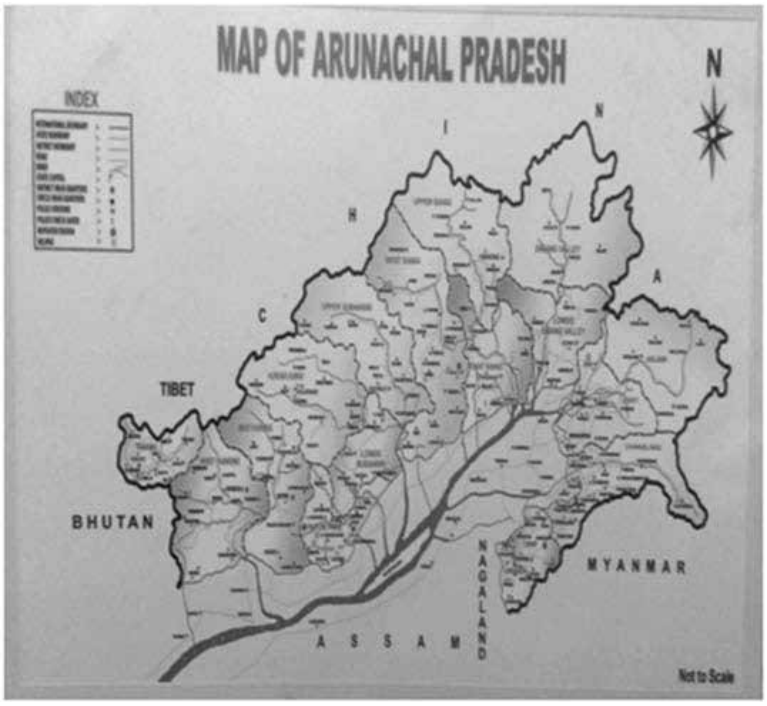
10

Fact-finding Report on Daporijo District Hospital

BACKGROUND

District Hospital is a hospital at the secondary referral level responsible for a district of a defined geographical area containing a defined population. Its objective is to provide comprehensive secondary health care services to the people in the district at an acceptable level of quality and being responsive and sensitive to the needs of people and referring centres. Every district is expected to have a district hospital. As the population of a district is variable, the bed strength also varies from 75 to 500 beds depending on the size, terrain and population of the district.

Service Delivery District Hospital should be in a position to provide all basic speciality services and should aim to develop super-specialty services gradually. District Hospital also needs to be ready for epidemic and disaster management all the times. In addition, it should provide facilities for skill based trainings for different levels of health care workers. In this IPHS document, Services that a District Hospital is expected to provide have been grouped as Essential (Minimum Assured Services) and Desirable (which we should aspire to achieve). The services include OPD, indoor and Emergency Service. Besides the basic specialty Services, due importance has been given to Newborn Care, Psychiatric services, Physical Medicine and Rehabilitation services, Accident and Trauma Services, Dialysis services and Anti-retroviral therapy. It is desirable that Super-specialties and related diagnostic facilities be made available, in more than 300 bedded hospitals. Every district hospital should provide facilities of Special Newborn Care Units (SNCU) with specially trained staff. Provisions for patient safety, infection control and health care workers'safety have been added. It is desirable that every District Hospital should have a Post Partum Unit with dedicated staff to provide post-natal services, all family planning services, safe abortion services and immunization in an integrated manner. The requirement of the above-mentioned services has been projected on the basis of estimated case load for hospital of this strength. The guidelines of hospital building, planning and layout, signage, disaster prevention measures for new facilities, barrier-free access and environmental friendly features have been included. Provisions for quality assurance in clinics, laboratories, blood bank, ward unit, pharmacies, and accident and emergency services have been made. Manpower has been rationalized and additional manpower has been provided for physical medicine and rehabilitation services, dental, radiotherapy, and immunization.



INDIAN PUBLIC HEALTH STANDARDS (IPHS)

India's Public Health System has been developed over the years as a 3-tier system, namely primary, secondary and tertiary level of health care. District Health System is the fundamental basis for implementing various health policies, delivery of healthcare and management of health services for defined geographic area. District hospital is an essential component of the district health system and functions as a secondary level of health care which provides curative, preventive and promotive healthcare services to the people in the district. Every district is expected to have a district hospital linked with the public hospitals/health centres down below the district such as Sub-district/Sub-divisional hospitals, Community Health Centres, Primary Health Centres and Sub-centres. However, at present there are 605 district hospitals in 640 districts of the country as per NRHM data as on 30-6-2010. The Government of India is strongly committed to strengthen the health sector for improving the health status of the population. A number of steps have been taken to that effect in the post independence era. One such step is strengthening of referral services and provision of speciality services at district and sub-district hospitals. Various specialists like surgeon, physician, obstetrician and gynaecologist, paediatrician, orthopaedic surgeon, ophthalmologist, anaesthetist, ENT specialist and dentist have been placed in the district headquarter hospital.

The district hospitals cater to the people living in urban (district headquarters town and adjoining areas) and the rural people in the district. District hospital system is required to work not only as a curative centre but at the same time should be able to build interface with the institutions external to it including those controlled by non-government and private voluntary health organizations. In the fast changing scenario, the objectives of a district hospital need to unify scientific thought with practical operations which aim to integrate management techniques, interpersonal behaviour and decision making models to serve the system and improve its efficiency and effectiveness. By establishing a telemedicine link with district to referral hospital (Medical College) with video-conferencing facility (desirable), the quality of secondary and limited tertiary care can be improved considerably at district hospitals. The current functioning of the most of the district hospitals in the public sector are not up to the expectation especially in relation to availability, accessibility and quality. The staff strength, beds strength, equipment supply, service availability and population coverage are not uniform among all the district hospitals. As per Census 2001, the population of a district varies from as low as 32,000 (Yanam in Pondicherry, Lahaul & Spiti in Himachal Pradesh) to as high as 30 lakhs (Ludhiana, Amritsar districts). The bed strength also varies from 75 to 500 beds depending on the size, terrain and population of the district. The second phase

OBJECTIVES OF INDIAN PUBLIC HEALTH STANDARDS (IPHS) FOR DISTRICT HOSPITALS

The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the district. The specific objectives of IPHS for District Hospitals are: To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital. The term District Hospital is used here to mean a hospital at the secondary referral level responsible for a district of a defined geographical area containing a defined population. Grading of District Hospitals The size of a district hospital is a function of the hospital bed requirement, which in turn is a function of the size of the population it serves. In India the population size of a district varies from 35,000 to 30,00,000 (Census 2001). Based on

the assumptions of the annual rate of admission as 1 per 50 populations and average length of stay in a hospital as 5 days, the number of beds required for a district having a population of 10 lakhs will be around 300 beds. However, as the population of the district varies a lot, it would be prudent to prescribe norms by grading the size of the hospitals as per the number of beds. Grade I: District hospitals norms for 500 beds Grade II: District Hospital Norms for 400 beds Grade III: District hospitals norms for 300 beds Grade IV: District hospitals norms for 200 beds Grade V: District hospitals norms for 100 beds. The disease prevalence in a district varies widely in type and complexities. It is not possible to treat all of them at district hospitals. Some may require the intervention of highly specialist services and use of sophisticated expensive medical equipment. Patients with such diseases can be transferred to tertiary and other specialized hospitals. A district hospital should however be able to serve 85-95 per cent of the medical needs in the districts. It is expected that the hospital bed occupancy rate should be at least 80 per cent.

A district hospital has the following functions: It provides effective, affordable health care services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (district head quarter town) and the rural population in the district. Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres. To provide wide ranging technical and administrative support and education and training for primary health care.

STATE PROFILE: ARUNACHAL PRADESH

Arunachal Pradesh is one of the most sparsely populated States of the country. APR lies for a large part in the Himalayas, covering a total area as big as 83,743 sq. km and an estimated population of 1,441,71,612. Almost three-quarters of households in the state reside in rural rather than urban areas 13. The rugged and undulating terrain in combination with the immensurable rivers and streams make physical transport and communication largely difficult. Infrastructural options are likewise very limited: APR does not have an airport and only a minimal connection to the Indian Railway".

These natural features of Arunachal Pradesh determine the state's social economic development dilemmas. With its large rural population, agriculture is the primary driver of the economy. Disparities in urban and rural development are significant. Arunachal Pradesh has one of the lowest rural human development indexes of all Indian states. Even more worries is indication that rural human development has been little progress since 1983. Furthermore Arunachal has the lowest literacy rate of all north eastern state, especially amongst rural population.

For 83 per cent of households in Arunachal Pradesh, the public medial sector is the main source of health care (88 per cent of rural household). Among household that do not use government health facilities, the principal reasons given for not doing so are the lack of nearby health facilities and poor quality of care. There is a strong correlation between wealth and the uses of private healthcare facilities that are nearby have good quality of care. Widespread access to wealth, education and most notably health all contribute to Arunachal Pradesh is low performance in terms of human development.

Upper Subansiri

In 1987, Arunachal Pradesh fromed two new districts called Upper Subansiri and Lower Subansiri. Upper Subansiri is spread at an area of 7032 kilometres and according to the census in 2011, the population of the district was 83,448. The sex ratio of this district is 982 females per thousand males. The literacy rate of the district is 64 percent. This district is about 360 kilometres away from Itanagar, the capital of Arunachal Pradesh. It shares its border with Lower Subansiri, Kurong Komiye and Upper Siyang. It also has international borders. The major river flowing through the district is called Subansiri. The whole district is surrounded by hills and mountains and houses of people are constructed on the slopes of the mountains. Most of the houses are made of wood. The main occupation of the people of this district is vegetation in the forest and rearing the animal "Mithun". Most people are meat eaters here. The headquarters of Upper Subansiri is in Daporijo. All the district level offices are situated in Daporijo.

METHODOLOGY

The visit to Daporijo Distict Hospital was carried out by Lalu Ram Gameti and Vijaypal of Prayas along with Vishal Dua, a social activist in Arunachal Pradesh. The team carried out site visits and met with two families who had sought treatment of the women of their house who were pregnant. Unfortunately one of the women died after delivering the baby. The fact-finding mission was conducted on 6th of April, 2017.

OBSERVATIONS

The fact finding team visited the district hospital in Daporijo and carried out detailed observation keeping in mind:

1. District Hospital Daporijo
2. Human resources
3. Investigation facilities
4. Infrastructure
5. Maternal health care facilities

About District Hospital Daporijo

The district government health facility of Upper Subansiri is situated in Daporijo. This health facility is of utmost importance for the people of Upper Subansiri because if any patient is referred out from this hospital, then she or he has to travel a distance of 350 kilometres and get the chekup and treatment done in Naharlogan. The transport facility in this area is very poor and there is a dearth of a lot of options for travel here. There are five community health centres in the district namely, Daporijo, Maro, Tahila, nacho and Muri Murli. In Upper Subansiri, there are 15 primary health centres aand four of the PHCs were actually sub health centres that were upgraded into PHCs last year in 2016. The district hospital has 150 beds currently and in the year 2016, a new building was constructed. However many facilities that are supposed to be in a district hospital are still not available right now.

Human Resources

S. No.	Personnel	In position	On contract
1.	General Surgeon	2	
2.	Physician	1	
3.	Gynaecologist	1	
4.	Paediatrician	1	
5.	Anaesthetist/Trained Mo	1	
6.	Public Health Programme Manager	0	
7.	Eye Surgeon	0	
8.	General Medical Officer	3	
9.	Orthopaedic	1	
	Total	10	

Assistant Human Resources

S. No.	Personnel	In position	On contract
1.	Public Health Nurse	2	
2.	ANM	20	16
3.	Staff Nurse	16	12
4.	Dresser	2	
5.	Pharmacist/ Compounder	3	
6.	Lab. Technician	7	5
7.	Radiographer	1	
8.	Ophthalmic Assistant	0	
9.	OPD Attendant	7	
10	Statistical/ Data entry operator	2	2
11	OT Attendant	2	
12	Registration clerk	0	
13	Class IV Employee	20	

Investigation facilities

S. No.	Facility	Yes/ No
1	ECG	Yes
2	X-ray	Yes
3	Ultrasound	No
4.	Sonography	No

INFRASTRUCTURE

In 2016 a new building for the hospital was being constructed and this hospital has been shifted to the new building now. But the old building is still functional for a number of investigations. All the facilities are not available in the current building as of now. Water is available in the hospital for 24 hours a day but it is only in toilets and for washing hands. There is no availability of clean drinking water in the hospital. There is electricity in the hospital and it has a 3 phase connection. A generator was also found at the facility so that the hospital can ensure availability of electricity for 24 hours.

For communication, there are landlines phones in place but they are not functional and no intercom phone system was found at the hospital. And there was no internet facility in the hospital as well. Talking about waste management in the hospital, the fact-finding team couldn't find any facility for safe dumping of waste. Medical waste generated by the hospital was emptied outside the hospital in the open. During the visit, the team also could not find the different dustbins for different kinds of waste. Everything was thrown in a common dustbin. No ambulance service was found in the hospital that could take patients if referred during any emergency situation. No emergency ambulance service specially meant for pregnant women was found in the hospital. The hospital in-charge said that every month atleast 20 patients are referred to other health facilities but no transport facility was provided to them.

MATERNAL HEALTH-CARE FACILITIES

The fact-finding team met with two families who shared their experiences of seeking medical care from the district hospital of Daporijo.

Case 1: Maternal Death

Yagim is a 45-year-old and lives with her husband Tapa Kamsar in Piyun Colony of Daporijo. She got pregnant in the year 2016 and her labour pains started on 22nd January, 2017. This was her fourth delivery. During the labour pains,Yagim's gums started bleeding and she experienced a lot of pain in the gums and teeth. Yagim was taken to the district hospital and her pregnancy was more than 8 months at that point of time. The doctor at Daporijo district hospital referred Yagim to Naharlagon district hospital which is about 360 kilometres away from Daporijo. It is etremely difficult to find a mode of transportation and Yagim's husband tried his best to arrange for a vehicle but despite all his efforts he couldn't find a single taxi or jeep that could take Yagim to the referred hospital. The next day, he was able to book three seats in a daily transport Tata Sumo jeep that charged him Rs 2,400. They reached Naharlagon on 23rd January around 5 pm in the evening. The doctor at the hospital admitted Yagim upon their arrival. Her sonography was conducted and it was found that her child in the womb is upside down. This test was done on 24th of January, 2017. On 26th January, 2017, Yagim Kamsar gave birth to her child through caesarean section. The weight of the new born was 2 kilograms. The husband revealed that he spent almost Rs 45,000 on medicines and various tests. In Naharlogan, Yagim had her sonography

done twice from outside the government hospital. Despite being admitted in the hospital in Naharlogan, Yagim didn't feel healthier and she had trouble breathing. On 28th of January, she was referred to Guwahati from Naharlogan hospital. The hospital arranged for an ambulance but charged Rs 4,000 from them for petrol. She was admitted to a private hospital in Guwahati and she was admitted in the emergency ward. The total expenses for her treatment came up to Rs 46,000. Next day, on 29th January, 2017, Yagim died at 6pm in the evening. The family was unable to procure all the documents of treatment as most of the documents were lost or not provided by the hospital.

The fact-finding team met with the in-charge of diagnostics and he said that basic tests and investigation facilities are available in the district hospital of Daporijo. Except for the tests covered in JSSK (Janani Shishu Suraksha Karyakram), all the other tests are not for free and the hospital charges money from the patients for the same. But all tests for pregnant women are not available in the hospital. The women have to get some of the tests from outside. Sonography and ultrasound machines are available in the hospital but there is no one in the hospital to run these machines. The team also interacted with the person in-charge of distribution of medicines. He said that in one year, medicines at state level are provided at the hospital only two times. So these medicines are given to the patients for free. During the time of visit to the hospital, the team found out that only 15-20 kinds of medicines were available in the hospital. The team also interacted with some pregnant women at the hospital and found out that they have to buy most of the medicines from outside and pay a lot of money out of their pocket.

Case 2: Out of Pocket Expenditure

Yanam Mugli lives in Daporijo and she is 22-year-old. This was her first pregnancy. On 28th of January, 2017, she delivered her baby. She walked to the hospital for the delivery. Upon interacting with her the team found out that that the family had to spend Rs 3,500 on medicines. They also had to buy the gloves for nurses. After delivering her child, she again walked back to her home as no vehicle was provided to her by the hospital. She had been given two tetanus injections before pregnancy, during her ANC checkups. She got three ante natal checkups. Whatever medicines were bought for her, no receipt was given. They medicines were written on a piece of paper.

GUIDELINES AND POLICIES

National Rural Health Mission

National Rural Health Mission (NHM) was launched in the year 2005 to strengthen the Rural Public Health System and has since met many hopes and expectations. The Mission seeks to provide effective health care to the rural populace throughout the country with special focus on the States and Union Territories (UTs), which have weak public health indicators and/or weak infrastructure. Towards this end, 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 January/ February, 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 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 will 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 should 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.

Objectives of Indian Public Health Standards (IPHS) for District Hospital

Objectives of Indian Public Health Standards (IPHS) for District Hospitals. The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the district. The specific objectives of IPHS for District Hospitals are:

- To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of the people of the district and the hospitals/centres from where the cases are referred to the district hospitals

Service Provided in DH

OPD Services and IPD Services: General, Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Dental and Ayush services.

- Eye Specialist services
- Emergency Services
- Laboratory Services
- National Health Programmes

Care of Routine and Emergency Cases in Surgery

Essential

- This includes dressings, incision and drainage, and surgery for hernia, hydrocele, appendicitis, haemorrhoids, fistula, and stitching of injuries
- Handling of emergencies like intestinal obstruction, haemorrhage, etc
- Other management including nasal packing, tracheostomy, foreign body removal etc
- Fracture reduction and putting splints/plaster cast
- Conducting daily OPD

Care of Routine and Emergency Cases in Medicine

- Specific mention is being made of handling of all emergencies like dengue haemorrhagic fever, cerebral malaria and others like dog and snake bite cases, poisoning, congestive heartfailure, left ventricular failure, pneumonias, meningoencephalitis, acute respiratory

conditions, status epilepticus, burnss Shock, acute dehydration etc. In case of National Health Programmes, appropriate guidelines are already available, which should be followed.

- Conducting daily OPD

Maternal Health

- A minimum of four ANC check-ups including registration and associated services: As some antenatal cases may directly register with DH, the suggested schedule of antenatal visits is reproduced below

  1st visit: Within 12 weeks—preferably as soon as pregnancy is suspected—for registration of pregnancy and first antenatal check-up.

  2nd visit: Between 14 and 26 weeks

  3rd visit: Between 28 and 34 weeks

  4th visit: Between 36 weeks and term

- 24-hour delivery services including normal and assisted deliveries
- Managing labour using Partograph
- All referred cases of complications in pregnancy, labour and post-natal period must be adequately treated
- Ensure post-natal care for zero and third day at the health facility both for the mother and new-born and sending direction to the ANM of the concerned area for ensuring 7th and 42nd day post-natal home visits
- Minimum 48 hours of stay after delivery, 3-7 days stay post delivery for managing Complications
- Proficiency in identification and Management of all complications including PPH, Eclampsia, Sepsis etc. during PNC
- Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions
- Provisions of Janani Suraksha yojana (JSY) and Janani Shishu Suraksha karyakram (JSSK) as per guidelines.

Newborn Care and Child Health

- Essential Newborn Care and Resuscitation by providing Newborn Corner in the Labour Room and Operation Theatre (where caessarian takes place).
- Early initiation of breast feeding with in one hour of birth and promotion of exclusive breast-feeding for six months.
- Newborn Stabilization Unit.

- Counseling on Infant and young child feeding as per IyCF guidelines.
- Routine and emergency care of sick children including Facility based IMNCI strategy.
- Full Immunization of infants and children against Vaccine Preventable Diseases and
- Vitamin-A prophylaxis as per guidelines of Govt. of India. Tracking of vaccination drop outs and left outs.
- Prevention and management of routine childhood diseases, infections and anemia etc.
- Management of Malnutrition cases.
- Provisions of Janani Shishu Suraksha karyakram (JSSk) as per guidelines.

Family Planning

- Full range of family planning services including IEC, counselling, provision of Contraceptives, Non Scalpel Vasectomy (NSV), Laparoscopic Sterilization Services and their follow up.
- Safe Abortion Services as per MTP act and Abortion care guidelines of MOHFW.

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 to 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.						

Chandrima delivered in a government health facility which entitles her to receive the JSY benefit. She died in the month of August last year and it has been more than eight months but Vijendra has not received a cheque of Rupees 1400 yet. This is a violation of the guidelines of this scheme.

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.

RECOMMENDATIONS

- The district hospital does not have the required number of human resources available. It is urgently required to fulfil this gap as patients are otherwise referred to Nahalogan district hospital which is about 360 kilometres away from Daporijo. And there is not proper transport facility available to travel such a distance. Since it is a hilly area it is extremely dangerous for mother and the child to take such a risk and travel.
- There should be an ambulance service, at least two, for picking pregnant women from their homes and dropping them back after their delivery.
- Operation theatre must be transferred to the new building as well as the post delivery care unit.

- There must be a sitting area for the patients and the people who accompany them.
- Clean drinking water must be made available for the patients.
- All the wards must have three kinds of dustbins for medical waste- red, green and blue coloured dustbins.
- Increase in the number of bed in the wards and replace the old ones that are rusted with new beds.
- Clean sheets and blankets should be made available for the patients.
- A pit outside the hospital must be made for waste disposal.
- The ultrasound machine and sonography machine must be put to use and for that someone must be appointed to run the machines.

CONCLUSION

The district hospital of Daporijo needs serious reforms in place as soon as possible. It is really inhumane to refer pregnant women and other patients for Naharlogan hospital which is 360 kilometres away. Since it is hilly and no proper transport facility is in place, it becomes extremely difficult for the people of Daporijo to travel all the way to Nahalogan. If the problem of human resources is solved in the distirct hospital of Daporijo, then they wouldn't have to be referred. In the two cases discussed above, one of the women died as she was referred to nahalogan and in a critical condition she had to travel a long distance. Her family spent a lot of money with no good returns. Another woman had to walk all the way back to her house due to no transportation made available to her. This shows the lack of will of the hospital staff and the government of Arunachal Pradesh to think about the patients of Daporijo.

The Reproductive Rights Initiative at HRLN works toward the realization of reproductive rights in India as defined in the Programme of Action of the International Conference on Population and Development (1994), which "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence."

The Initiative uses the legal system to combat violations of reproductive rights, ensure implementation of reproductive rights schemes, and to demand accountability where implementation is left wanting. Through these efforts, the initiative is striving to establish, a human rights based approach towards reproductive health care.

Through its work, the Reproductive Rights Initiative has bought focus to the issues of preventable maternal mortality and morbidity, the right to food and nutrition, discrimination against HIV positive pregnant woman, coercive population control policies, inhumane sterilization camps, unsafe abortion services, unethical surrogacy and sex selective abortion.

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