MATERNAL DEATHS IN BARWANI DISTRICT:

ACCOUNTABILITY, QUALITY OF CARE AND REFERRAL SYSTEMS

Mothers and their newborns in a Verandah: Pati CHC, District Barwani, Madhya Pradesh

AGCA TEAM'S VISIT TO BARWANI: MARCH 29 - 30, 2011

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THE CONTEXT

The District Hospital in Barwani, the headquarters of a predominantly *adivasi* district in south-western Madhya Pradesh (MP), recorded 26 maternal deaths from April to November in 2010. Nine of these deaths were reported in the month of November, 2010 alone. The issue shot into limelight through concerted community action under the banner of the *Jagrit Adivasi Dalit Sangathan* (JADS). Two mass protests, held in December 2010 and January 2011 sought to demonstrate against what JADS activists reported as the extreme callousness and ill-treatment regularly meted out to women in pregnancy and labour by the public health system, particularly at the District Hospital. These attempts by the people to raise critical issues were met by denial, complete blocking of dialogue and legal charges being brought against JADS activists by the district administration.

Subsequently, three teams carried out fact finding processes in Barwani. An official team from the MP Health department / NRHM and a civil society team of JSA-CommonHealth-SAMA representatives, both visited Barwani in end of January; detailed reports of both teams have been reviewed before the AGCA team's visit and formed the basis for the team's visit. Subsequently a team of two officials from the Maternal Health division, Union Ministry of Health and Family Welfare also visited Barwani in end February, 2011. This report is not yet available. Both official teams appear to have largely focused on the technical and administrative aspects of health services in the situation. The civil society team in its report has dealt with health services as well as accountability, responsiveness, transparency aspects of the situation; there is an elaborate set of recommendations concerning both aspects, included in this report as **Annexure I**. MP State health officials have publicly promised a range of actions to improve service delivery.

In recognition of the fact that the situation in Barwani is not unique to a district or a state and has implications for the status of maternal health in the entire country, it was decided that a team from the AGCA would visit Barwani and recommend action at the national level. The team included the following AGCA members:

- Dr. H Sudarshan
- Dr. Abhay Shukla
- Dr. Abhijit Das
- Ms. Poonam Muttreja

Dr. Arundhati Mishra (Additional Director, Population Foundation of India) and Ms. Sona Sharma (joined the team from Population Foundation of India which is the AGCA Secretariat. Dr. Ajay Khare, Deputy Director (ASHA) and Dr. Chandrashekhar, District Facilitator (Maternal Health), joined the team as state government representatives.

THE FOCUS

Community monitoring had been initiated in Barwani district as part of the nine-state pilot phase. Even though community monitoring had not continued officially after the pilot phase got over, communities here were mobilized and aware about their rights and entitlements.

This led to community action on the issue of maternal deaths in the district hospital which resulted in complete breakdown of dialogue between the service providers and the community. Keeping in mind this background and the given mandate of the AGCA, the AGCA team decided to focus primarily on three aspects during the visit:

1. ***Accountability and responsiveness issues*** which contributed to fuelling mass protests including governance oversights, and the present state of accountability and transparency processes and mechanisms concerning health services in Barwani.
2. ***Referral mechanisms*** which enquire into the process through which women reach a District Hospital, essentially a referral centre. Was there a way in which these women could have been managed at a lower but legitimate centre?
3. ***Quality of care of services*** provided at the District Hospital (DH) and at also lower centres of obstetric care. Specifically the patient-provider relationship and management of adverse outcomes.

THE VISIT DETAILS

The team reviewed the situation in Barwani District at four levels: the community (village level), the PHC (Primary Health Centre), CHC (Community Health Centre) and District Hospital. The places visited were:

I. **Village Piparkund** under PHC Bokrata in Pati block, where about 80-100 Village Health Committee (VHC) members, ASHAs and village level activists associated with the people's organisation *Jagrit Adivasi Dalit Sangathan* (JADS), drawn from ten villages had assembled to meet the team.

II. **Bokrata PHC** – functioning as a location of Institutional Delivery, is a small four-room building, well painted on the outside and uncluttered interiors with mostly unused equipment/furniture inside. An ANM (Auxiliary Nurse Midwife), a Compounder and a Cleaner were present when the team visited the PHC. The Medical Officer was on leave and there were no patients at all at the centre.

III. **Pati CHC** - located in the block headquarters at Pati, and a designated Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) but not functioning as such. The CHC is currently located in a dilapidated set of buildings with the *verandah* also functioning as a ward for patients. A new half constructed, large multi-storey building on one side is where the CHC is to shift once the construction is complete.

IV. **Barwani District Hospital** – the functional CEmONC Centre for the district. Barwani District hospital, a pre-independence institution set up by the erstwhile Raja of Barwani, is a long established and well attended hospital with 300 beds, of which 60 beds are in the women's hospital. The Women's Hospital is across the road from the General Hospital and the Neo-natal unit is also in the General Hospital.

The team also held meetings with the recently appointed Chief Medical and Health Officer (CMHO), Dr. Rajesh Neema and the Superintendent of Police (SP). The District Collector was not available to meet the team in spite of repeated attempts for a meeting.

OBSERVATIONS

1. ACCOUNTABILITY FRAMEWORK

Accountable health services was one of the areas of critical concern for concerted action which was to be addressed through National Rural Health Mission (NRHM) (Para III.6 NRHM Implementation Framework). Improved Management Information System (MIS), Community/ Panchayati Raj Institution (PRI)/ Rogi Kalyan Samiti (RKS) for accountability, Monitoring and Evaluation, adopting standard treatment guidelines for each facility and different levels of staffing and developing a road map to achieve them were important actions to overcome the constraint of accountability. Management by PRI Committees was seen as a mechanism for improving accountability of staff. The broader accountability framework included communalization as a key component and community as well as the PWC/ RKS would be expected to monitor the performance of the health facilities.

For the accountability framework to be truly community owned, the effort was supposed to ensure that at least 70 percent of the total NRHM expenditures are made by institutions and organizations that are being supervised by an institutional PRI/community group. In addition to community monitoring the following mechanisms were also supposed to provide improved accountability:

- Periodic Health Facility Survey at the Sub Health Centre (SHC), PHC, CHC, District level to see if services guarantees are being honoured. [By District/ Block level Mission Teams/ research and resource institutions].

- Formation of Health Monitoring and Planning Committees at PHC, Block, District and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.

- Sharing of all data and discussion at habitation/ village level to ensure full transparency.

- Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.

- Sample household and facility surveys by external research organizations/NGOs.

- Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

The Rogi Kalyan Samiti and the Health Planning and Monitoring Committees are also seen as important institutions for grievance redressal. *Madhya Pradesh also has in place a Sevottam model for public redressal.*

In order to understand the monitoring/evaluation and accountability mechanisms in place in the district of Barwani the team reviewed MIS formats, RKS minutes and accounts at the District and Block levels and held discussions with;

- members of the community,
- community activists,
- NRHM related community associates: ASHAs and VHSC members,
- Health care providers - the Chief Medical Officer (CMO), Medical officers.

KEY OBSERVATIONS

At the Village Level

- There are active groups of village health committee members (basically associated with and mobilised by JADS) in at least ten villages Bokrata area, who have been monitoring and holding regular dialogues for improved antenatal services, immunization, *anganwadi* services and the Deen Dayal Upadhyay Antodaya Yojna (DDAUY) cards at village level. The fact that all these services need to be monitored and demanded reflects on the state of these services, at the same time the presence of these active groups needs to be encouraged and built upon in the further strategy for community accountability for better health services in this area.

- The activists mentioned that they had made a number of representations about their grievances with stamped receipt to the District Collector and CMO but they have received no responses.

- The Village Health Committee (VHC) members and village level activists, including both men and women, shared the following details:

  - They have organised groups of five persons, including both women and men in ten villages, who belong to the VHSC and take up various health issues at local level.

  - They meet once a month, though most groups did not report having met during the last one month. Their meetings are not usually attended by the ANM, but the village Accredited Social Health Activist (ASHA) does participate in the meetings.

  - They have carried out small surveys on the availability of antenatal services, immunization coverage, nutrition services at the *anganwadi* centre and access to Deen Dayal Antyodaya Upchar Yojana (DDAUY) cards in their villages, followed by putting pressure on providers to improve these services and facilities.

  - In their previous survey of antenatal care in ten villages, it was found that pregnant women were not being tested for blood pressure or Haemoglobin (Hb) and nor were abdominal examinations conducted, though some of them had received Tetanus Toxoid (TT) and Iron Folic Acid tablets.

  - Collection of information by these VHC members followed by dialogue with ANMs has led to some improvements in immunization of children and distribution of hundreds of additional DDAUY cards to people who had not received these earlier despite their meeting the criteria. Availability of DDAUY cards appears to be a significant problem in villages in this area.

- Many of the assembled VHC members had participated in the recent protests organised by JADS in Barwani. They shared that they had joined these to protest against the death of Vyapari bai (who died 40 hours after being admitted into the District Hospital in November, 2010; reference: Fact finding report of Dr. Subha Sri, Sarojini N and Renu Khanna) , and because large number of maternal deaths and deaths of children were taking place in the district hospital.

- Instead of responding to the issues raised during the protests, the district administration had charged Ms. Madhuri and 200 others (names not mentioned in the First Information Report (FIR) under Indian Penal Code (IPC) section 168 and 147. There have been no arrests so far, as the state government had asked for the case file, however, the threat of legal action against the activists sometime or the other remains, as the case has not been closed.

At the CHC Pati and PHC Bokrata

1. Rogi Kalyan Samiti (RKS) meetings are not being held regularly. The last District RKS meeting took place on 26 August, 2010 even though the provision mandates to convene meetings every two months. The Block office could not show the RKS minutes register despite asking a few times.

2. The RKS mechanism in Madhya Pradesh follows pre-NRHM (2001 hospital management committee) parameters. These parameters do not include any role for the RKS in monitoring and grievance redressal. The principal function is hospital and user fee management. The membership does not include any role for NGOs or community participation. The only citizen participation is by donors with levels of donation for different levels of facility.

3. According to the existing operational guidelines the RKS in MP manage only two out of the three components of RKS funds (Annual Maintenance, Untied funds and Corpus Funds). Thus a CHC is only provided one lakh rupees a year for RKS purposes. Even then the RKS at Pati had a balance of nearly 1.75 lakh rupees indicating very little use of RKS funds even though the premises were crumbling and desperately in need of cleaning and maintenance.

4. A new RKS guideline dated 28 October 2010 has been sent by the state which includes grievance redressal and patient welfare and citizen rights. This guideline is not yet operational even though it has been issued about six months ago. There are some problems in the membership of the committees as they are heavily stacked with officials with minimum representation from civil society and users.

5. The examination of home delivery data in the district reveals an interestingly inconsistent pattern of one month showing high Skilled Birth Attendant (SBA)

Month 2010	August	September	October	November	December	January 2011
SBA	18	13	158	111	8	123
Non SBA	149	158	12	3	126	0

delivery and the next month showing high non SBA delivery as the table below will reveal for Pati block. The Block Medical Officer on being queried about SBA

deliveries was not able to distinguish between a trained Trained Birth Attendant (TBA) and an SBA.

At the District Level

6. Though Barwani was included in the pilot phase of community monitoring during 2007–09, the project has been suspended by Government of Madhya Pradesh (GoMP) for the last two years. There was no knowledge of the District Planning and Monitoring Committee.

7. The Hospital Management Information System (HMIS) data is by and large inaccurate even through cursory examination. For example it shows that the number of women having Hemoglobin less than 11 as '0' for the months of April, June July, August, September, December 2010 and January 2011. Physical visits showed that Hb estimation is not being conducted and is also not possible at even PHC and CHC (there are no Haemoglobinometers) and people's evidence said no estimation is done at community level during the Village Health Nutrition Day (VHND). Blocks submit incomplete forms in hard copy to the district. The data management officer at the district level makes efforts to get additional information from the block; however there is no review of the data by any of the officials who sign the forms.

8. Discussion with providers also confirmed that there is no discussion on data and even findings in terms of types of complications to understand and improve mechanisms for case management.

9. After the incident at the District Hospital was highlighted there have been some suspensions and transfers. The CMHO was first transferred and later suspended. The Civil Surgeon and District Immunization Officer (DIO) have been suspended. However, the compounder responsible for denial of care to Baniya Bai in Menimata PHC (reference: Fact finding report of Dr. Subha Sri, Sarojini N and Renu Khanna) was only transferred to the District Hospital, Barwani.

Key concerns

- No mechanisms have been set up for monitoring and evaluation or for grievance redressal.
- The 'communization' of accountability processes a key NRHM expectation is completely absent.
- The new RKS guidelines are perhaps on the lines of operationalization of the *Sevottam* mechanism, but they remain on paper. Even in content they need to be refined to include a more robust citizen participation.
- In pockets where community monitoring and accountability processes have been proactive and people have been successful in raising their voices, the immediate response of the government has been to curb them through legal action. However, with the media highlighting the issues, the state government has responded positively with some stringent action. The implementation of proposed action framework needs systematic follow up to see this through.

Overall Opinion:

In the absence of any community oriented monitoring and evaluation system, quality of service delivery is expected to suffer. Response of district officials to recent protests

regarding inadequate services has been largely negative leading to near breakdown of dialogue.

Improving monitoring to improve service delivery was one of the focus areas under the NRHM, however, with more than five years into the implementation this simple truism and acknowledged constraint has not been operationalized despite clear guidelines being provided in the NRHM Implementation Framework.

In addition, the excess work burden due to *Janani Suraksha Yojana* (JSY) has perhaps contributed to a further decline in the level and quality of other health services. In spite of public outcry no grievance redressal mechanism has been operationalized. Madhya Pradesh has not only 'claimed' a good 'record' in terms of improved skilled attendance at birth and institutional delivery but buttressed their improved service delivery 'record' with a supposedly model grievance redressal mechanism – the *Sevottam* mechanism. Unfortunately, both claims seem extremely premature and exaggerated at this point in time.

2. REFERRAL LINKAGES

The success of the JSY, the current programmatic intervention to improve maternal health depends upon the critical assumption that there will be trained personnel available at health institutions and that once a complication is identified there will be provisions for quick and appropriate referral to the next level of care. The maternal deaths that took place in District Hospital Barwani, may be investigated in the context of these two assumptions.

Information gathered from different sources including observation and examination of records provides the following scenario;

At the Village Level

- VHNDs do not take place regularly. ANMs do not stay at their sub centres, nor have VHSC meetings regularly. The ANC checkups are merely focused on providing Tetenus Toxoid injections.

- The ASHA and VHSC members in these villages have been trained separately by a local organization. They identify women who have not been provided TT injections and ask them to get immunized at the Bokrata PHC. The ASHA's and VHSC members clarified that no blood pressure investigation or abdominal examination or blood or urine examination takes place.

- Many home deliveries take place in the villages. One ASHA we met identified herself as a TBA. She said that if the delivery pains last more than one day or she identifies a breech or transverse lie or the vaginal discharge is bloody, she immediately asks for the woman in labour to be taken to the hospital in Pati.

- The *Janani* Express is useful but the woman has to be carried in a sling up to the road head which can take up to an hour or more. The local *Janani* Express is stationed at Bokrata. It is a regular jeep without any arrangements to accommodate a stretcher or for a person to lie down.

At the PHC Level

The Bokrata PHC has a labour room. On inspection it did not appear that there had been any delivery conducted in it for quite some time. However the ANM on duty initially said that she conducted deliveries. Later, on probing, she confided that she did not want to take chances here since if something happens, she will be held responsible. So for the last few months she had not conducted any deliveries.

- On examining the labour register it appeared that almost all the deliveries are noted as 'born in the way'. Of the 17 deliveries which had been recorded in the OPD register and not yet transferred to the labour room records 15 were noted as 'born in the way' and two had been referred out. On an average 50 to 60 such 'institutional' deliveries are noted to have been conducted at Bokrata PHC.

Labour room at Bokrata PHC

- The ANM was asked to check the blood pressure of a team member and it was evident when she tried to do so, that she did not know how to.

- No ward or laboratory facilities were observed in Bokrata PHC.

At the CHC Level

- Pati CHC is currently operating in an extremely dilapidated building with a new construction coming up right next to it. The new CHC premises are expected to be operational in a month's time (although the staff was not entirely convinced it would be). Pati CHC is designated as a CEmONC but does not have either qualified personnel or the necessary infrastructure. Only normal deliveries are conducted here by the ANMs assisted by *dais*.

- There is only one delivery table in the labour room. The ANMs informed that if there is more than one delivery at the same time, which does happen often, the other woman has to lie on the floor.

- There is a laboratory with two technicians in Pati CHC, but it does not conduct any tests related to pregnancy care- Haemoglobin estimation, Urine albumin included.

- The examination of HMIS records at Pati Block revealed that for the last few months 270 to 330 deliveries are recorded each month. Of these roughly one-third are noted as home deliveries, one-third as institutional deliveries from the three constituent PHCs and one- third at Pati CHC. The majority of the home deliveries, if not all, were noted as having being conducted by Skilled Birth Attendants (SBAs). On enquiring how many SBA (SBA trained ANM) deliveries can be anticipated from the region, it was clarified that these were 'trained'

dais, and not ANMs. The officials involved including the BMO, under whose signature these records were being sent for incorporation into the HMIS were not clear about who is an SBA and who is not. This data was revalidated at the district level and the same discrepancy was noted.

- Payments were being made under JSY to women who had delivered at home in the period April 2010 onwards. The circular for this had just been received, and there were many women queued up. Pati CHC did not have an accountant and an accountant from a PHC had been deputed to make these payments.

At the District Level

- The Barwani district female hospital caters to the population of neighboring districts as well. Currently 500 to 600 deliveries take place in this hospital every month, around 30 percent of the total deliveries in the district. The day before the visit (30 March) 15 deliveries had taken place in the hospital. The hospital is staffed with three obstetricians, nurses and *ayahs/dais.*

- There are three obstetricians of whom two are also Laparoscopic Tubectomy surgeons and one of whom is expected to conduct camps on four days a week, the other conducted camps on two to three days a week. However, these doctors also did emergency surgery after returning from camps.

- Discussion with specialists revealed lack of team coordination among the obstetricians and anaesthetists. They have never met to discuss how services could be made more efficient/effective. Anaesthetists are usually called in at the last minute for consultation even when patients are in the hospital for some time.

- The nursing shift includes three nurses and *dais/ayahs* in the morning shift and only one nurse and one *dai/ayah* in the day and night shifts. This staff of two is expected to manage the labour room, post operative ward, ante-natal ward and post natal ward for 16 hours. There are 60 beds and at the time of the visit to the hospital, all but two or three beds appeared occupied.

- Before the start of NRHM and JSY the hospital had the same staff strength but two new wards have been added. At that time the hospital conducted abut 180 to 200 deliveries a month.

- *Most of the normal deliveries in the hospital are conducted by the dais/ayahs* because the nurses are busy attending to in-patient needs. In the last shift all the deliveries were conducted by the *dai*.

- The doctors at the female DH mentioned that they were overworked but managing the increased workload due to NRHM/JSY. Lack of proper communication between patient 'party' and providers was mentioned by both the doctors and nurses.

- Severe anaemia is a major problem. The anaesthetist often refuses to provide anaesthesia with such low Hb levels. It was reported that the patient party often refuses to donate blood, the blood bank often does not have rare blood groups available. Under such circumstances referral out of DH becomes necessary.

- The case of Vyapari Bai is a perfect example of the glaring gaps in the referral mechanism: Vyapari Bai was initially taken to the Bokrata PHC, where the doctor refused to even see her, the family then took her to Pati CHC, from where she was promptly referred to Barwani district hospital. After around 40 hours at the district hospital with the doctor checking her only once, Vyapari Bai breathed her last.

Key concerns:

- Safe delivery, even in institutions, is a myth in the district of Barwani. In contrast to this, the official data notes high levels of institutional delivery and skilled birth attendants in home deliveries.

- The district hospital was the only institution which was performing its functions. The system below the district hospital was completely dysfunctional. The fact that the health services at the lower levels were not functioning, and meant that the district hospital was managing a load which it was not equipped to handle.

- There is complete lack of any ante-natal support. The lack of Hb% estimation facilities even in a CHC in an anaemia endemic area denotes a complete lack of coordination between different levels of care. Incidentally the HMIS reports Hb estimation regularly and low levels for Hb below 11gm percent.

Janani Express stationed at Bokrata

- While *Janani* Express appears to be working, the local Bokrata PHC vehicle was inappropriate for the purposes of transporting women in labour.

- The sole indicator for measuring the success of JSY i.e. institutional delivery and the emphasis on SBAs has lead to a situation where there is gross misreporting/over-reporting and despite an elaborate and computerized HMIS there is no oversight.

Overall estimation:

- ***HMIS*** – Inaccurate gross overestimation;
- ***Services*** – Absent below the level of DH and DH is understaffed and overstretched compared to its patient load;
- ***Referral Mechanisms*** – Unsystematic;
- ***Team-work*** – Absence of Horizontal and Vertical coordination
- ***Staff*** – Only DH team was functional, but it was grossly inadequate/ understaffed.
- ***HR Management*** - No oversight, no coordination.
- ***Distraction at the DH level*** (only functioning level) – Emphasis on Family Planning Targets.

3. QUALITY OF CARE

The overall purpose of the NRHM is summarized as, "*The mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.*" Quality is obviously a central concern and a key process for the achievement of reduction in mortality and morbidities. Quality standards and quality services are key strategies and assessment of Quality of Care is a central component of the district level planning framework. This assessment is expected to include technical competence, interpersonal communication, client satisfaction, client participation in management, accountability and redressal mechanisms. Quality of Care systems are seen as the last but not the least in the list of priorities under institutional arrangements.

One of the classical frameworks to understand quality of care is to understand quality under the three pillars of Structures, Processes and Outcomes (Donabedian 1968, 1986, 1988) . A simple way to understand these three aspects is as follows:

- Structures: the attributes of settings where care is delivered
- Process: whether or not good medical practices are followed
- Outcome: impacts of the care on health status

The field visit allowed the team to observe the operations of three levels of facility – the PHC at Bokrata, the CHC at Pati and the District Female Hospital at Barwani. All these three institutions are classified as part difficult area or most difficult area facilities according to a classification of health institutions made by GoMP and made available at their website. The expectation is that this classification will assist in planning and allocation of resources. The observations at these three centres can be summarised under the three pillars as follows:

Pati CHC: Registration Counter

Structures: The NRHM provides for additional inputs in terms of staff, equipment, supplies and finances and also provides standards for different levels of care through the Indian Public Health Standards.

Bokarata PHC – One ANM, a compounder and a sweeper were present at the time of the visit. The Out Patient Departments (OPDs) room was reasonably clean but there were no patients. The labour room did not appear to have been used for some time and the toilet was dirty. There was no operational laboratory in the PHC. There was no ward. The visiting team was told that the Medical Officer came from time to time.

Pati CHC – The Pati CHC was crowded and the buildings were in disrepair. One of the major and obvious problems is lack of staff, despite being designated as a CEmONC there are only two non-specialist doctors and three ANMs. Patients, including women in labour were attended on the *verandah*. It appeared that the *verandah* of the CHC served as the inpatient wards. The *verandah* also served as the registration counter and the pharmacy. The labour room was accessible directly from the dusty crowded courtyard and was dirty. Upkeep and

cleanliness of the ward and labour room was quite inadequate. The operation theatre did not appear to conform to any standards but was used regularly for laparoscopic tubectomy.

The shabby condition of building, poor maintenance and inadequate space were apparent problems. The RKS or Annual Maintenance Grant funds were not being used significantly to improve the condition of the existing building based on the logic that a new building is being constructed.

There is an X-ray machine which is rarely used. The X-ray room was locked and when opened, the X- ray table was covered with dust indicating that it had not been used since some time. In fact, the equipment didn't even have electric connections in the room.

A baby warmer lay covered, unused, in one corner in a room. The nurse present was not aware of its function and reported that while it was lying in the CHC for the last two-three years, no one had informed them about its utility, nor was anyone trained to use it. Similarly, a store room was stacked with blood pressure machines, weighing scales and a suction apparatus. The dust layers clearly indicated that these have also been in the CHC for a while but for some reason, have not been distributed or used. A number of cervical collars were also stacked in the store room.

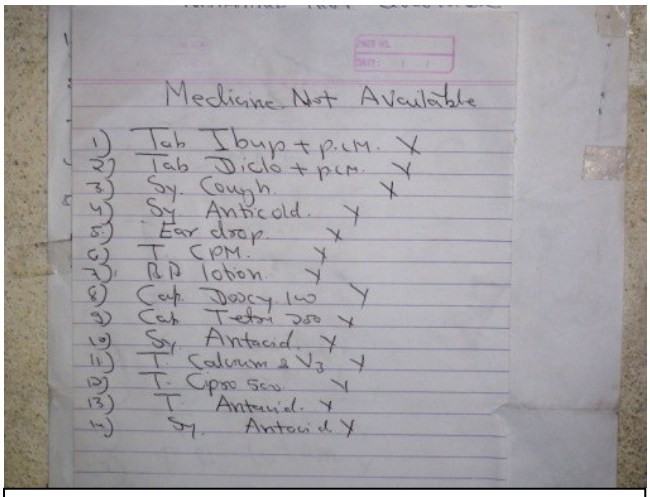
Unused Weighing scales and Suction apparatus:

Barwani District hospital

District Women's Hospital – The District Women's Hospital is located across the road from the general hospital. The neonatal ward is located in the general hospital. The hospital has an OPD, emergency, inpatient wards, one nursing station, one eclampsia room. The rooms are arranged around a courtyard. In general the wards and the courtyard appeared clean. Two wards have been constructed recently after the launch of NRHM. There has been a promise of additional financial resources and staff for this hospital but even though NRHM is in its sixth year these additional positions have not yet been made available.

General Hospital **-** In the general hospital, there are three Medicine specialists, two Paediatricians, three General surgeons, two Anaesthetists, three Eyes Nose Throat (ENT) specialists and two Orthopaedic Surgeons. The number of these specialists is inadequate given the high indoor patient load in the hospital. There are only five general duty Medical Officers, whose number is seriously inadequate to handle the wide range of indoor patients and emergencies being handled. The hospital has 33 nurses compared to the sanctioned number of 100 nurses required. During visit to the OPD at 10 a.m., most of the doctors were not present, the reason being given that they were all conducting rounds in the wards.

There is a functional blood bank which handles about 500 units of blood for transfusion every month. In 2009-10, a total of 6793 units were collected and 6498 units were supplied. In the period, January to March 2011, 1475 units have been collected and 1415 units have been supplied. Presently there is a stock of 135 units stored in a large blood refrigerator. A significant proportion of these units are donated by relatives of patients as replacement. While there are three technicians handling the Blood bank, there is no Pathologist since the previous Civil Surgeon, who was a Pathologist, has been suspended.



Status of Medicines

There is a functioning X-ray unit run by three X-ray technicians. There is an ultrasound machine, however currently no ultrasound examinations are being done, since the radiologist has resigned and is engaged in private practice.

The medicine store for OPD patients revealed large scale shortages of medicines. For example, there was nil stock of Paracetamol tablets in the OPD store during the period 10 to 18 March; subsequently 10,000 tablets have been received. Similarly, Ciprofloxacin tablets (a commonly used antibiotic) were in nil stock in February and first half of March, though recently stock has been received.

Recent indents and corresponding supply information revealed major shortages in medicine supply for the OPD. For example, in the most recent indent on 15 March, 25 medicines had been indented but only three were supplied on 18 March. There was a similar major shortfall between indent and supply in recent indents on 7 and 25 February. There is no regular pharmacist for the OPD store, which is being managed by a contractual employee.

The paediatric wards are among the highest patient occupancy wards in the hospital. There are 40 beds and on the day of the visit (30 March) there were 68 children admitted and as a result, some of the children were lying on the floor inside or outside the wards. There are two paediatricians to manage all these patients, supported by ten nurses for all shifts. There is a small neonatal care unit, which is not equipped as a Neonatal Intensive Care Unit (NICU) but has baby warmers and provides some degree of isolation for sick neonates. The paediatrician complained of severe overwork due to staff shortages, and the need for additional paediatricians to handle the high case load.

The paediatric ward displayed similar large scale shortages of medicines and supplies as the OPD store. The staff informed that there are no intravenous fluids available, and all patients have to obtain these from medical stores. The most recent stock position available was for 20 December, which showed that out of 37 expected medicines, 35 were in nil stock. The recent indent made on 9 March had requested 24 items out of which only four were supplied. Although Below Poverty Line (BPL) patients with DDAUY cards can avail of free medicines, this can only be a complementary arrangement and cannot be a substitute for adequate, regular main supplies and does not address the serious problems faced by numerous patients without DDAUY cards.

Subsequently the team visited the main medicine storage facility for the entire district hospital to understand the underlying dynamics of medicine shortages. The pharmacist informed that due to 'budget shortage' they had not been able to order medicines from the Tamil Nadu Medical Services Corporation (TNMSC) since several months. This has led to a situation of stock out of almost all commonly used medicines over the last six to nine months. The stockout position of some common medicines enquired about is as follows:

Medicine	Period of stock out (nil stock since when)
Paracetamol tablets	December 2010
Ciprofloxacin 500 mg tablets	September 2010
Ciprofloxacin 250 mg tablets	August 2010
Septran single strength tablets	June 2010
Doxycycline capsules	June 2010
Norfloxacin tablets	June 2010

Processes: Appropriateness of treatment, nature of client – provider interaction, maintenance and review of records (MIS) are included within this dimension of quality of care.

Bokrata PHC - The waste management procedures were hazardous and consisted taking the PHC waste including sharp needles and glass vials and ampoules and biomedical waste and dumping them in the stream running behind the PHC. There was no needle-hub cutter and needles were disposed without any care. The issue of inaccuracy in maintenance of labour room records where almost all deliveries were recorded as 'born in the way' has been referred to earlier. No patient interactions were noted in this centre. However, the community members had reported that the doctor refused to even check women who had come for delivery and would refer them to Pati CHC or the District Hospital, Barwani – as in the case of Vyapari Bai.

Waste Management: Down the Hill

Pati CHC **-** Pati CHC was crowded with patients. The doctor present was very unfriendly, sometimes even threatening in his interactions with the patients. The review of HMIS even to see whether the data being provided is consistent was not being done at Pati CHC.
The team experienced the extremely casual attitude of one of the medical officers who was absent during main duty hours (at around 12 noon) when our team reached even though the entire staff was aware of the team's visit. He turned up later, only after being repeatedly asked for.

Current problems pointed out include ongoing conflict between the two doctors due to which patient care suffers, lack of proper examination of patients and poor communication with them, lack of bathing facilities for patients especially women in immediate post-natal condition, only normal deliveries being performed and many women in labour being immediately referred to the district hospital.

There have been earlier complaints of women undergoing institutional deliveries not being given the full JSY amount, due to 'deduction' of a few hundred rupees by ANM and other providers. However the Sangathan protested on this issue which led to illegally charged money being returned to several women and by and large such illegal charging has stopped.

District Women's Hospital – The hospital provides both obstetric and gynaecological services. Emergency surgical procedures were conducted in the hospital. However normal deliveries appeared to be exclusively conducted by *dais* under the broad supervision of nurses. Earlier reports indicate that the DH refers a large number of patients to the medical college in Indore. Inadequate blood banking and lack of proper support from the patient's relatives were mentioned as constraints. During the visit a large number of patients were found waiting for the doctors. The team visited the hospital after 9.30 a.m. but the OPD, which was supposed to start from 8 a.m. had not started even when the team left the hospital at 12 noon. There appeared to be a lack of teamwork with the anaesthetist and there was an overall lack of review and planning in the context of obtaining the maternal health goals of NRHM. The RKS of the district hospital did not include any members from the District Women's Hospital and there seemed to be a lack of dialogue between the doctors of the women's hospital and the hospital management committee.

The gynecologists reported that they manage private practice as well from their residence as officially, private practice is permitted after duty hours. The additional efforts required for private practice after a heavy case load in the hospital too, could adversely affect the quality of care provided at the hospital.

With reference to the case of Vyapari Bai, the doctors and ANMs did not respond to continuous requests by the mother and mother-in-law (both ASHAs) to check the patient. In fact, at 11.30 p.m., when the mother-in-law went to the doctor's residence to request her to come and examine Vyapari Bai, she did not concede to the request and only asked them to go to Indore. No attempts at delivery either by induction of labour or caesarean section, as is standard practice in management of eclampsia, were attempted during the entire duration of hospital stay of almost 40 hours. Vyapari Bai's family members mentioned that she continued to have convulsions in the hospital, which was however not recorded in the case records. In spite of her poor general condition, she was sent outside in a private vehicle for an ultrasound which had no bearing on management of her condition. The hospital staff brought an oxygen cylinder for her, but it was too late as Vyapari Bai had already died by then.

Outcomes: The background of the field visit was the occurrence of a large number of maternal death cases at the District Hospital. The large number of referrals out from this hospital indicates that the appropriate therapeutic outcomes are not being obtained from this hospital, which is expected to be the final port of call within the JSY mechanism.

A large number of maternal deaths are related to severe anaemia, which is highly prevalent and which could have been addressed with adequate antenatal care at the sub-centre/PHC. The other major cause of maternal deaths is eclampsia, which could have been diagnosed early during ante natal checkups.

Overall assessment – The main operational approach of NRHM appears to be improving/ increasing inputs. There is little attention to processes and less to outcomes. The main outcome measure through which maternal health outcomes are being monitored is the rate of institutional delivery and does not include any quality parameters and the Barwani field visit indicates that there is serious over-reporting on this count. Thus quality does not appear to be an important operational concern for NRHM. Considering the range of services that are necessary and accepted as concrete service guarantees in the context of NRHM, the first assessment is that the whole range of services is not available nor being provided systematically to all women in Pati Block. Antenatal care services can be considered in the range of inadequate to absent. The absence of Hb% estimation in an area which the

obstetrician's first cause of concern was maternal anaemia can be considered a service lapse. Delivery services are also of poor quality considering the fact that most institutional normal deliveries take place either in unhygienic circumstances or by non-prescribed providers (*dais* in hospitals) or are fictitious (born in the way). The complete unreliability of the MIS and the lack of any review processes indicate apathy towards quality. Overall it appears that the classification of health institutions that has been done by the GoMP (as a planning exercise) has not led to any additional interventions for these institutions and consequently no changes in the status of these institutions and their capacity to delivery services.

To summarise, Barwani district hospital has significant shortages of specialists, duty medical officers and nurses which leads to overload for staff and likely impact on the quality of care. The paediatric ward is currently overcrowded and also understaffed. While the blood bank seems to be working well, facilities like ultrasound are presently non-functional. Large scale shortages of essential medicines are a serious problem, which need to be remedied by both adequate, timely budgets and more effective procurement mechanisms.

4. Additional Area of Concern

The manner in which the family planning programme is being implemented in the district is an additional area of concern. Conceptually family planning is an important complementary strategy to support maternal health programmes in overall reduction of maternal mortality and morbidity. However, the way the programme is being implemented indicates that the family planning programme is not only taking valuable resources from the maternal health programme but is also being implemented in blatant disregard of quality norms and Supreme Court guidelines.

Promoting a One Child Norm?

- India officially declared a Target Free Approach to family planning after the International Conference on Population and Development (1994), however the obstetricians indicated that districts are being provided targets for laparoscopic tubectomy. The target for Barwani was 13,000 cases for the year, but that for a neighbouring district was higher. The MP Chief Minister has made public announcements of achieving 7.5 lakh sterilisations which in itself can be considered a target. This district has a 67% tribal population. The Government of India policy is not to aggressively implement permanent methods of family planning in tribal districts. This makes the imposition of targets even more unethical for Barwani district.

- In operational terms a target of 7.5 lakh immunisations per year indicates a more than two fold jump from the achievements in 2005–06 of about 3.7 lakh. This means that most ANMs in the peripheral health system would be involved in 'motivating'

family planning (read sterilization) acceptors. This means that they would have much less time to devote to maternal health services.

- One of the gynaecologists met during the field visit mentioned conducting up to three camps in one day and over 200 laparoscopic tubectomies. Her 'record' for the last year was 360 operations in a day. This is in blatant violation of quality norms (Standards in Sterilisation Services – Manual I) and Supreme Court guidelines which mention a maximum of 30 operations per surgeon. This also indicates that the quality assurance mechanisms that have been indicated in the programme guidelines are also not being followed.

Safe, Healthy and Happy: When will this be a reality ensured for all women?

Recommendations

1. Accountability measures

Although health services in Barwani district suffer from various deficiencies, one positive aspect of the situation is the presence of strong community organisation and community initiatives on health rights issues, particularly in Pati block. This is linked with mobilisation by the community based organisation JADS. This needs to be built upon and taken into account while suggesting accountability measures for the area.

While making the following general suggestions for accountability measures, it may be emphasized that concrete design and operationalisation of such measures should be done based on suggestions and in consultation with the community based organisation and civil society groups active on health rights issues in the area. The following recommendations also draw from those in the JSA-Commonhealth-SAMA report and suggestions given by activists of the people's organisation.

Help desk

Help desks must be started in District Hospital and Women's Hospital as soon as possible. These could be run by persons who would guide patients to access services, inform patients about their entitlements, facilitate filing of complaints, and give feedback on patient's problems to relevant officials. Help may be taken of the existing NGO volunteers who are currently assisting patients in the district hospital on a daily basis. It would be desirable to appoint full time social workers who could speak in local *adivasi* languages, keeping with IPHS stipulations. The model being implemented in Karnataka could be adopted.

Grievance redressal mechanism

An effective Grievance Redressal System (GRS) needs to be set up promptly. Based on complaints that are received, the District Collector and CMHO / Civil surgeon should be responsible to take effective action within one week, on all matters which are within their domain and Action Taken Report may be sent to the Mission Director NRHM at the state level.

Issues beyond the purview of the district level authorities should be forwarded to the Mission Director for appropriate action within a defined period of two days. Action in these cases should also be taken promptly.

The complainant should be notified within 15 days of the action taken on the complaint.

Regular participatory review and Jan *Sunwais*

It needs to be ensured that various measures for improvement of health services in Barwani that are promised and planned, are actually implemented. Towards this objective, it would be desirable to develop a locally relevant plan for regular participatory review of health services. State level authorities have promised to visit Barwani once in every two months to carry out such reviews. These reviews should cover the Barwani District Hospital and Women's Hospital, CHCs in Pati and other areas, and Primary health care providing maternal and child health services. These periodic review meetings should be carried out with involvement of local civil society organisations active on health issues. This would help to monitor improvements and to address gaps and deficiencies in a participatory manner.

In addition it would be desirable for the District health authorities to conduct Jan *Sunwais* once a month or every two months, where ordinary people and representatives of

community based organisations could present specific complaints for redressal and corrective action, and accountability oriented dialogue could take place.

Modifying community monitoring and review based on the Barwani context
Although community based monitoring was implemented in Barwani district during 2007-08, there were various problems in implementation and the 'standard model' of CBM did not prove to be particularly effective. The locally relevant specific modes of activity and mobilisation on health rights by the community based organisation, and significant non-responsiveness of local officials contributed to this situation. Hence any form of community monitoring in Barwani (including by periodic reviews and Jan *Sunwais*) would need to be developed based on discussions with the community based organisation, civil society groups and district health officials to ensure its appropriateness and effectiveness.

Overall, it is extremely necessary to implement accountability measures to ensure that the full range of services is provided and health system strengthening, corrective measures are implemented. These measures need to be locally contextualized and developed in consultation with the community based organisation and civil society groups.

2. Referrals

Strengthening the district health system
The entire spectrum starting from ASHAs, to Sub-centres, PHCs, CHCs/FRUs and sub-divisional hospitals need to be strengthened in light of the additional burden on institutions owing to JSY. Providing therapeutic and prophylactic iron supplements and early detection of eclampsia by measuring blood pressure and urine examination during ante natal checkups needs to be operationalized.

Audit of delivery related referrals
There should be an audit of all delivery related referrals from Barwani District Hospital to the private hospitals in Barwani and also to Indore, during last six months. If certain referrals are found to be inappropriate, expenses that patients have incurred due to wrong referrals should be reimbursed to patients. In future, referrals should be based on defined criteria and guidelines, to ensure that unnecessary referrals are minimized. One way to ensure this is that referrals to MY Hospital, Indore would be allowed only when justified in writing with indications and ratified by the CMHO/Civil Surgeon.
Indications for referral should be clearly mentioned in all referral slips. Free referral transport must be made available to all patients who are referred at various levels in the Public health system.

3. Quality of Care

Accreditation of district hospitals and FRUs for QOC: Standard operating procedures (SOPs) and Standard Treatment Guidelines including referral mechanisms should be in place through National Accreditation Board for Hospitals /Quality Assurance/ International Organization for Standardization.

Waste Disposal: Appropriate waste disposal as per guidelines needs to be adhered to at all levels-district hospital, CHC and PHC. Practices like open disposal of medical wastes should be stopped immediately.

Improve quality of infrastructure: Allocations made under the provisions of the NRHM should be judiciously planned and utilized. The RKS and VHSC should be actively involved in prioritizing the infrastructure needs of the health facilities.

Additional posts to be sanctioned – proper recruitment mechanisms (not just word of mouth): The district should actively pursue for the recruitment of vacant posts through open advertisements and ensure transparent selection procedures. The incentives and accommodation facilities for staff located in remote areas would help in staff retention and improve coverage of health services.

Training for Skilled Birth Attendant: The district should develop a plan for conducting trainings of all health staff in skilled birth attendance. Support from the state could be sought to complete the trainings on a priority basis.

Availability of essential medicines: Budgets for essential medicines at DH and lower levels need to be substantially increased and should be disbursed in regular, timely manner. District as well as state level procurement mechanisms need to be overhauled to ensure continued, adequate availability of all required medicines and supplies. Instead of relying on the distant TNMSC for major portion of regular supplies, a similar arrangement for transparent and effective procurement may be set up in MP itself.

HMIS: The quality of data collection and periodic reviews needs to be strengthened at the block and district level. Understanding of staff responsible for preparing HMIS reports need to be developed on the key reporting indicators like deliveries by skill birth attendants. The District MIS Officer needs to review block data and provide regular feedback to the BMO. Plans need to developed for areas with poor coverage of health services like immunization, ANC, institutional deliveries etc.

Women's Hospital and Paediatric services have to be integrated- There needs to be integration of services and regular interaction among the women's hospital and the paediatric unit. The CMHO and the Civil Surgeon needs to organise regular meetings among the unit to ensure effective follow of the services among the two disparate units.

Maternal death reviews –In spite of the high maternal death cases in the district over the last year no maternal death reviews were conducted by the district health officials. The reviews would help in identifying the reasons for high mortality and morbidity among women and children in the district as well help in developing strategies to plug the existing gaps. A component of community maternal death review may be incorporated in the MDR process. The district health officials need to be trained for conducting these reviews and developing a follow up plan. The review team also needs to include civil society organizations and external experts to provide critical inputs into the process.

Annexure I

Section from chapter on recommendations in report - ***Maternal Deaths and Denial of Maternal Care in Barwani District, Madhya Pradesh: Issues and Concerns*** *by Subha Sri, Sarojini N and Renu Khanna, published by Jan Swasthya Abhiyan, CommonHealth and SAMA - Feb 2011; p 45-47.* ***A few points have been added which are highlighted****.*

Improving Governance and Accountability

The Barwani situation shows that there is a serious crisis of governance and accountability within the health system. Therefore, we recommend that -

- The State should accord highest priority to addressing the issue of Maternal Health in Barwani and Madhya Pradesh. The Chief Minister should take immediate cognisance of the issue, and should ensure implementation of these recommendations.
- The State should initiate immediate detailed review of the maternal deaths that have taken place in the district since April 2010, looking at systemic issues, as well as failures of individuals or systems in individual cases.
- State level health officers should take immediate action against those who are found to have failed to discharge their duty and have proved to be negligent at the district level and in the DH in Barwani.
- The State should review all the maternal deaths and immediately provide full compensation to all the families of the women who died due to negligence.
- The State should take stringent action against those found guilty of corruption, in order to deliver a clear message that corruption will not be tolerated at any level.
- The State should take immediate action to ensure prevention of maternal deaths, which are mostly preventable, but continue to take place routinely.

Grievance Redressal System

- An effective Grievance Redressal System (GRS) should be immediately set up. The District Collector and CMHO should be directed to take immediate and effective action, within one week, on all matters which are within their competence. An Action Taken Report must be sent immediately to the Mission Head NRHM/ Director Health Services who should follow up on the same. In matters that are beyond the competence of the District Collector and/or CMHO, they should, within a period of two days, forward the complaint to the Mission Head/ Director Health Services for appropriate action. Action in these cases should also be taken immediately, while punitive action should be taken within 15 days. The complainant should be notified within 15 days of the action taken on the complaint.
- GRS should constitute of two components:
    - *Immediate response system* – Names and phone numbers of concerned officials to be displayed, who can be contacted and who should solve problems faced by patients in real time. Also, installation of a complaint box which is to be opened in presence of citizen representatives and reviewed as below:
    - *Review and systemic correction system* – as part of a regular review/ monitoring process, all issues that are reported through the GRS and complaint box should be periodically discussed in a joint forum (including officials, Sangathan and citizen representatives) to ensure

that the problems are not repeated and the underlying deficits are addressed effectively.

- Some concrete action to improve grievance redressal would be to develop, through a participatory and transparent process, a facility-based or regional system of ombudsmen to receive grievances and pursue timely redress. This mechanism should be easily accessible to women with little or no formal education. Further, early response systems should be developed, including a telephone hotline for health-related emergencies for women facing obstetric emergencies. (HRW Report)

Effecting change in Organizational Culture

- As discussed earlier, there are serious issues in the culture of health systems--corruption, individual personal gain, dereliction of duty--that need to be changed. Staff at all levels, from doctors in the DH, to MOs in CHCs and PHCs, to ANMs and MPWs, need to undergo sensitization programmes about responding to patients needs and observing patient rights, behaving respectfully with patients, especially adivasi patients including women, and use of common health related terms in local adivasi language. Sensitisation and Reflection Workshops need to be conducted as part of an Organisational Development effort. These could ddress issues like professional ethics, commitment to duty, sensitivity to the concerns of the poor, tribals and women, power relations, Indian constitution, human rights, and respect for all individuals

Rebuilding Public Confidence

- Keeping in view the present scenario of complete lack of responsiveness of local officials and the urgent need to re-establish public confidence in the public health system, State level officials should at the earliest organise a multi-stakeholder meeting / Jan Samvad in Barwani, and report the key findings of the official investigation team. This should be accompanied by a statement of time bound plan of action for improving health services in Barwani (including disciplinary actions) and addressing the concerns of JADS, civil society organisations and residents of Barwani.

- To ensure that these measures are actually implemented in an accountable manner, such a meeting should also work out an appropriate plan for participatory monitoring / review of health services, in Barwani District Hospital & Women's Hospital and CHCs in Pati and other areas, in consultation with JADS, which may include periodic review meetings to address issues and complaints in a regular manner.

- A help desk should be started at the earliest in Barwani District Hospital and Women's Hospital, with a person to guide patients to access services and to help them communicate their problems to relevant officials. Such desks are clearly stipulated in IPHS for 200-300 bedded hospitals. Hence in due course this should be managed and run by the Hospital itself, with appointment of two full time social workers (conversant with local languages) as specified in IPHS.

- Exposure and awareness visits of all ASHAs and VHSC members to DH Barwani should be organised in batches, to familiarize them with the services, procedures, patient rights, and grievance mechanisms Available, so that they can effectively guide/ accompany patients as required.

- Mass awareness campaigns on issues of ante-natal care, nutrition, delivery care, danger signs in pregnancy, and labour should be carried out by the Health staff in villages, with involvement of VHSCs and ASHAs, to ensure widespread popular awareness on these issues. This should be accompanied by regular participatory

review of provision of the relevant ANC, delivery, and nutrition related services, based on feedback from Sangathan members and VHSC members.

- There should be an audit of all delivery related referrals in last six months, from Barwani District Hospital to the private hospitals in Barwani and also Indore. If referrals are found to be inappropriate, expenses that patients have incurred due to wrong referrals should be reimbursed to patients.

Transparency

- Guaranteed health services should be displayed in Barwani district hospital and Women's hospital, all CHCs and PHCs, thus enabling people to demand these services. This should be accompanied by display of phone numbers of officials to be contacted in case of grievance, and the grievance redressal mechanism in simple language. Various types of information related to the performance of health services, maternal and child deaths, usage of RKS / IPHS / Untied funds at various levels should be displayed and updated on a regular basis in respective facilities (as per mandatory display under RTI act – mentioned in IPHS). All such information should be made available to ordinary citizens and civil society members on request.
- Public dissemination of the analysis of Health Management Information System (HMIS) data that is collated both at district and state level, along with systemic actions taken based on these findings, should be done to increase transparency. In addition, flow of HMIS data downwards would improve local ownership of data. Data collected and action taken at every facility could be proactively disclosed in culturally appropriate formats to local communities, along with local participation in decision making.