FACT-FINDING REPORT ON MATERNAL HEALTH IN SONITPUR DISTRICT, ASSAM

5-11 JULY 2013
I. Introduction

In July 2013 health rights activists conducted a fact-finding mission in Sonitpur District, Assam to follow-up on the situation of maternal health on Tea Estates and on the implementation of National Rural Health Mission’s (NRHM) guidelines for standards in public health care facilities in rural Assam. The fact-finding team consisted of two health activists from New Delhi, and Austin Kawa a staff member at Promotion & Advancement of Justice, Harmony, and Rights of Adivasis (PAJHRA), who acted as a guide and translator.

The fact-finding took place from 7-10 of July 2013. The team visited 11 health care facilities including Tea Estate (TE)/Tea Garden (TG) hospitals and government facilities. The facilities and TE hospitals visited are within three blocks in the Sonitpur District: Balipara, Biswanath Chariali, and Rangapar. Furthermore, the team visited the Biswanath Sub-Civil Hospital, Tezpur Civil Hospital, and the Guwahati Medical College.

The proposed methodology was to seek first hand evidence of compliance from doctors, Accredited Sexual Health Assistants (ASHAs), Auxiliary Nurse Midwives (ANMs), other government employed medical staff, community activists/NGOs, and patients through conversation and interviews.

II. Background
India has the highest number of Maternal Deaths in the world with a Maternal Mortality Rate (MMR) of 212. Maternal Mortality Rate is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management. There are three delays that contribute substantially to preventable maternal mortality: a delay is seeking treatment, a delay in reaching treatment, and delay in receiving adequate treatment upon reaching a medical facility. The MMR measures the number of maternal deaths per 1 lakh deliveries. Assam has the highest MMR in India at 391 deaths per lakh deliveries, almost double the national MMR of 212. The most recent MMR for Sonitpur District is 367. In addition to the overall UN Millennium Development Goals (MDG) India has a state-by-state breakdown of goals it hopes to achieve by 2015. Assam’s MDG target for MMR is 177.45. With the current MMR, experts agree that Assam will not reach its MDG goal by 2015.

Tea Estates function as small, autonomous communities with their own schools and hospitals; TE workers have very little contact with others outside of the Tea Estate. Sonitpur district has 73 Tea gardens. Each Tea Estate (TE) worker must pluck 24 kg/day to receive the daily wage of Rs. 89, which is below the minimum wage.

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If 24 kg is not reached, then the worker will often receive only half of the pay, Rs. 44.50 for the day.

A majority of the tea workers are adivasis, a tribal and aboriginal population of India. The adivasi community has historically been marginalized, and the government of India has instituted protections in an effort to safeguard the community from future exploitation. In Assam, however, Adivasis are not recognized as “Scheduled Tribes” and are deprived of such protection. The community tends to be geographically isolated, low skilled, has low literacy levels, poor access to health care, and have a distinctive culture.

The government of Assam under National Rural Health Mission (NRHM) has entered into a Memorandum of Understanding (MoU) with many tea gardens in Assam under Public Private Partnership (PPP) to provide better health care facilities to the permanent and temporary tea garden workers. “The primary objective of the partnership is to extend the health care services to tea garden areas as there is high prevalence of diarrhea, cholera, maternal and infant deaths and other preventive and curative cases in these areas due to non-availability of basic health infrastructure,” said Union Minister of State for Commerce and Power Jairam Ramesh. It is common among pregnant women to work into their ninth month.

III. Issues of Concern

a. Anemia

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3 http://www.hindu.com/2008/12/21/stories/2008122153920700.htm
The team found anemia was one of the most common health concerns noted by hospital staff: ANMs, GNMs, and doctors. Anemia is a condition where blood has a lower than normal number of red blood cells or of hemoglobin in the blood, often caused by iron or folic acid deficiency, which results in pallor, weariness, and weakness.

Anemia leads to a “several-fold increase in the risk of a mother dying in childbirth.” The National Family Health Survey-3 (NFHS-3) and other studies indicate the notable prevalence of anemia as a cause of maternal mortality in India. Anemia is a contributory factor in maternal deaths caused by hemorrhage, septicemia and eclampsia, and in severe cases anemia can even cause cardiac arrest.

The percentage of maternal deaths caused by hemorrhage has been attributed to higher rates of anemia in Indian women. Pregnant women who are anemic face multiple health risks in addition to the risk of maternal death. Anemic women are increasingly susceptible to communicable diseases such as tuberculosis (TB) and malaria, which are associated with adverse outcomes during and after pregnancy.

In India, anemia is far more prevalent in women than in men, with the NFHS-3 reporting that 55% of women have anemia, as compared to only 24% of men. This is the case in Sonitpur district, and is noted by staff in TE hospitals and government facilities.

The fact-finding team encountered extreme cases of anemia throughout the district. At the Tezpur Civil Hospital a pregnant woman with a hemoglobin level of 2.3 and had just lost her child. The
doctor was amazed that she was still alive. The average hemoglobin level in a healthy adult female is 12 to 16. Anemia also represents one of the basic delays that contribute to preventable maternal mortality: delay in women seeking treatment. Prenatal care includes both iron and folic acid supplements, both help to combat anemia among pregnant women.

The overwhelming appearance of anemia among women in Sonitpur district is concerning as it is a symptom of gender-based discrimination in access to food, nutrition and health care throughout the life of women contrary to article 15 in the Constitution of the India.

b. Medicine Shortages

The team found that many facilities lacked essential and lifesaving drugs per government standards under NRHM. Basic medicines like paracetamol, common antibiotics and essential drugs used post-delivery and life-saving vaccines were found unavailable or, according to staff, frequently out of stock at a sizeable number of primary health centers (PHC), community health centers (CHC), and TE hospitals.

The staff at most facilities attributed to the drug shortages to a number of causes. First, flooding of rural road, especially in the rainy season makes transportation to more rural areas impossible. Second, the terrible condition of the roads, even without flooding, often hampers many delivery trucks from being able to access the various
health centers. Third, the failure of orders to arrive in a timely fashion; many doctors reported requesting fresh stocks of drugs without results.

As per the government guidelines, PHCs must have adequate medicine stock at any given point of time. Primary Health Centers are an important part of the healthcare system in the state. In remote and rural areas, they are the only available medical facility for local residents. Hence, a center with an adequate stock of basic and common medicines is necessary to prevent the first delays that prevent to maternal mortality. The non-availability of medicine and material at the health facilities forces patients to purchase essential drugs from private sources, where the cost of medicine is substantially higher. This contributes to preventable maternal mortality by creating a delay in receiving adequate treatment upon reaching a medical facility.

c. Facilities and Hygiene
Almost all of the facilities the team visited did not have the government mandated basic facilities and equipment. Furthermore, the facilities were in disrepair and hygiene was severely lacking. Most facilities do not meet basic Indian Public Health Standards (IPHS).

The team visited facilities where operating theaters and infant and newborn wards were not yet constructed. There were also facilities not in proper repair, for example, buildings with cracked walls, no fans in wards, and bed frames without mattresses. Furthermore, there were facilities, which had space allotted for a specific use, an adolescent health center, but were not in fact being used at all as the program or services were discontinued. Thus, there was structure with space that was not being used. Lastly, there were a number of sites where construction was underway, or had been underway for over two years.
A majority of the facilities visited did not meet basic hygiene parameters. Medical waste was not properly disposed of and strewn about the premises. There were dilapidated cardboard boxes filled with bloodied gauze, cotton, and needles. Many of the delivery rooms were covered in old and new blood, showing a disregard for even the most basic cleanliness. The mattresses in the wards did not have sheets, and were covered with dirt and dust. Furthermore, women recovering from delivery remained in the same bloodied and dirty clothing they wore to the hospitals and gave birth in. In the cases of episiotomy and cesarean section procedures, clean clothing and bandages were not provided or used.

Hospitals are recklessly disregarding the basic standards of IPHS as mandated by the government.

d. Referral System

TE hospitals refer everything but the simplest of cases to government facilities. Though the TEs have accepted large sums of money from
the government of Assam to implement the NRHM, the TE facilities rely heavily on the government health system through referrals. Thus, the government is paying for TE hospitals and for TE workers to receive basic care at public health centers.

TE hospitals, even those with doctors on staff, will refer pregnant women with something as simple as a fever to the nearest PHC rather than addressing the issue on site. In other facilities, the lack of staffing necessitates referral. PHCs do not always have appropriate staff or operating theatre and refer cesarean section deliveries to the Tezpur Civil Hospital, which is understaffed and overcrowded. In these urgent cases, women have to delay treatment and travel at least three hours to reach adequate treatment.

This is a crucial delay in reaching adequate care and contributes to preventable maternal mortality. Once women seek care they are sent to the next facility increasing the delay of administration of adequate health service. This delay is further exacerbated by horrendous road conditions, sometimes taking 30 minutes to traverse less than two kilometers.

e. Staffing

In TE hospitals, there was a consistent lack of necessary and appropriately trained professionals. The TE management has not ensured basic standard of living for doctors; TE don’t pay competitive salaries, and infrastructure is quite poor. TE have a responsibility to
their workers and to the government of Assam, through MoUs pledging to implement the NRHM in exchange for money.

Many TE facilities did not have doctors, leaving the TE workers to rely on ANMs or visiting or rotating physicians for care. Those that did have doctors were unable to retain people for an extended amount of time, a crucial component for building understanding and trust with the TE patients. The most frequently cited reason was that the salary was less than those offered by government and private facilities.

In government facilities there is also a shortage of doctors due to a underestimation of needs or delay in installing posts. Data from the health ministry reveals that 11% of the PHCs do not have a doctor (this is 17% in Assam). At the CHC level, only 49% of the required specialist posts have been sanctioned so far, and 25% positioned. Less than a third of the required number of staff nurses have been positioned. This problem persists despite installment grants of Rs. 20 lakh provided to all district hospitals of the country to improve their basic services.

The quality of the health workforce is crucial in delivering good health outcomes. Reports have highlighted a shortage of manpower – of doctors at the PHC level and specialists at the CHC level. This contributes to preventable maternal mortality by creating a delay in receiving adequate treatment upon reaching a medical facility.

f. Janani Suraksha Yojana (JSY)
When JSY was launched in 2005 under the National Rural Health Mission, the financial assistance of Rs. 500/- available uniformly throughout the country to BPL pregnant women under National Maternity Benefit Scheme (NMBS), was replaced by graded scale of assistance based on the categorization of States distinctions between rural/urban deliveries. Cash payments are made out to pregnant women for institutional delivery in both government and private accredited hospitals. The purpose of the scheme is to incentivize institutional deliveries and bring down the MMR and infant mortality rates. Therefore, according to the government’s guidelines for JSY, “the scheme’s success is determined by the increase in institutional delivery among poor families.”

JSY Benefit (in Rs.) for Institutional Deliveries:

<table>
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<tr>
<th>Categor y of States</th>
<th>Rural Package to Mother</th>
<th>Package for the Accredited Worker</th>
<th>Total</th>
<th>Urban Package to Mother</th>
<th>Package for the Accredited Worker</th>
<th>Total</th>
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<tr>
<td>LPS*</td>
<td>1400</td>
<td>600</td>
<td>2000</td>
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<td>200</td>
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<td>HPS**</td>
<td>700</td>
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* Low Performing States: Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu & Kashmir.

** High Performing States: All other states
In Low Performing States (LPS), like Assam, all pregnant women, irrespective of poverty status, number of births and age are eligible for JSY incentives. Many of the women the team spoke with had never heard of the JSY Scheme. Some women had a vague idea but they were not clear on what requirements were in place to become eligible. This is problematic as the cash that is entailed in JSY is part of an effort to overcome barriers to service use – such as awareness and cost.

Furthermore, large portions of the women believe that they would be unable to collect any money unless they had a bank account. Consistently, the team learned that women were unable to take advantage of the JSY scheme because they did not have bank accounts and/or could not deposit cheques. This is problematic as another purpose of JSY is to give money directly to poor women who otherwise may have little access to or control over cash.

Issues of Concerns: Conclusion

All of the issues of concern listed above represent regular delays in the Assamese health system that directly contributes to maternal mortality. Anemia, medicine shortages, poor hospital facilities and poor hygiene, ineffectual referral system, inadequate staffing, and non-implementation of government health schemes represent the failure of the State of Assam to provide adequate access to healthcare for its citizens, a constitutionally recognized right. The preceding “Issues of Concern” section is a summarization of the
IV. Findings

The following is a factual account of the 11 health care facilities including Tea Estate (TE) hospitals and government facilities in the Balipara, Biswanath Charilia, and Rangapara Blocks. The facts are gathered through conversations with hospital staff, patients, and the first hand experience of health activists.

a. Rangapara Block

   i. Dhendai TE

The TE is owned by a Kolkata-based company, the Kanhoi Group. There are approximately 750 permanent workers and more than 500 temporary workers and their families, amounting to a total of 4500 residents.

Full time staff consists of: one auxiliary nurse midwife (ANM), one general nurse midwife (GNM), one ayurvedic doctor, one ward boy, cleaning staff, and a pharmacist. The team spoke to Dr. S. Sorkar who is an Ayurvedic doctor, he has been at the TE hospital for six months. All the staff at Dhendai TE hospital with exception of the ANMs, who are all Adivasi, live on the Tea Estate.
This is the doctor’s second TE posting. Prior to his arrival there was a three-month gap where the TE management failed to post a doctor at the hospital. It is difficult to find doctors willing to work at the TE hospital as the salary the TE management offers is less than what is offered at government facilities. As there is no female doctor, the ASHA often acts as the primary resource for information, non-invasive contraception (barrier methods like condoms and hormonal contraception like pills), and prenatal care for the women under their care.

The TE hospital has three separate wards. a TB/Malaria ward with 20 beds, a male ward with ten beds, and a female ward with ten beds. There are 60 to 65 out-patient visits per month. The team did not see the records, so we could not determine whether the facility accurately maintains a register.

On average there are three births at this TE hospital per month. The TE hospital tries to send all deliveries to the Rangapara PHC, a 20-minute trip in a vehicle, if possible. In the case of a complicated delivery, patients are referred to the Tezpur Civil Hospital, which is about two hours away; the travel on these roads is virtually impossible in anything other than a 4 x 4 vehicle. In direct violation of the NRHM TE MoUs, the facility refers virtually all maternal health cases to government facilities. Thus, the facility has no instances of maternal death, infant death, or stillbirths. On occasion pregnant women with ASHA workers visit the estate hospital for prenatal check ups.
Though the hospital used to provide contraceptives, it stopped doing so in January of 2013. They no longer carry contraceptives including pills, condoms, and inter-uterine devices (IUD). The ASHA workers must instead get contraceptives from the Rangapara PHC in order to distribute contraception directly to women in their care. The hospital does have a family planning camp, which consists of education – not surgery, and 20-25 women attended the last camp. The frequency of such camps is unclear. The Civil Hospital in Tezpur performs all family planning surgeries and Inter-Uterine Device insertions (Copper T).

The nurse stated that the major health problems she sees are diarrhea, malaria, water borne diseases, flu, anemia, and occasionally tuberculosis.

ii. Sonajulie TE

A Kolkata-based company, Surya, owns Sonajulie TE. The total population of residents, including workers, is 5,600 including 1,230 permanent TE workers. There are 13 beds in the female ward, 14 in the male. There is a dispensary on-site. The TE management has not posted a doctor to the hospital for two years, since the previous female doctor left.

Team spoke with Sister Priti Daimari (GNM) who has been working at the TE Hospital for 2 years. On average the TE Hospital sees 100 patients per day: 10 children, 20 males, and 70 females. If the case is
complicated or critical, the patient will be referred to Rangapara PHC, which is 3km away. The roads from the TE hospital to the PHC are incredibly bad, it took the team 30 minutes to traverse two kilometers.

The team spoke with Margaret Hial (ANM) who has been at this hospital for 17 years. In all her years, she claims to never have an instance of maternal or child death at the hospital. Though she says there are a few maternal deaths among women who deliver at their homes on the TE.

Approximately three girls per month come in complaining of severe lower abdominal pain, these girls are sent to the Rangapara PHC. The hospital staff was unable to produce referral forms. It seems that a great many instances get referred including abscesses, fractures, and burns.

The most common ailments Margaret Hial sees on a daily basis among the Tea Estate community are fever, dysentery, and sometimes hypertension. Among pregnant women, she sees high rates of Anemia.

Birahmoni Munda, age 35

This is her sixth pregnancy; her eldest child is 16. She is a temporary tea estate worker and her husband is a permanent worker. She had four antenatal check-ups at the TE hospital and received a TT
injection. Her ASHA worker was at the hospital with her and answered many of the questions regarding pre-natal care.

The team asked Birahmoni Munda if she used spacing methods between her pregnancies to prevent pregnancy. She told the team that she has attempted to use oral pills, but that she stopped after her husband started beating and scolding her for using spacing methods. Her husband wants more children. After this delivery she plans to get sterilization surgery, she heard about this option from her ASHA worker who said, “get the operation.” The incentive for sterilization is now Rs. 250, down from Rs. 600 before. The ASHA, Fulmani Uraon, took 21 women for sterilization in 2012.

Birahmoni Munda delivered her first, second, third, and fifth child at home. Her fourth child was delivered at the Tezpur Civil Hospital. If she had assistance at home, she said that she would have delivered at home. She was admitted to the hospital on 7th July, 2013, when the team spoke to her she was awaiting transport to the PHC for a referral, she did not know why the TE hospital referred her.

**Jyoti, age 22-23**

When the team spoke to Jyoti, she was about to deliver her second child. She has a five year old daughter. She is a temporary worker at the TE. She stopped working at the end of the season, which coincided with her pregnancy. She has not worked during her pregnancy, and does not have immediate plans to return to work.
after giving birth. Her labor pains had just started when the team interviewed her. She came to the TE hospital with her mother-in-law. She received monthly check ups at the TE hospital, for which she came alone and she took vitamins that were given to her. The ASHA registered her pregnancy.

Her father-in-law works in the hospital at the dispensary. Her first child was born at home, she would have had this child at home as well, however, she experienced some pain and came in for a checkup. The hospital staff told her to stay as she would be delivering in the next few days, and the pain was continuing.

She did not use any spacing/contraception methods between pregnancies. She is unaware of such methods, and has not
considered her family planning options after this delivery. She is furthermore unaware of where to access contraception; she said no one talks about it.

She was not aware of the specifics of JSY, though she had heard of something similar from a friend. She said she is unable to collect such a payment because she does not have a bank account.

iii. Rangapara PHC

This Primary Health Center (PCH) see 150-200 patients daily; a majority of the patients are women and 40-50 children come every day. The population served by this PCH is largely Below Poverty Line (BPL). 13 TE hospitals (Borjulie, Kolony, Nahorani, Namgaon, Kacharigaon, Gorali, Sonajulie, Dhulapdung, Mainajulie, Rupajulie, Sessa, Tarajulie, Hatibari & Dhendai Tea Estates) refer patients, especially deliveries, to this PHC, and local residents rely on the PHC for primary care.

The team spoke with Marami Saikia, an Auxiliary Nurse Midwife (ANM), who has been working at this PCH for 23 years. There are a total of 12 ANMs at this facility; six ANMs from the State Health Services of Assam and another six from the National Rural Health Mission (NRHM). There is one female doctor on the staff, however, she was on leave and, therefore, the facility did not have a doctor on the premises. The doctor is normally on site from 8 AM- 4 PM Monday-Saturday, and will be on call when not on site. There was
only one patient on the premises on Sunday, the day of the visit, a woman who had delivered in the afternoon.

Marami Saikai noted that women do not come to the PHC for antenatal care, and in her experience women do not come to the PHC prior to delivery. She said that they would likely seek antenatal care from ASHA workers based in their communities.

For access to contraception, women have to approach their ASHA directly and apparently do not solicit such items from the PHC. The PHC has some stock of IUDs, condoms, and contraceptive pills. Team could not verify the PHC’s contraception stock as it was a Sunday and the dispensary is closed and locked on Sundays. The PHC does not have family planning camps, nor do they have sterilization targets to reach. The ASHA workers are said to have targets and will encourage women with more children to have surgery.

The ANM on site handles deliveries and at times handles multiples deliveries at once. The PHC refers almost all medical termination of pregnancy (MTP) to the Civil Hospital, Texpur. If there is an OBGYN visiting and that matter is extremely urgent, an MPT can be performed on the premises. Referral booklet was seen, and it appears to be properly maintained.

In April, there were 55 deliveries, and one stillbirth at this PHC. There were no maternal deaths. In May, there were 35 deliveries, one stillbirth, and no maternal deaths. In June, there were 29 deliveries,
nine of which were referrals from the TE. There were two miscarriages and two stillbirths. Any complication in pregnant women is referred to Tezpur Civil Hospital, and an ambulance is on the premises for such cases. In June the PHC referred eight women to Tezpur Civil Hospital. ANM stated that almost all complicated pregnancies are referred to the PHC from TE hospitals. There were no maternal deaths at this PHC in 2013, however, there were “some” in 2012 although no details were provided.

There is an adolescent clinic structure, however, the ANM noted that very few youth come to the facility. There is supposed to be a newborn care center, however, it was not completed, this ward was also under construction in 2011 – when the first team visited and no progress had been made.

The delivery space did not meet hygienic standards under Indian Public Health Standards. There were rusted trays with bloodied tools, medical waste sitting on various desks, and large insects in both the consultation and delivery rooms. Additionally, there were dogs on the premises, including the waiting area and at the doors of the delivery room.
Leelaboti Kor, age 24

Lelavathi gave birth to her first child at 12:26 PM, hours before the team arrived. Her pre-natal care consisted of a Tetanus Toxic (TT) injection and folic acid and iron supplements during her pregnancy. She lives three miles from the PHC and came in a 108 ambulance, which arrived 15 minutes after it was called brought her to the facility. Her mother-in-law accompanied her. She had a natural birth with an episiotomy, or cutting of the perineum. Lelavathi will be discharged in 48 hours. She was in the post-natal wing, which had two dogs sitting in the entranceway. There was one bathroom at the end of the room, but it had not been cleaned recently. She brought her own sheets and was wearing the clothes she delivered in despite her fresh sutures.

iv. Residence of Bhorjule TE Workers
Himathri Goala, age 21

Is a permanent worker at the Tea Estate, has been ill for the past 5 months. She had not worked during this time. Though she a permanent worker, she is only allotted 14 days paid leave. Her husband is working elsewhere in a more urban setting, on occasion he will send small sums of money back. She had three children; eldest is 6 and youngest is 2.5 years. Himathri showed the fact-finding team her recent TB test and the team noted that the test was positive. She goes to the TE Hospital daily to receive her TB medicine. Her health has improved since her diagnosis and treatment but she is still unable to work.

Suman Bhaiya, age 20
Is a temporary tea garden worker has been at Bhorjuli for three years. She married two years ago. She is not currently pregnant nor does she have any children. When she is not feeling well she will visit the TE hospital, there is one doctor there.

General Conversation with many TE residents:

The most common health ailments are fever, stomachache, and headache. Also, waterborne diseases are quite common. In the past five years the people the team spoke to remember the death of one child. Similarly, the residents could only remember one recent death of a fairly new mother – 5 months after giving birth it seems a woman fell ill and passed away.

b. Balipara Block

i. Barlipara Block PHC

Though the center has three doctors on staff who should work 24/7, there was no doctor at the PHC when the team arrived. The facility does not have an OBGYN doctor. This is the referral cite for three tea estates.

All women who reach the facility for delivery come with an ASHA worker. There were 29 deliveries in May, 26 deliveries in June, and ten deliveries as of the eighth of July. Of those ten deliveries, there
were four complicated deliveries in July: there was one premature delivery, one hypertensive women, one case of fetal distress, and one anemic patient who was also hypertensive. All four of these complicated cases were sent to Tezpur Civil Hospital in the PHC ambulance. They have no record of any maternal death at the PHC in the past one-year. However, the closest CHC, just 5 kms away, lost two pregnant women referred from Balipara PHC. The facility makes JSY payments to women and ASHA workers in the form of a check.

The Balipara PHC is stocked with condoms, pills, Copper T (insertion also happens at the PHC, on average 10/month). All family planning counseling is left to the ASHA workers. Therefore the PHC does not provide this service. On occasion women do ask for contraception; the most commonly requested form of non-invasive birth control at the PHC is the monthly pill.
If the doctor is solicited and the woman has a larger family, he/she will suggest going for sterilization at a camp. All sterilization procedures are referred to the civil hospital. Many report having pain and infection following the procedure. Previously the PHC used to perform MTP, but now even this is referred to the CHC. There is also a schedule (district-wise) for Vesectomy procedures, which is male sterilization.

The most common issues among pregnant patients are Anemia and Hypertension. Among the general population the PHC sees, the major health concerns include malaria, jaundice, and typhoid fever. Pelvic Inflammatory Disease (PID) is also common, though there is a low prevalence of Sexually Transmitted Infections (STIs).

When the PHC refers a patient, the staff fills out a referral form and calls the ambulance for free transportation. If the ambulance is busy then patient receives referral money of 400 Rs. for (private) transportation. There are usually one to two referrals per day.

The PHC frequently runs short of most medicine, including even the most basic drugs: paracetamol, antibiotics, and anti-diarrheal pills. At the time the team visited, the doctor reported that the facility did not even have paracetamol. The pharmacy from the CHC is supposed to make regular deliveries of drugs, however, despite frequent requests, the CHC has not delivered medicines. When there is no medicine available at the PHC BPL and APL patients must go to the chemists and pay for drugs out of pocket.
The premises were clearly unhygienic. The floors did not appear to be swept, the women’s ward had dirty walls, floors, was extremely dusty, and even the beds, which did not have sheets, appeared unclean. Like at many other facilities, there were dogs on the PHC premises.

c. Biswanath Charali

i. Dhullie TE

The team spoke with the Doctor on staff, Dr. Dominic Basumatary, who lives on the Estate. He has been working at the TE hospital for seven years and he does not know how much longer he will do it. He has taken the position because the payment here is better than many other places.

On average there are 1000 patients per month at the TE hospital. The doctor sees two to three pregnant women per month. In his early years there were a few cases of maternal mortality, however in more recent years the doctor has not had any deaths. Many women visit the TE hospital for delivery with ASHA workers. The doctor does not see women for antenatal care.

They have stock of contraceptives, including: condoms, pills, and copper T. He has recently had female patients who have begun asking for these products, whereas in his early years this was not the
case. He is able to insert inter-uterine devices. Aside from the contraception stock, the hospital experiences shortages of medicine, as medication deliveries are infrequent and hampered by flooding and extremely poor road conditions.

If women request an MTP they are referred elsewhere at their own cost as this is not a required service under the Planation Labor Act. The TE management at this plantation is apparently uncomfortable providing this service, an entitlement under NRHM and therefore an obligation per the MoU with the government of Assam to implement the NRHM.

Many patients come with diarrhea, fever, and water borne diseases, especially during the rainy season. There are fewer instances of TB and jaundice, though malaria is quite common. The facility is well constructed and clean, this includes the restrooms.

Punam Gorh, 22

She has come to the TE hospital with her one and half month old baby. She delivered in the Tezpur Civil Hospital and received Rs. 1400 JSY payment. She was referred to Tezpur because she was very anemic, and considered a high risk for complicated delivery. She is at the TE hospital due to a fever.
There are four doctors on staff: one Senior Physician (he is retired from his practice, and comes in only on occasion), one doctor in charge, and two junior physicians. All have MBBS degrees. Team spoke with Junior Doctor Driti Sunder Dutta, who has been working at this hospital for two and a half months.

According to Dr. Dutta, not many Tea Estate workers come to the CHC, most will go to Balipara PHC and do not get referred further. There are only two tea estates that send patients straight to the CHC. Many Boro, Garo, and other tribal peoples (though not Adivasis) do use the CHC.

The CHC has 30 beds total, and during the rainy seasons the facility sees 140-150 patients per day. During the winter the numbers drop to 40-50 out patients per day. Women and children make up 60-70% of the patients. There are 30-40 deliveries per month in the summers; this number increases to 60-70 in the winter. By way of prenatal care, during the 3rd trimester women are sent to Tezpur Civil Hospital for a sonogram.

There was one maternal death at the CHC in May 2013. The doctor stated that labor was prolonged and after the birth the mother experienced post partum hemorrhaging, she was sent to the Civil Hospital but died there. The baby survived.

Tubectomy and Vesectomy used to be performed at the CHC, though this is no longer the case. This is because the operation theatre is not
functional, due to inadequate staff, not because of insufficient equipment or infrastructure. The CHC provides pills, condoms, and Copper Ts. The Copper T insertions can be done by 2 of the 4 doctors on staff who are trained in this area. MTPs are also performed on the premises.

The facility prescribes generic drugs when it can. The hospital usually does not experience shortages in drugs except for at the end of the rainy seasons. If the drug is not available then the patient must go to a nearby chemist and pay out of pocket. Though the available drugs are given free of cost, patients will be charged 5 Rs. for a prescription note (pad) for the note itself.

The most common health problems the doctors see are: Lower Respiratory Tract Infections (LRTI), diarrhea with vomiting, UTI in women, and neurological issues and joint pain among the elderly. Additionally, there was a regular instance of malaria until recent years. Since 2009/10 the instances have decreased.

The CHC has one ambulance under JSSK which is used exclusively for maternal healthcare and is free for those women who qualify. Though the hospital advertises JSSK, it does not fully implement the scheme; tea, biscuits, and water were not provided to the women in the maternity ward per JSSK requirements. The maternity ward was very dirty, there was no ventilation, the smell was quite strong, and no sheets were provided to patients. The team spoke with four women at the facility.
A young woman who had given birth that morning was in the clothes that she gave birth in, and blood dripped from her episiotomy wound throughout our conversation. The women were all in the same clothes they gave birth in.

**Seenimai, age unknown**

Seenimai gave birth to a baby girl on 7th July. She traveled one hour in a hired vehicle, costing her Rs. 350, to reach the CHC. This is her third child. She delivered her first two at home. During her pregnancy, she traveled to the CHC once a month for check ups. She decided to have an institutional delivery for this birth because the ASHA worker told her she could get money. When the team spoke to her, she had not received her JSY money. She has never used spacing methods and she has no plan to do so in the future, though she does not want any additional children.

**Indira, Age 19 (likely younger)**

Indira was in pain from an episiotomy and was given some medicine for the pain. This was her first pregnancy and delivery. She is from Singamari Vihar village, which is one hour away. She came in a private vehicle and paid Rs. 200. She came with the ASHA worker who told her to tell the doctors that she was 19. She is vaguely aware of the JSY scheme, but she says you need a bank account to avail the scheme. Blood was dripping from Indira’s stitches while the team
spoke to Indira and her mother. Despite having an ASHA worker she is completely unknowledgeable about contraception, the forms, their use, and therefore has never used or enquired about these options.

Moon Devi, age 24

This is her second delivery, her first child was born at the CHC and is 2 years and 3 months old. She delivered on July 7, 2013, and was in a great deal of pain, her mother-in-law said she was given a tablet for the pain. They live just 1.5 KM from the facility. They know about JSY, but they need to open a bank account to get the money. She came to the CHC for check ups and she went to the Civil Hospital in Tezpur once for a sonogram. They came to the CHC because of the trained staff and medicine.

Pulsiri, Age 20

Delivered on July 7, 2013. She lives on the Arunachal Pradesh border 1.5 hours away. This is her first delivery. They called the ambulance and it brought them to the CHC. She does know about JSY. Her family gave her ASHA worker Rs. 200 “out of love,” but they haven’t paid for other services. They traveled to the CHC for antenatal check ups during the pregnancy as well.

iii. Biswanath Sub-Civil Hospital
There is one female OBGYN at this hospital. The facility had two OBGYNs, but the government has not appointed the second OBGYN. There are 11 other doctors at the hospital who can see patients in the ward. There are 22 GNMs. Team spoke to Horeswari Deuri, who has been the Ward Manager since 2009 and was previously a nurse at the facility from 1988-2009.

ASHA workers accompany most pregnant women for delivery. In April there were 161 births, no maternal deaths, and two infant deaths. In May there were 158 births, one maternal death due to anemia, and one child death. In June there were 142 births, no maternal deaths and no child deaths. The records of births appeared to be well organized and maintained. There is a record of Maternal Death, the reviews are filed with the hospital Administrator, and therefore we could not verify the existence or content.

Most common issue the staff sees among pregnant women is anemia, in fact the Ward Manager stated that “almost every pregnant woman seen has anemia.” High Blood Pressure is also quite common. The hospital is able to do Cesarean Section, MTP, and Laparoscopic sterilization. Vasectomy is done only at camps during specific dates.

Contraception is provided at the immunization center, which is another building in the same compound. Condoms, Copper T, and both emergency and monthly pills are available through the ANMs at the Immunization center.
The facility has not experienced substantial shortages in medicine though there are some instances where a specific drug runs out. If for some reason some drug is missing, patients purchase the medicine at a nearby local pharmacy. The Sub-Divisional center refers patients to Tezpur Civil hospital.

The facility was undergoing construction, and the premises were incredibly dusty as a result. There were too few washrooms, those available were far from the maternity ward, and in extremely unhygienic conditions. Women who may have just given birth and may have stitches have to travel great distances and risk infection in using the washroom.

d. Tezpur Civil Hospital

i. Tezpur Civil Hospital

The facility is a large compound with several wards and specialized services; the team visited only the maternity ward. There are 4 OBGYNs on staff, all male. There is an ANM and 4 GNMs. There are 4 anesthetists on staff, and usually 2 on duty at any given time.

According to the register of births kept, there were 40 births in the last three days of May, 301 in June, and as of July 9, 56 births. While the number of maternal deaths at the hospital has decreased, preventable maternal mortality occurs. In May there were no
maternal deaths, but the facility had three maternal deaths in June, and one thus far in July.

The instance in July occurred due to a culmination of all three delays. First, the patient delivered at home, so there was a delay in seeking treatment. Second, she went to a local health center and was referred to the Tezpur Civil Hospital which is a good distance from most rural areas; this amounts to a delay in reaching treatment. Lastly, due to the extreme overcrowding in the maternity ward and insufficient bed space there was a delay in receiving adequate treatment upon reaching a medical facility. The new mother passed away due to post-partum hemorrhaging.

The premises are incredibly dirty. The Hospital has a courtyard in the middle of the maternity ward where medical waste is strewn about including dirty needles, dirty gloves. The delivery room was also lacking in hygiene. There was fresh blood on the floor in front of the
delivery table. When a new patient got onto the delivery table, blood from a previous patient remained on the floor. The team did not see the staff sterilize or clean the table between patients. For an average of 10 deliveries per day, there are 5 delivery slabs in the room.

The Doctor on duty was supposed to arrive at 8 am; however, he arrived at 9:30 am. The team spoke to an OBGYN, not currently on duty. He has been at the Civil Hospital for 13 years. Over the course of his time he has seen an increase in institutional deliveries without an expansion of facilities. The 200-bed district hospital has 56 beds in the maternity ward. The ward is extremely overcrowded; many pregnant and new mothers line the sides of the stairs, around the disgusting courtyard, and are out in the elements.

The Doctor noted that government maternal health schemes have not resulted in a decrease in anemia. The doctor attributes high rates of anemia to inadequate education among the general public (especially
women). In 2012 there were 35 maternal deaths at Tezpur Civil Hospital. Of these deaths, 16 women were Adavasi (9 anemia, 7 eclampsya). Both anemia and eclampsya are treatable and preventable with proper antenatal care and support.

There is a separate post partum center on the campus that performs procedures like MTP. There are approximately three or four requests per day for the procedure. The post partum center is also where women access contraception, including condoms, pills, and IUDs. There is a lab on the compound, an emergency room with 24/7 service, as well as round the clock ambulance access. The blood bank is open, and operational, and usually for every request for blood someone must donate blood. Otherwise the cost is 500 Rs. per liter.

There is a new hospital being built 3.5 kilometers away, which will hopefully lessen the burden on the civil hospital. However, this new facility will be exclusively for maternal care. The OBGYN stated it may decrease the effectiveness of the new facility if other specialists and facilities are not on the premises, for example, general surgeons and a blood bank are often necessary in complicated maternal health cases.

e. Guwahati

i. Guwahati Medical College
Team went to the administrator’s office and was told to wait. A member of the fact-finding team waited for approximately one and half hours. When the administrator still had not arrived, the team went to observe the hospital and to meet with doctors or patients. No hospital staff would speak with the fact-finding team unless there was a signed letter from the administrator.

The delivery rooms and entire ward are off limits to non-delivering women. The ward is actually guarded by an armed police officer. The team was unable to see the standard of the facilities.

There are 150 beds in the regular delivery ward. This area had dirty floors; there were no sheets on the beds, and the women were in bloodstained clothing from their deliveries. Food did not appear to be provided, evidenced by the large quantity of packaged food brought by family members. The doctor at the regular delivery ward was approached but appeared to be the only doctor on staff and was therefore unable to speak with team members.

There are additional wards where new and expecting mothers can be found including the OBGYN (surgical) ward, and the Cesarean section ward where there are 60 beds. The Cesarean ward was full, a medical student on rotation in the ward said that there are usually 50 new patients per day, most staying three days. This ward was cleaner than the regular post-partum ward, however, the beds did not have sheets and once again women with fresh incisions were in the clothes they delivered in.
The team members requested to speak with the head matron and a number of nurses in various maternal wards and were rebuffed as there was no written consent from hospital administrators.

Conclusion:

The facts as presented above show a clear and systematic failure of the state government and Tea Estates with MoUs through acts and omissions to adhere to Constitutional obligations to protect women’s reproductive rights, including the right to life and health enshrined in the Constitution of India and various international treaties.