FACT-FINDING REPORT ON MATERNAL DEATH RI-BHOI DISTRICT OF MEGHALAYA, INDIA

Report by:

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1. Introduction

According to the report "Trends in maternal mortality: 1990 to 2015" by World Health Organisation (WHO) and some of its partner organisations, the health complications arising at the time of pregnancy, labour and post-delivery are mostly avoidable or curable. However, the lack of proper health facilities and treatment can aggravate the condition and may lead to death of the child or mother. Vir (2006) states that a high percentage of women in India, despite economic progress, continue to be undernourished and anaemic, undergo motherhood at young age and suffer due to unwanted pregnancies, domestic and sexual violence. Effective implementation and scaling up of of essential interventions that address direct high-impact interventions for improving child, adolescent and maternal health and nutrition should be the priority challenge.

Maternal deaths are preventable by providing adequate treatment and care. There may be many direct and indirect causes of maternal deaths in the country. According to a recent WHO report, nearly five women die every hour in India from complications developed during childbirth. Nearly 45,000 mothers die due to causes related to childbirth every year in India which accounts for 17 per cent of such deaths globally (PTI 2016). Retained placenta[1], if not treated adequately, can be life-threatening resulting in infection and even death. Even if the fragments of placenta does not pass out from the vagina, the woman can develop symptoms at home after child birth like - heavy bleeding, cramps, smelly vaginal discharge, fever and (or) lack of breastmilk. One can opt for physiological (natural) third stage or a managed third stage to clear the uterus of the placenta.

In this report, I will analyse of how Melina Dohling died during child birth. According to her mother, the cause of her death is due to the bleeding that was caused by the placenta that was

[1] Retained placenta means that all or part of the placenta or membranes has stayed inside the womb (uterus) after the birth of your baby. Normally, the body expels the placenta and membranes after the baby is born, and they slide out easily through the vagina which is called the ‘third stage of labour’.

stuck after she gave birth (retained placenta). An activist from Human Rights Law Network, conducted a fact finding visit to Ri-Bhoi District and met Melina's family.

2. Maternal health and maternal mortality in India

The World Health Organisation (WHO) defines maternal death as:

> "...the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death."

Live births are defined by the WHO as:

> "... the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born."

Factors causing maternal death may be direct or indirect. Direct causes of maternal deaths are those that are a consequence of the complication of pregnancy, delivery, or management of the two. Indirect causes of maternal deaths are pregnancy related deaths, but the cause is a pre-existing or newly developed health condition unrelated to the pregnancy.

According to WHO Maternal Mortality Factsheet, 2014, the most common causes of maternal death have been found to be post-partum bleeding, complications from unsafe abortion, hypertensive disorders of pregnancy, postpartum infections and obstructed labour. Other causes include blood-clots and pre-existing conditions. Some of the common indirect causes of maternal deaths are malaria, anaemia, HIV/AIDS, and cardiovascular diseases, all of which may complicate pregnancy or be aggravated by it.

India's Maternal Mortality Ratio has declined from 212 deaths per 1,00,000 live births in 2007 to 178 deaths in 2012. The decline has been even more drastic over the past 25 years. The current Maternal Mortality Ratio is India is about 174 per 1,00,000 live births.

But India cannot afford any complacency despite this development. We are still a long way from home. On the global stage, India still has the second highest number of maternal deaths in a year, only after Nigeria. About 800 women still die every day of preventable causes related to pregnancy and childbirth; 20% of these women are from India. It has been found that a whopping 45,000 women in India lose their lives during childbirth in year.

Some of the developed countries have Maternal Mortality Ratio of less than 10 per 1,00,000 live births. Such must be the aspiration of India. India, as a member of the United Nations, has recently adopted the Sustainable Development Agenda (SDA) which sets forth 17 goals for building a better world by tackling issues relating to poverty and inequality. Goal 3 of the SDA which concerns good health and well-being specifically calls on member states to reduce maternal mortality to less than 70 per 100 000 by the year 2030.

2.1 Maternal health situation in Meghalaya

The PHC at the community level was a novel concept to make healthcare services accessible. Primary healthcare is a core component for enhancing institutional delivery rates. Institutional deliveries along with good health care services at the PHC level, the presence of doctors and associated services are basic requirements to make a PHC functional. However, in Meghalaya,

there are constant reports of resource constraints both structural and manpower in PHCs across the state. The situation is worse in the rural areas where the reported non-functioning PHCs or CHCs is blamed on the absence of doctors and basic health infrastructure. The people complain against the apathy of the city-based doctors who have no passion to serve the rural folks. Doctors complain that the government quarters are inhabitable. General complaints are the lack of medical provision for newborn, inadequate medicines, negligible ambulances services to cater to emergencies, etc. There are also complaints of malpractices, incorrect diagnosis, discrimination by doctors etc. compelling NGOs to intervene and aggravate the situation (Pyrtuh 2016).

There is also the flip side about PHCs and Sub-Centres being poorly equipped. This results in doctors recommending patients to the Community Health Centres (CHCs), the Shillong Civil Hospital or Ganesh Das Hospital in case of delivery. Many women from interior villages have delivered inside vehicles while on the way to Shillong. Quite a few have died because of complicated deliveries. Meghalaya still has very poor indices in terms of maternal and child health. The maternal and infant mortality rates are higher than the national average (Mukhim 2016).

Key Indicators NFHS-4 (2015-16) - State Factsheet - Meghalaya			
Population and Household Profile		*Rural*	*Total*
1	Population (female) age 6 years and above who ever attended school (%)	80.2	83.0
2	Population below age 15 years (%)	38.7	36.5
3	Sex ratio of the total population (females per 1,000 males)	991	1005
4	Sex ratio at birth for children born in the last five years (females per 1,000 males)	1030	1009
Marriage and Fertility		*Rural*	*Total*
5	Women age 20-24 years married before age 18 years (%)	19.3	16.5
6	Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	10.1	8.6

Maternity Care (for last birth in the 5 years before the survey)		*Rural*	*Total*
7	Mothers who had antenatal check-up in the first trimester (%)	50.7	53.3
8	Mothers who had at least 4 antenatal care visits (%)	46.3	50.0
9	Mothers whose last birth was protected against neonatal tetanus	77.6	79.3
10	Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	33.2	36.2
11	Mothers who had full antenatal care (%)	20.9	23.5
12	Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	94.6	93.6
13	Mothers who received postnatal care from a doctor/nurse/ LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	42.6	47.5
14	Average out of pocket expenditure per delivery in public health facility (Rs.)	2,987	2,892
Delivery Care (for births in the 5 years before the survey)		*Rural*	*Total*
15	Institutional births (%)	45.7	51.4
16	Institutional births in public facility (%)	37.3	39.4

Table 1: Source - International Institute for Population Sciences 2017a

The recently released NFHS - 4 data reveals that just 50.7% of pregnant women living in rural Meghalaya received ANC in the first trimester, and merely 20.9% of women received full ANC. These low figures of services for pregnant women and lactating mothers is despite the reality that 94.6% of women have MCP card. The state is falling terribly short in providing women with comprehensive ANC. This is one of the reasons why the rate of institutional births in rural Meghalaya is merely 45.7%.

3. Legal obligations of maternal health

Right to Health has been recognised as a fundamental right under Article 21 of the Constitution of India. The right to maternal health is part of right to health, and has been expounded upon by numerous court judgments. And not just by the Constitution of India, but this has been recognised and legally enshrined by the international community through the adoption of numerous treaties. Furthermore, the Indian government has established schemes in an attempt to lower the Maternal Mortality Ratio.

3.1 International Treaties

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

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

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

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

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

Article 10(2)

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

Article 12(1)

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

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

Article 12

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

3.2 Indian Constitution

The Right to Maternal Health is indirectly enshrined in the Constitution of India in terms of Article 21 and Article 47 which have been examined by the Courts in numerous cases.

> Article 21
>
> No person shall be deprived of his life or personal liberty except according to procedure established by law.
>
> Article 47
>
> The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

3.3 Case Laws

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

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

In *Parmanand Katara v. Union of India &Ors., [1989 SCR (3) 997],* the Supreme Court held that ***Article 21 of the Constitution places an obligation on the state to preserve life. Every medical***

practitioner's duty is to treat emergency cases with expertise and never refuse to offer treatment for such cases.

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

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

In *Laxmi Mandal v. Deen Dayal Harinagar Hospital &Ors., [W.P. (C) 8853/2008],* the Delhi High Court held that an inalienable component of the right to life is "***the right to health, which would include the right to access government health facilities and receive a minimum standard of care. In particular, this would include the enforcement of the reproductive rights of the mother."***

In *Sandesh Bansal vs. Union of India & Ors.,[W.P. (C) 9061/2008]* the Indore High Court concluded that timely health care for pregnant women is essential to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India. The Court held, ***"…[w]e observe from the material on record that there is shortage not only of the infrastructure but of the man power also which has adversely affected the effective implementation of the [National Rural Health Mission] which in turn is costing the life of***

mothers in the course of mothering. It should be remembered that the inability of women to survive pregnancy and childbirth violates her fundamental rights as guaranteed under Article 21 of the Constitution of India. And it is primary duty of the government to ensure that every woman survives pregnancy and childbirth, for that, the State of Madhya Pradesh is under obligation to secure their life."

3.4 Government schemes

The Government of India has tried to back its efforts of improving the maternal health situation with a series of schemes. They are the National Rural Health Mission, National Maternity Benefit Scheme, Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, National Family Benefit Scheme, and the Indian Public Health Standards.

- ***National Rural Health Mission (NRHM)***

The preamble to the NRHM provides that recognising the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organisational structures, optimisation of health manpower, decentralisation and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalising community health centres into functional hospitals meeting Indian Public Health Standards in

each block of the country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

- ***Janani Suraksha Yojana (JSY)***

The Janani Suraksha Yojana (JSY) launched on 12 April, 2005 was implemented by the Central government to lure pregnant women to opt for institutional deliveries and in the process improve the maternal health conditions in India. It is a centrally sponsored scheme and provides cash assistance for pre and post deliver care. A pregnant woman from rural area is given INR 700 and that from urban area is given INR 600 for delivery in Govt. and accredited hospitals in Meghalaya. INR 500 is given for home-delivery for BPL women. Also the responsible ASHA worker gets Rs. 600 for every delivery in Govt. and accredited hospitals in the rural areas.

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

- Early registration of pregnancies with the help of the village level health workers like ASHA or the equivalent;
- Early identification of complicated cases;
- Providing at least three antenatal care, and post delivery visits;
- Organising appropriate referral mechanisms and providing referral transport to the pregnant mother;
- Convergence with Integrated Child Development Services (ICDS) worker by involving the Anganwadi worker (AWW);

- Ensuring transparent and timely disbursement of the cash assistance to the mother and the incentive to the Accredited Social Health Activist (ASHA) or an equivalent worker with fund available with ANM.

- ***Janani Shishu Suraksha Karyakram (JSSK)***

Janani Shishu Suraksha Karyakram (JSSK) was launched by the Government of India on 1st June, 2011. This scheme supplements the cash assistance given to a pregnant woman under Janani Suraksha Yojana (JSY) and is aimed at mitigating the burden of out of pocket expenses incurred by pregnant women on herself and sick newborns.

The following are the free entitlements for pregnant women:

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

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

- Free treatment
- Free drugs and consumables
- Free diagnostics

- Free provision of blood
- Exemption from user charges
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Free drop Back from Institutions to home

- ***The National Food Security Act, 2013***

The National Food Security Act, 2013 (also Right to Food Act) is an Act of the Parliament of India which aims to provide subsidised food grains to approximately two thirds of India's 1.2 billion people. Further, the NFSA 2013 recognises maternity entitlements. The Midday Meal Scheme and the Integrated Child Development Services Scheme are universal in nature whereas the PDS will reach about two-thirds of the population (75% in rural areas and 50% in urban areas). Pregnant women, lactating mothers, and certain categories of children are eligible for daily free meals.

- ***National Family Benefit Scheme (NFBS)***

National Family Benefit Scheme (NFBS) is a component of National Social Assistance Programme (NSAP). Under the National Family Benefit Scheme assistance is given in the form of a lump sum family benefit for households below the poverty line on the death of the primary breadwinner in the bereaved family. The amount of benefit is Rs.10000/- in case of death of primary breadwinner due to natural or accidental causes. The family benefit is paid to the surviving member of the household of the deceased who, after local inquiry is determined to be the head of the household.

- ***Indian Public Health Standards (IPHS)***

Health care in India is provided by means of a tiered system. In 2007, the Indian Public Health Standards (IPHS) were published to provide a set of uniform standards for each health centre in an attempt to improve the quality of health care delivery in the country. The IPHS have since been updated in 2012. An overview of the standards of each centre with specific reference to maternal health is provided below.

4. Case Study

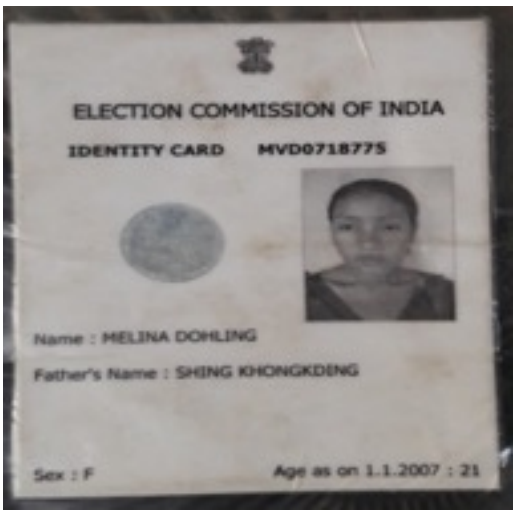
During a fact-finding mission by HRLN Meghalaya Chapter, a case was encountered where a maternal and infant death had occurred mainly due to the lack of appropriate facilities in order to undertake the emergency treatments of deliveries and poor implementation of Government schemes. The facts of the case as inferred from an interview with the deceased's mother, Pharmon Dohling are presented below:

Name: Melina Dohling

Age: 30

Father's name: Shing Khongkding

Address: Mawdiangum, Nongpoh, Ri-Bhoi District, Meghalaya.



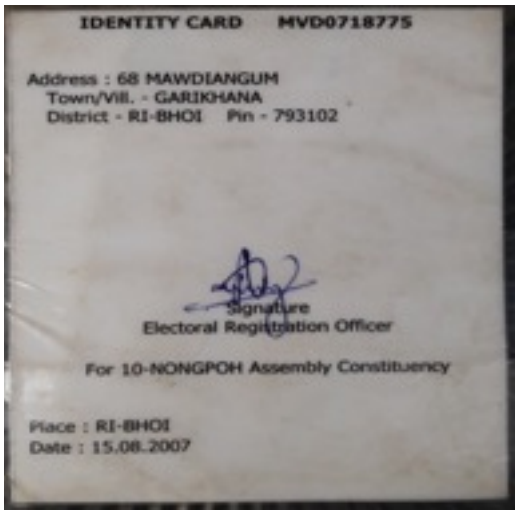


Photo 1.1 and 1.2: Election card of (L) Melina Dohling.

The Social Activist from Human Rights Law Network visited Mawdiangum on the 16th November, 2016 in the morning to meet the family of (Late) Melina Dohling. There are 11 members in the family, including four children of Melina. The father (Shing Khongkding) of the

deceased woman, and the 3rd child of the parents (Melina's brother), are the only two bread winners of the family. The family depends on agriculture for livelihood. Only the mother of the deceased (Pharmon Dohling), one of her sisters, and the three children of Late Melina were at home. The rest were at work in the fields. Pharmon cannot get involved in any cultivation activities ever since Melina passed away on the 30th January, 2016.

Photo 2: The three children of Melina Dohling, and her mother (Pharmon Dohling), whereas the eldest one was at school.

Melina was married to a man named, Kanlus Syngkli, a labourer who depends on daily wages for livelihood, at the age of 24 and left behind her 4 children (2 boys and 2 girls). The eldest child is a boy of 7 years, the second is a girl of 5 years old, the third is a boy of 3 years old and the youngest is a girl of 9 months old.

ANC check up	Date	Weight	Blood Pressure
1st trimester	15/10/2014	41 kg	110/70
2nd trimester	10/12/2014	43 kg	100/70
3rd trimester	13/5/2015	44 kg	-

4.1 Medical history

Melina was a very healthy and hardworking person, and always energetic. She usually helped her husband in supporting the family by engaging herself in cultivation. She was never ill or unhealthy. Even when she was pregnant, she would still go to the fields to cultivate crops. She was engaged with cultivation in the fields until day prior to the child birth of her youngest daughter. She also had a regular check up during her pregnancy, an ASHA worker added. But she preferred to deliver her child at home.

Photo 3: ANC card of Melina Dohling.

4.2 Death

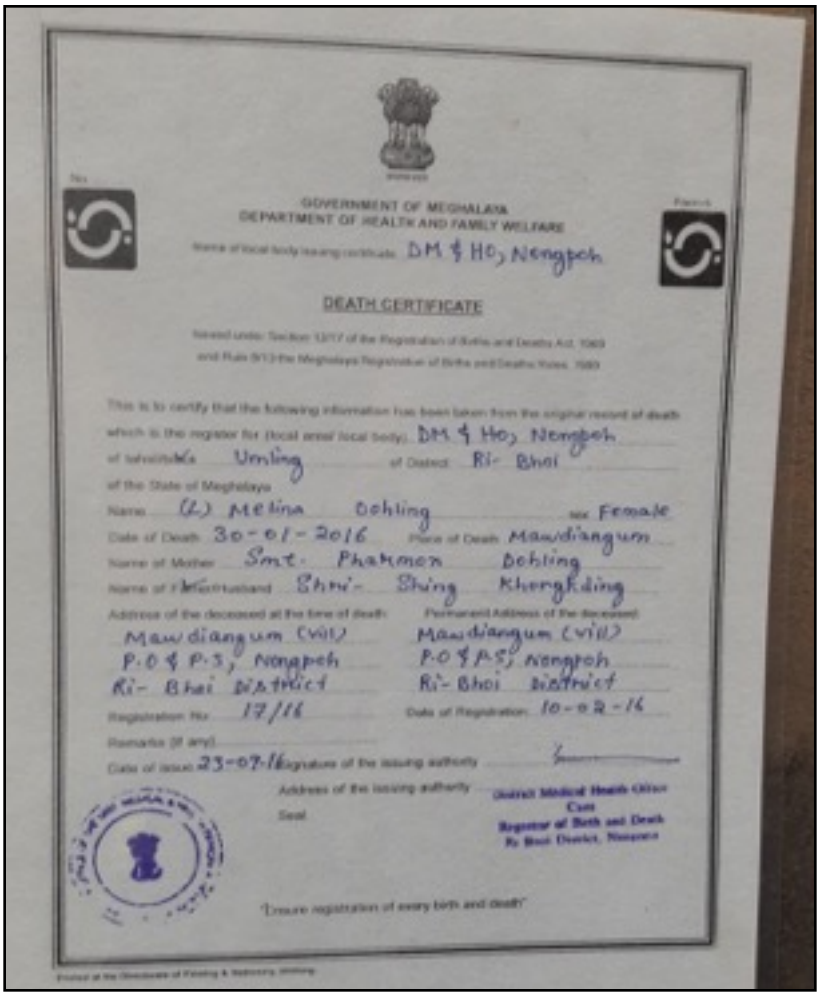
Melina delivered her youngest daughter (1 year 7 months now) on the 30th of January, 2016 and passed away on the same day. She had a normal delivery, but due to 'Placenta Retention' she was taken to the Nongpoh District Hospital after she delivered her child. Due to the emergency situation, she was taken to the hospital in auto-rickshaw rather than wait for the ambulance.

Unfortunately, she couldn't be saved and the doctors said that the situation was amplified due to extreme bleeding and low BP (blood pressure). In addition, the doctors mentioned that she was brought in too late to the hospital. According to her mother, Pharmon Dohling, Melina was kept unattended for about 20-25 minutes even after reaching the hospital, and was declared 'dead' just a few minutes after she was attended to. Melina's sister added that they were possibly discriminated and looked down up as the family was there without proper dress in a hurry, some were without even footwear.

Pharmon also stated that though she had witnessed the irresponsibility or the delay of the staffs towards attending the patients such as Melina Dohling who need immediate or emergency treatment, but she won't say that the death of Melina was due to that. She said that it is the will of God who had the wish to take her away from this earth and away from her children. However, due to the fear that has been installed in her mind now, she will never encourage anyone close or relatives to go to the institute for delivery after she has witnessed what has happened to her daughter, Melina.

On asking for clarification, Pharmon asserted that her daughter had died in the hospital and not at home. She was countered asking if Melina had died at home, why would she be taken to the hospital? Pharmon was very surprised when she was informed that according to the death certificate it shows that Melina had died at home and not in the hospital. Pharmon added that they were taken advantage just because they cannot read and understand English. (The death

certificate attached below shows Mawdiangum, her village, as the place of death which means that the death was recorded as died at home and not in the hospital).



GOVERNMENT OF MEGHALAYA
DEPARTMENT OF HEALTH AND FAMILY WELFARE

Name of local body issuing certificate: DM & HO, Nongpoh

DEATH CERTIFICATE

This is to certify that the following information has been taken from the original record of death which is the register for (local area/ local body): DM & HO, Nongpoh
of sub-division/s: Umling of District: Ri- Bhoi
of the State of Meghalaya
Name: (L) Melina Dohling Sex: Female
Date of Death: 30-01-2016 Place of Death: Mawdiangum
Name of Mother: Smt. Pharmon Dohling
Name of Father/Husband: Shri- Shing Khongkding
Address of the deceased at the time of death: Mawdiangum (Vill) P.O & P.S; Nongpoh Ri- Bhoi District
Permanent Address of the deceased: Mawdiangum (Vill) P.O & P.S; Nongpoh Ri- Bhoi District
Registration No: 17/16 Date of Registration: 10-02-16
Remarks (if any):
Date of issue: 23-07-16 Signature of the issuing authority:
Address of the issuing authority:
Seal:
District Medical Health Officer
Cum
Registrar of Birth and Death
Ri Bhoi District, Nongpoh

"Ensure registration of every birth and death"

Photo 4: Death certificate of (Late) Melina Dohling.

Schemes benefitted

When asked about the benefits from the schemes such as JSSK and JSY, Pharmon Dohling said that Melina didn't get any benefits from such schemes and till date the amount that the staff from hospital promised us has not been received. When asked about the benefit from the NFSA 2013 scheme, she said that nothing as such has been received by Melina and she don't think that such a scheme is even received by any other women as far as her knowledge is concerned.

5. Analysis

During a physiological third stage of labour, the womb naturally starts to contract again after the birth. During this process, the placenta detaches from the wall of the womb, and helps the woman to push it out. During a managed third stage, the midwife gives an injection as soon as the baby is born. This is likely to be either a combined injection of ergometrine and oxytocin, or oxytocin alone, if the woman had complications like high blood pressure or pre-eclampsia during pregnancy. This injection helps the womb to contract down and push out the placenta and membranes. Having a managed third stage reduces the risk of heavy bleeding immediately after the baby is born.

Melina was expecting for a physiological third stage, but it did not go as hoped. The placenta was taking longer to come out. In some cases, the ANM or ASHA can shorten the third stage through an injection of oxytocin. This makes the womb to contract strongly and helps the placenta to come away. In case of Melina, the ASHA was not equipped with the appropriate drugs to administer the injection. It was imperative to provide medical aid for retained placenta to a woman if the placenta is not delivery within an hour of the baby's birth in case of physiological third stage. This could have been done by the ASHA herself if she was equipped with the drugs to handle the situation.

Melina's pregnancy was registered at the Nongpoh District Hospital where the ASHA, Odalina Kharhunai is also registered. The Home Delivery Kit of the Skilled Birth Attendant needs to have oxytocin injections. However, it wasn't present due to the non-supply from the state health department. Therefore, it was imperative to immediately take her to the next referral centre with a labour room. The child was delivered around 12:00 pm. She was taken to the Nongpoh District Hospital by an auto rickshaw that her husband drives. They reached the hospital by 1:00 pm. There she was not immediately treated for the Retained Placenta. Crucial time was lost while waiting for Melina to be diagnosed and administered with essential drugs.

According to Melina's mother, within a few minutes of being treated, Melina lost her life. However, her death certificate states that her place of death was her village and not the hospital. Her parents were unaware of what was written in the Death Certificate as they are illiterate and do not read or speak English. The hospital was not only callous with handling an emergency case but also refused to take any responsibility for the same by wrongly mentioning the place of death in the death certificate. Given the poor economic condition of the deceased and her family, she was seen as dispensable and her life or death did not matter to the authorities.

She was brought to the hospital with extreme bleeding. Haemorrhage (bleeding) that occurs during and after childbirth can be a major hazard if severe, and needs immediate medical attention. One of the reasons why post-partum haemorrhage can occur is when the placenta is attached to the uterine wall. Though women can lose upto 15% of her blood volume at the time of delivery without her blood count dropping or developing anaemia, the condition of Melina was very different. Melina was losing significantly higher amount of blood due her condition of Retained Placenta. She would have need extensive treatment like blood transfusion and immediate transfer for the operation theatre. However, the Nongpoh District Hospital does have a blood bank that could have improved her situation.

In some cases, if the placenta wouldn't have been released after the initial treatment, the doctor would have had to remove it by hand but the patient would be need a regional anaesthesia such as a spinal or epidural. This can be administered only by an anaesthetic as administering general anaesthesia would carry more risk for the mother. This would have only further complicated the matter for Melina and her child as she would not be able to breastfeed the child immediately after procedure as there may be traces of the anaesthetic drugs in her breastmilk. The Nongpoh District Hospital does not have an regular anaesthetist[2]. According to the IPHS guidelines, a 100 bedded District Hospital must have at least two Anaesthetics. Even a 50-100 bedded sub-district, sub-divisional hospital must have at least one Anaesthetic.

[2] The Anaesthetic who visits the Nongpoh District Hospital is based in Shillong.

Hence, in the light of the above mentioned points, one can conclude that the multiple lapses of the Meghalaya Government at various stages led to the death to Melina. Her death could have been easily avoided if the government would have proactively worked towards plugging the loopholes that exist in the public health system of the state. Retained Placenta is not an unusual case that would have needed highly specialised mechanism to deal with. At every step, Melina encountered difficulties that eventually resulted in her death.

6. Recommendations

To provide a compensation of INR 500,000 to the mother of the deceased for the failure of the state public health system to protect the life of her daughter and the subsequent trauma caused to the petitioner and her family, as well as the resulting death of the daughter of the petitioner. The petitioner now takes care of the children as the father of the children has abandoned the children.

To issue directions for the constitution of a committee of doctors including a paediatrician and a dietician for charting out the nutrition dietary plan for the grandchildren of the petitioner for the next three years. To issue directions for the provision of the nutritional requirements of the grandchildren of the family through the next three years.

To ensure free and compulsory education for all the children of Melina Dohling.

To ensure that every health centre has the complete Home Delivery Kit[3] as per the IPHS guidelines.

Immediate appointment of a permanent Anaesthetic at the Nongpoh District Hospital.

Disciplinary action against the doctor on-duty in the emergency/maternity ward during the time of the maternal death.

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[3] **Home Delivery kit (according to the IPHS guidelines)**
The delivery kit should contain disposable items, as well as supplies and essential drugs required for conducting a home delivery.

Pocket 1: Disposable Delivery kit
Soap, new blade, clean thread, clean sheet, gloves, plastic apron, gauze piece.

Pocket 2: Drugs
Injection Gentamicin, Injection Magnesium sulphate 50%, Injection Oxytocin, Capsules Ampicillin, tablet Metronidazole, tablet Misoprostol, tablet Paracetamol, ORS.

Pocket 3: Supplies
Syringes with needle (2ml, 5ml, 10ml) Needles 22G, Intravenous set, Ringer lactate solution 500 ml, Adhesive tape, blood pressure apparatus with stethoscope, Measuring tape, Partographs, Dipsticks for testing sugar and proteins in urine, Puncture –proof box, thermometer, Spirit, cotton and gauze, torch, Plain Rubber catheter and Foley's catheter, Mucus sucker, Ambu bag and mask, Mouth gag, trash bag.

7. Conclusion

The State's health (of Meghalaya) depends on the health of its citizens. Maternal and infant are two of the most important segments of health. Thus it is imperative that efforts should be made to improve the situation. Proper implementation of the health schemes at all levels with proper awareness can drastically improve things in a short span. (Pyrtuh, 2016)

Maternal death in Meghalaya continues to be caused by conditions that are curable and does not tantamount to death with proper medical care. The continuous lapses of basic facilities and drugs even years after the implementation of various central government schemes are the reasons behind the reported maternal deaths in the state. The endemic poverty in the rural parts of Meghalaya compounds the situation as people cant afford private health care in the absence of public facilities.

Pharmon Dohling said it is a enormous challenge for the entire family now, especially in terms of financial aspects, because Kanlus Syngkli (husband of Melina and the father of four surviving children) got married to another woman just after a few months after the death of Melina. He left the responsibility of the children on Pharmon and her husband to raise these children. It is really a challenge for the family, but her husband, as a grandfather of the children, tends to ignore the hindrances and works very hard to look after these children as well. She also added, now that their grandfather is able to work, and their uncle is still unmarried, it is somehow manageable for the meal to fill the stomach. However, she is worried about what may happen to these children when their grandfather cannot work anymore and the uncle gets married. The lapses of the State Government has put an entire family is disarray and jeopardises the future of four innocent children.

Patients' grievances against a doctor or a health care facility (in Meghalaya) must be addressed with proper compensation for any wrongdoing. The health care system needs to be comprehensively revised to bring in transparency and accountability. The benefits of such an exercise would accrue to those who need basic health care the most (Pyrtuh, 2016). It is now the

responsibility of the State Government to ensure that the lives of the children are not in continuous peril and they are provided with a safe and healthy childhood.

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