

Fact Finding Report

**Maternal Health Care in
Balrampur District,
Uttar Pradesh**

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Introduction

In August 2017, the death of more than 60 infants within a month in Gorakhpur, Uttar Pradesh, made news across the country as well as internationally. Soon afterwards, in Farrukhabad, 49 infants died within a similar time span. While the frequency of infant deaths in the Gorakhpur and the Farrukhabad incidents is undeniably horrific, it is only the tip of the iceberg. India has some of the highest rates of infant and maternal mortality in the world. Especially in rural districts, with poor public health care facilities, which are difficult to access, the infant mortality rate (IMR) and maternal mortality rate (MMR) are way too high.

The district of Balrampur, situated less than 200 km north-east from Gorakhpur at the border to Nepal, continues to have one of the highest IMR and MMR in the country. IMR in the district is 87 per 1,000 live births (far above state and national average; AHS 2012-2013), while the MMR is 366 per 100,000 live births, also exceeding both national and state average by far (AHS 2012-2013).

Background

Access to healthcare is a basic human right. The right to health is considered a fundamental right and has been recognized under Article 21 of the Indian Constitution. Reproductive health rights are an integral part of the right to health. The WHO defines maternal health as the health of women during pregnancy, childbirth and the postpartum period.

Maternal mortality continues to be a global problem, especially in many developing countries. Maternal death has been defined by WHO as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes". Maternal mortality is appraised through the MMR, which is the number of maternal deaths per 1,00,000 live births. Maternal mortality has at many places reached epidemic proportions. Although the overall number of maternal deaths in the world is falling gradually, a lot of countries in the world are still having an alarming rate of maternal mortalities. A total of 73 out of 184 countries have an MMR of 100 or more. On January 1, 2016 the new

Sustainable Development Goals (SDGs), adopted by the UN General Assembly in 2015, came into effect, aiming to establish a new agenda for maternal health and to reduce the global MMR to less than 20 per 1,00,000 live births by 2030.

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

Infant mortality is defined as the death of young children, usually those of less than one year of age. It is measured in the earlier mentioned infant mortality rate (IMR) which displays the number of infant deaths per 1,000 live births. According to the United Nations World Population Prospects (the 2015 revision), the world-wide infant mortality rate is 49.5 per 1,000 live births. With an infant mortality rate of 41.3 for the years 2010-2015, India ranks better than the world average, but is still only at number 126 out of 175 on an average of the last 15 years. In comparison, European countries have IMRs between 2 and 5.

A number of schemes have been introduced and implemented like the Janani Suraksha Yojana, National Maternity Benefit Scheme and the Janani Shishu Suraksha Karyakram under the overall umbrella of the National Health Mission to improve the maternal health situation in the country. Still, only 4.7% of the country's GDP is spent on health. To compare, advanced countries like Germany and France spend more than 10 percent of their GDP on healthcare.

In this report we are going to look at how systematic failures in the governmental health care system in Balrampur deny the residents -- especially pregnant women, lactating mothers and newborn infants -- access to proper and necessary health care.

Objective

The visit was conducted to investigate why Balrampur has such a high IMR and to identify measures that have been omitted by the central and the state government to reduce these numbers. Further, it was to scrutinize the general conditions of health care provided to pregnant women, lactating mothers and newborn infants in the district. The questionnaires were focused

on the kinds of services provided in the hospitals, the quality of the services and the lack of resources which prevent adequate health care. After a first overview gained through interviews in one of the district hospitals, our focus was on the lack of personnel and the handling of bio-medical waste in the different health care facilities.

Methodology

To explore the conditions in government health care facilities in this district, a team consisting of lawyers, social activists and legal interns from HRLN conducted a fact-finding mission to Balrampur district, from the December 10-12, 2017. The team consisted of five members: two lawyers from HRLN (Aman Khan and Ali Jibrán) and three law interns (Vikas Muralidharan, Sai Sathyanarayanan and Leon Rauch). They visited District Hospitals, Community Health Centres (CHCs) and Primary Health Centres (PHCs) and conducted interviews with the staff (medical and administrative), ASHA workers and patients (pregnant women and lactating mothers).

The interviews were conducted by referring to questionnaires prepared beforehand according to the IPHS Guidelines. A copy of the questionnaire is annexed to this report. Further the team analysed data on the number of home and institutional deliveries, still and live birth as well as mortality rates.

The team faced difficulties insofar as high ranking personnel was not available in every facility. Further there was a lot of distrust between the medical personnel and the ASHA workers, with the latter being afraid of sanctions (up to loss of their job) when they were too critical about the respective facilities.

A profile of the location

Uttar Pradesh

Uttar Pradesh (UP) is the most populous state in India, with about 200 million inhabitants. It consists of 18 divisions and 75 districts. The main ethnic group is the Hindavi people. The most widely spoken and official language is Hindi. The state is bordered by Uttarakhand (which was part of UP until 2000) Nepal to the north, Bihar to the east, Madhya Pradesh to the south, Rajasthan to the west, and Haryana, Himachal Pradesh and Delhi to the northwest. To the southeast, it touches the states of Jharkhand and Chhattisgarh. It covers almost 250,000 square kilometers, making it the fourth biggest Indian state by area. UP has India's second largest economy, statewise, with a GDP is about Rs. 14.46 lakh crore. It is mostly based on agriculture and service industries (travel and tourism, real estate, insurances and financial consultants).

44.4 million people live in urban areas, which is the second highest value of all states. 15 urban agglomerations have a population of 500,000 people or more. The sex ratio in UP is 908 women to 1000 men, lower than the national average of 933 (2011 census). According to a 2009-2010 report by the Planning Commission 59 million people in UP were living below the poverty line, more than in any other state. Almost 80 % of UP's population are Hindus, 19% are Muslims and the other 1% is divided amongst the other religions (Sikhs, Christians, Jains, etc.). According to the 2011 census the literacy rate is 67,7 % (national average: 74 %), with a literacy rate for men of 79 % and for women 59%.

The population of the state has been increasing by more than 25% in the 15 years prior to 2012-2013, but the public health care system has not kept up its pace. On the contrary, according to the Annual Health Survey 2012-13, the number of public health centres has decreased by 8%. The life expectancy of a newborn in UP is between 5 to 7 years -- less than in neighbouring states. After Assam, it has the highest MMR (258 per 100,000 live births) and 62% of pregnant women do not have access to minimal ante-natal health care (Annual Health Survey 2012-2013). The IMR is 50, also above the national average (as of 2013). According to a report by the Ministry of Health and Family Welfare, Gol ("State of Urban Health in Uttar Pradesh"), 42% of pregnant women have home deliveries, out of which almost two-thirds are considered unsafe. According to a report by the Centre of Inquiry into Health and Allied Themes (Public Private

Partnership in Uttar Pradesh Health Care Delivery System), one third of the rural population has no access to primary health care infrastructure.

Balrampur District

Balrampur district part of the Devipatan division in eastern UP, 162 km from the capital Lucknow and bordering to Nepal. It has a population of roughly 2,150,000 people according to the 2011 census. The population density is 642 inhabitants per square kilometre. Between 2001 and 2011 the population has grown around 28%. The district is divided into three sub-districts (Tehsils): Balrampur, Tulsipur and Utraula.

Out of the entire population, 1,992,000 is considered as rural population. The sex ratio (number of females per 1000 males) is 927, which is above the state average, but below the national average. The child sex ratio (number of females per 1000 males in the age group of 0-6) is 968 and therefore way above the state average (899). The total literacy rate is 51.76 % (below state and national average), with a male literacy rate of 61.66% and a female literacy rate of just 40.92%.

IMR in the district is 87 per 1,000 live births (way above state and national average; AHS 2012-2013), while the MMR is 366 per 100,000 live births, also exceeding both national and state average by far (AHS 2012-2013).

Legal Aspects

Constitutional Guarantees & relevant Case Laws

Article 21

Article 21 of the Indian Constitution states that “*no person shall be deprived of his life or personal liberty except according to procedure established by law*”. The Supreme Court has held in several cases, that the Right to Life as established by Art. 21 also includes a Right to Health and the right to live with dignity, as well as freedom from degrading treatment.

Right to Health

- In *Francis Coralie Mullin v. Union Territory of Delhi & Ors.*, [1981 SCR (2) 6] the Supreme Court observed that the right to live with dignity and the protection against torture and cruel, inhuman or degrading treatment are implicit in Art. 21.
- 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 affirmed that providing “adequate medical facilities for the people is an essential part” of the government’s obligation to “safeguard the right to life of every person.”
- In *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 Madhya Pradesh High Court concluded that timely health care is of the essence for pregnant women to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India.

Right to clean and healthy environment

- In *Subhash Kumar v. State of Bihar*, 1991 SCR (1) 5, the Supreme Court not only observed that “right to life guaranteed by Art. 21 includes the right of enjoyment of pollution-free water and air for full enjoyment of life”, thereby recognizing the right to a clean and healthy environment as a fundamental right, but also that governmental agencies may have to be compelled to take positive measures to improve the environmental conditions.
- In *M.C. Mehta v. Union of India*, 1987 SCR (1) 819, the Supreme Court reaffirmed that the Right to a clean and healthy environment is a fundamental right.

Articles 14 & 15

Art. 14 provides for equality before the law, while Art. 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. While the burdens of pregnancy and childbirth are inequitably borne by women, the ability to reproduce should not increase women's chances of death, disability, or illness.

- The Supreme Court held in *Apparel Export Promotion Council v. Chopra* [AIR 1999 SC 625] that Art. 14 is one of the “most precious Fundamental Rights guaranteed by the Constitution of India”.
- In *Maneka Gandhi v. Union of India* [(1978) 1 SCC 248] the Supreme Court held it is not enough that a provision is constitutionally valid. If the implementation of the provision is infringing on a person's fundamental right, that state action is ultra vires.

Article 38

Art. 38 guarantees access to medical services regardless of status.

International Conventions

Besides natural justice principles and legal precedent, international law places obligation on States to for quality healthcare. Despite being subject to customary international law, India is a party to several conventions which impose obligations that can well be enforced (unless in direct conflict with national legislation) as held by the Supreme Court in *Vishaka & Ors. v. State of Rajasthan* [(1997) 6 SCC 241].

- **International Covenant on Economic, Social and Cultural Rights (ICESCR)**, adopted by the United Nations General Assembly in 1966, entered into force in 1976 - India acceded to it in 1979.
 - Art. 12 (Right to enjoyment of the highest attainable standard of physical care)
 - General Comment No. 14
 - Art. 15 (Right to enjoyment of scientific development)

- Art. 12 of the **Convention on Elimination of All Forms of Discrimination Against Women (CEDAW)**
- Art. 25 of the **Universal Declaration of Human Rights (UDHR)**

Rules and Regulations

Bio-Medical Waste Management Rules, 2016

The Bio-Medical Waste Management Rules, 2016 were issued under Sec. 6, 8 and 25 of the Environment (Protection) Act, 1986 to replace the Bio-Medical Waste (Management and Handling) Rules, 1998.

Under **Sec. 3** (f) bio-medical waste is defined as “any waste, which is generated during the diagnosis, treatment or immunisation of human beings or animals [...]”. An occupier as for the Rules is defined under Sec. 3 (m) as “a person having administrative control over the institution and the premises generating bio-medical waste, which includes a hospital, nursing home, clinic, dispensary, [...] pathological laboratory, blood bank, health care facility and clinical establishment, irrespective of their system of medicine and by whatever name they are called”.

Under **Sec. 4** it states that “It shall be the duty of every occupier to:

- (a) take all necessary steps to ensure that bio-medical waste is handled without any adverse effect to human health and the environment and in accordance with these rules;
- (b) make a provision within the premises for a safe, ventilated and secured location for storage of segregated biomedical waste in colored bags or containers in the manner as specified in Schedule I, to ensure that there shall be no secondary handling, pilferage of recyclables or inadvertent scattering or spillage by animals and the bio-medical waste from such place or premises shall be directly transported in the manner as prescribed in these rules to the common bio-medical waste treatment facility or for the appropriate treatment and disposal, as the case may be, in the manner as prescribed in Schedule I;
- (c) pre-treat the laboratory waste, microbiological waste, blood samples and blood bags through disinfection or sterilisation on-site in the manner as prescribed by the World Health Organisation

(WHO) or National AIDs Control Organisation (NACO) guidelines and then sent to the common bio-medical waste treatment facility for final disposal; [...]

(e) dispose of solid waste other than bio-medical waste in accordance with the provisions of respective waste management rules made under the relevant laws and amended from time to time;

(f) not to give treated bio-medical waste with municipal solid waste; [...]

(k) ensure treatment and disposal of liquid waste in accordance with the Water (Prevention and Control of Pollution) Act, 1974; [...]

(q) inform the prescribed authority immediately in case the operator of a facility does not collect the bio-medical waste within the intended time or as per the agreed time; [...]

(r) establish a system to review and monitor the activities related to bio-medical waste management, either through an existing committee or by forming a new committee [...];

Sec. 7 states that

(1) Bio-medical waste shall be treated and disposed of in accordance with Schedule I, and in compliance with the standards provided in Schedule-II by the health care facilities and common bio-medical waste treatment facility.

(2) Occupier shall hand over segregated waste as per the Schedule I to common bio-medical waste treatment facility for treatment, processing and final disposal: Provided that the lab and highly infectious bio-medical waste generated shall be pre-treated by equipment like autoclave or microwave. [...]

(4) In cases where service of the common bio-medical waste treatment facility is not available, the Occupiers shall set up requisite biomedical waste treatment equipment like incinerator, autoclave or microwave, shredder prior to commencement of its operation, as per the authorisation given by the prescribed authority. [...]

(9) After ensuring treatment by autoclaving or microwaving followed by mutilation or shredding, whichever is applicable, the recyclables from the treated bio-medical wastes such as plastics and glass shall be given to such recyclers having valid authorisation or registration from the respective prescribed authority. [...]

Sec. 8 states that

- (1) No untreated bio-medical waste shall be mixed with other wastes.
- (2) The bio-medical waste shall be segregated into containers or bags at the point of generation in accordance with Schedule I prior to its storage, transportation, treatment and disposal. [...]

Schedule I establishes different categories of waste (yellow, red, white, blue) depending on the kind of bio-medical waste and prescribes different disposal mechanisms. The yellow category contains, amongst other things Human Anatomical waste, Soiled Waste, Expired or Discarded Medicines and Discarded linen, mattresses, and beddings which are contaminated with blood or body fluid, which are supposed to be disposed through incineration, plasma pyrolysis or deep burial. Waste that has come in contact with microbiology, biotechnology and other clinical laboratory waste is to be disposed according to the WHO guidelines. Red category waste (Contaminated recyclable waste) is to be subjected to autoclaving or microwaving and then sent to the authorized recyclers. White category waste (waste including sharp metals, such as needles) has to be sterilized (dry heat) or encapsulated in a metal container and then sent for final disposal to iron foundries or a sanitary landfill or a designated concrete waste sharp pit. Blue category waste (glass ware, metallic body implants) has to be disinfected and then sent for recycling.

To summarize, the Bio-Medical Waste Management Rules, 2016 provide for a general obligation of the occupier to take all necessary steps to ensure that the handling for Bio-Medical Waste is not causing any adverse effect to human health and the environment.

Case Laws

The issue of waste management in hospitals was firstly before the court in *B.L Wadhera v. Union of India*, AIR 1996 SC 2969, before the first Bio-Medical Waste management Rules were put in place. The Supreme Court held that

- (a) All hospitals with 50 beds and above should install incinerators or any other effective alternate method under their own administrative control.
- (b) The incinerator or alternative methods should be fitted with necessary pollution control mechanism, approved and conforming to the standards laid down by the Central Pollution Control Board.

(c) The Central Pollution Control Board and the State Pollution Control Boards should regularly send its inspection teams in different areas to ascertain that the collection, transportation and disposal of garbage/waste is carried out satisfactorily.

Since the enactment of the first Bio-Medical Waste Management Rules in 1998 there has not been a Supreme Court case, but several High Courts dealt with the matter:

- In *State of Karnataka & Ors. v. B. Krishna Bhat & Ors.*, 2001 (2) KarLJ 1, the Karnataka High Court ordered the State Government to take action concerning the disposal of bio-medical waste and to ban the disposal of hospital waste in any public or common area. The orders passed also covered general infrastructure improvements (roads, sidewalks, prevention of dumping of debris, etc.).
- In *Courts on its own Motion vs. In the Matter of Statement made by Shri Raman Duggal, Adv.*, 2001 CrLJ 1064 the Delhi High Court ordered all private and governmental hospitals in Delhi to install incinerators or an equally effective alternative to dispose Bio-Medical waste.
- In *M. Vijaya v. Charimen and Managing Director, Singareni Collieries Co., Ltd., Hyderabad & Ors.*, AIR 2001 AP 502, the Andhra Pradesh High Court held that all hospitals shall be directed to dispose their waste according to the Bio-Medical Waste Management Rules and strictly comply with the provisions therein.
- In *Satish Chaturvedi s/o S. Chaturvedi v. State of U.P. through the Chief Secretary & Ors.* (MANU/UP/1662/2004) the Allahbad High Court gave orders to a Hospital to reorganize its waste management, as the garbage dump was located close to the post mortem operation theatre, causing a danger of infection and sickness to everyone in the hospital premises.
- In *Suo Motu v. Ahmedabad Municipal Corpn. & 46 others*, (2006) 2 GLR 1129, the Gujarat High Court ordered that hospitals run by the Government, having 30 or more beds have to construct and install their own incinerators or an equally efficient disposal mechanism.
- In *Maitree Sansad v. State of Orissa & Ors.*, 103 (2007) CLT 191, the Orissa High Court ordered the Chairman of the State Pollution Control Board to conduct an investigation into gross violations of the Bio-medical Waste Management Rules.

Schemes and Guidelines

National Health Mission (NHM)

In 2013, the Central government launched the National Health Mission (NHM) as an umbrella program with two main prongs: the National Rural Health Mission (NRHM), first launched in 2005, and the National Urban Health Mission (NUHM). The purpose of these schemes is to improve health infrastructure and health outcomes in India's rural and urban areas. Most notably the Indian Public Health Standards (IPHS) guidelines have been issued under the NHM/NRHM to ensure effective health care to the rural population. In addition to this, the NRHM houses numerous individual benefit schemes with a more targeted focus.

Indian Public Health Standards

The Government of India has also established the Indian Public Health Standard Guidelines (IPHS Guidelines) to ensure that quality healthcare is provided to all in District Hospitals, PHCs, CHCs, etc. The guidelines detail various requirements to be met in terms of infrastructure, manpower, drugs, transport facilities, laundry services, dietary services and other services to be provided. A brief of the guidelines as required for this report is as follows:

PHCs

The IPHS Guidelines for PHCs are as follows:

It is required that the PHC provide proper Antenatal care (ANC), Intranatal care and Postnatal care (PNC). It mandates a minimum of four ANC visits along with conducting minimum laboratory investigations, nutritional and health counselling and identifying and managing high risk pregnancies. There must also be promotion of institutional deliveries, appropriate and prompt referral for cases needing specialist care, pre-referral management, and management of pregnancy induced hypertension, etc. In terms of PNC, there must be directions sent to the ANM of the concerned area to ensure 7th and 42nd day home visits, as well as additional visits on the 14th, 21st and 28th days for babies born with Low Birth Weight (LBW). There must also be tracking of missed and left out ANCs and PNCs, and services under the Janani Suraksha Yojana (JSY) Scheme must be provided. Apart from these services, there must be a minimum of six hours of OPD Services, 24-hour emergency services, referral services and inpatient services (6 beds).

With regards to **infrastructure**, it is a mandate that the PHCs are located in an easily accessible area with facilities for electricity, all weather road communication, adequate water supply, etc. There must be a waiting area with adequate space, drinking water facilities, and toilets with adequate water supply. The OPD room must have separate areas for consultation and examination with the area for examination having sufficient privacy. An Operation Theatre, while being optional, should have a changing room, a sterilization area, operating area and a washing area and surgeries such as laparoscopy/cataract/tubectomy/vasectomy must be carried out. Labor rooms must have oxygen, suction machines and accessible electrical outlets with provisions for privacy of the women. There must be provisions for hand-washing and containment of infection control and separate areas for septic and non-septic deliveries. There must be restricted entry into the labor room and all essential drugs and equipment (functional) must be available. The labor room must be clean, well-maintained and fumigated at regular intervals. There must be a waste disposal pit as per the guidelines of the government or the Central Pollution Control Board.

PHC Manpower requirements are as follows:

Staff	Type A		Type B	
	Essential	Desirable	Essential	Desirable
Medical Officer- MBBS	1		1	1#
Medical Officer –AYUSH		1^		1^
Accountant cum Data Entry Operator	1		1	
Pharmacist	1		1	
Pharmacist AYUSH		1		1
Nurse-midwife (Staff-Nurse)	3	+1	4	+1
Health worker (Female)	1*		1*	

Health Assistant. (Male)	1		1	
Health Assistant. (Female)/Lady Health Visitor	1		1	
Health Educator		1		1
Laboratory Technician	1		1	
Cold Chain & Vaccine Logistic Assistant		1		1
Multi-skilled Group D worker	2		2	
Sanitary worker cum watchman	1		1	+1
Total	13	18	14	21

· For Sub-Centre area of PHC.

If the delivery case load is 30 or more per month. One of the two medical officers (MBBS) should be female. ^ To provide choices to the people wherever an AYUSH public facility is not available in the near vicinity.

There are also requirements for all the drugs as per the state/UT essentials list to be made available. There must be adequate transport facilities. There must also be laundry services with at least five sets of clean linen provided. Nutritious and well-balanced diet must be provided to all IPD patients. The “Guidelines for Health Care Workers for Waste Management and Infection Control in Primary Health Centres” must be followed.

CHCs

There is a mandate on CHCs to have two specialists -- an anesthetist and a Public Health Specialist -- in addition to specialists for surgery, medicine, obstetrics, gynecology and pediatrics. CHCs are required to provide OPD and IPD services (including Dental and AYUSH services), eye specialist services (at one for every five CHCs), emergency services, laboratory services, etc. The ANC, Intranatal care and PNC services required of CHCs is similar to that as required of PHCs. Women are required to stay in the CHC for 3-7 days of delivery in case of

complications, so that they can be managed. Essential and emergency obstetric care, including surgeries like C-Section, are essential as well as proficiency in identification and management of complications like PPH, Eclampsia, Sepsis, etc during PNC.

Newborns must be fully vaccinated and routine and emergency care of sick children must be undertaken. There must be prevention and management of routine childhood diseases, anemia, infections and malnutrition. National Health Programmes (NHPs) on communicable diseases, prevention and control of deafness, mental health, cancer, cardiovascular diseases and stroke, iodine deficiency disorders, etc, must also be implemented.

There must also be a blood storage facility and in addition to X-Ray and Lab facilities, ECG must be made available.

Manpower requirements at CHCs are as follows:

Personnel	Essential	Desirable	Qualifications	Remarks
Block Public Health Unit				
Block Medical Officer/Medical Superintendent	1		Senior specialist/ GDMO preferably with experience in Public Health/Trained in Professional Development Course (PDC)	Will be responsible for coordination of NHPs, management of ASHAs Training and other responsibilities under NRHM apart from overall administration/

				Management of CHC etc. He will be responsible for quality & protocols of service delivery being delivered in CHC.
Public Health Specialist	1		MD (PSM)/MD (CHA)/ MD Community Medicine or Post Graduation Degree with MBA/DPH/MPH	
Public Health Nurse (PHN) #	1	+1		
Specialty Services				
General Surgeon	1		MS/DNB, (General	

			Surgery)	
Physician	1		MD/DNB, (General Medicine)	
Obstetrician & Gynaecologist	1		DGO /MD/DNB	
Paediatrician	1		DCH/MD (Paediatrics)/ DNB	
Anaesthetist	1		MD (Anesthesia)/DNB/ DA/LSAS trained MO	Essential for utilization of the surgical specialities. They may be on contractual appointment or hiring of services from private sectors on per case basis
General Duty Officers				

Dental Surgeon	1		BDS	
General Duty Medical Officer	2		MBBS	
Medical Officer - AYUSH	1		Graduate in AYUSH	
Nurses and Paramedical				
Staff Nurse	10			
Pharmacist	1	+1		
Pharmacist – AYUSH	1			

Block Public Health Unit				
Block Medical Officer/Medical Superintendent	1		Senior most specialist/ GDMO preferably with experience in	Will be responsible for coordination of NHPs, management of ASHAs

			Public Health/Trained in Professional Development Course (PDC)	Training and other responsibilities under NRHM apart from overall administration/ Management of CHC etc. He will be responsible for quality & protocols of service delivery being delivered in CHC.
Public Health Specialist	1		MD (PSM)/MD (CHA)/ MD Community Medicine or Post Graduation Degree with MBA/DPH/MPH	

Public Health Nurse (PHN) #	1	+1		
Specialty Services				
General Surgeon	1		MS/DNB, (General Surgery)	
Physician	1		MD/DNB, (General Medicine)	
Obstetrician & Gynaecologist	1		DGO /MD/DNB	
Paediatrician	1		DCH/MD (Paediatrics)/ DNB	
Anaesthetist	1		MD (Anesthesia)/DNB/ DA/LSAS trained MO	Essential for utilization of the surgical specialities. They may be on contractual

				appointment or hiring
				of services from private sectors on per case basis
General Duty Officers				
Dental Surgeon	1		BDS	
General Duty Medical Officer	2		MBBS	
Medical Officer - AYUSH	1		Graduate in AYUSH	
Nurses and Paramedical				
Staff Nurse	10			
Pharmacist	1	+1		
Pharmacist AYUSH	– 1			

Note:

- If patient load increases, then number of General Duty Doctors may be increased.
- Funds would be provided for out-sourcing and providing support services as per need.
- One of nursing orderlies could be trained in CSSD procedures.
- Budget to be provided for outsourcing Class IV services like Mali, Aya, Peon, OPD Attendant, Security and Sanitary workers. * May be outsourced.
- Graduate or Diploma in Nursing and will be trained for 6 months in Public Health.

Note:

1. As a short term arrangement, MBBS doctors who have received short term training or having experience of at least two years in the particular speciality can be utilized against the speciality post. However, in such cases a specific order after posting such doctors must be issued.
2. One of the Class IV employees can be identified as a helper to Cold Chain & Vaccine Logistic Assistant and trained as Cold Chain Handler.
3. States shall as per provision under NRHM explore keeping part time/contractual staff wherever deficient. Outsourcing of services may be done as per State's policy.
4. One nursing staff/Lab technician may be trained for ECG.
5. One Ophthalmologist is recommended for 5 CHCs.
6. The Health Educator at PHC should work in coordination with block public health unit for organizing health education services.

The CHC must be located in the centre of the block as far as possible and must have sufficient electricity, water and must be easily accessible by all-weather roads. There must be proper disaster prevention measures and firefighting equipment. The OPD must be planned keeping in mind the maximum peak hour load with scope for further expansion. There must also be clinics for general medicine, general surgery, dental, obstetrics and gynecology, pediatrics and family welfare. There must be separate cubicles for general medicine and surgery, with all necessary facilities, sanitation and infrastructure for privacy. There must also be a waiting room, a pharmacy and an emergency room. Further, a treatment room is required with minor OT, injection and Dressing room and Observation Room. Separate Wards for males and females are also required with the patient area having enough space between beds, separate toilets for men and women and a separate space for patients needing isolation. There must also be an operation theatre/labor room with a newborn care corner. Apart from this, there must be a diagnostic zone with provisions for pathology, radiology, ultrasound, sample collection, etc.

For support services, there must be a Central Sterilization Supply Department and a laundry facility. Electricity/Telephones/water/civil engineering may be outsourced. Arrangements must be made for supply of 10,000 litres of potable water per day with storage capacity for 2 days. There must also be emergency lighting, a generator and minimum of two direct line telephones with intercom facility. There must be separate rooms for the administrative office and Stores.

With regards to residential quarters, there must be at least eight quarters for doctors, eight quarters for staff nurses/paramedical staff, a minimum of two quarters for ward boys and one quarter for driver. If accommodation cannot be provided due to any reasons, the staff may be given house rent allowance, but they must reside close to the CHC so they are available 24x7 on call.

Findings

Female District Hospital

The specialised Female (Mahila) District hospital of Balrampur is located within the proximity of 2 km from the town centre and covers a population of 22.5 lakh people. Being easily accessible, it is the most prominent health care facility for all women, including those pregnant and lactating. From the outside, the hospital looks barely satisfactory in terms of sanitation and hygiene with the sewer lines being visibly open, unclean pathways, and dirty waiting areas for patients.

There was however a promising knowledge of the various schemes and rights that pregnant and lactating woman were entitled to under the JSY and other schemes. This was made apparent through large signs and notices placed across the hospital.

We were able to get in touch with the CMS, Dr. Neena Varma who provided us with information regarding the operations of the hospital, functioning, personnel, etc. Alarming there were major deficiencies in the hospital. A common plight amongst all the hospitals in the Balrampur district was that there was no mode of conducting surgeries due to the lack of anesthetists as none have been appointed or posted to the district. Women would be referred to the next available hospital for surgery which is either Gonda (about 60 km away) or Lucknow (4 hour drive from Balrampur). The Mahila hospital was no exception.

The hospital was also extremely under-staffed. The doctors included three pediatricians, one gynecologist and the hospital superintendent who would perform multiples roles herself as a pediatrician and the keeper of accounts of the entire hospital and the monitoring of its operations as well. The staff nurses were a paltry sum of seven in total (four on a contractual basis) whereas the IPHS norms suggest at least a minimum of 75-100. As stated earlier, there is no anesthetist in the hospital, thus making the performance of C-sections impossible.

Though most of the equipment required for a district hospital were present, the required technicians to operate them were not. For example, there was an ultrasound machine but no sonologist to operate it.

The provision of ante-natal and neo-natal care is present from the provision of iron tablets for all anaemic women to free vaccination being provided to the infants after their birth. Both laundry

and dietary services are provided by the hospital to the pregnant and lactating women. However, there are complaints by the families stating that the food provided is insufficient in terms of required nutrition which is mostly just dal and rice/roti.

Ambulance services in the district are easily accessible and provided to all for free. Through interviews with the families, they contend that these services are merely free only on paper but would be required to pay a certain amount for the smooth transfer of the women to the hospital. They also state that though the services at the hospital are to be provided for free, corruption does exist in all areas.

For the admission of all women in the hospital, the responsibility lies with the ASHA workers in the district. We were able to interview them as well. And through the process were provided on the fact that for every woman brought to the hospital for delivery, an ASHA worker gets a commission of Rs. 500, which they believe to be unreasonable considering the work they are required to do. They must take care of the women throughout the term of pregnancy and should ensure that they obtain all entitlements as according to the various schemes in place. There is a recognised family planning doctor in the hospital. The post-partum intra-uterine contraceptive device (PPIUCD) services are at 39% but the target is set at 20%. Based on the reports, the number of tubectomies are still much higher than vasectomies.

The hospital has the capacity of only 30 beds in total which is comparatively far less than the IPHS guidelines.

Combined District Hospital

The combined district hospital functions in the capacity of serving both male and female patients in the district of Balrampur. Relatively new, and built in the year 2012; the combined hospital faces similar problems as that of the Mahila Hospital.

As the hospital is entrusted to cater to the total population of the district, it fails to meet several standards set in terms of the IPHS guidelines. At first sight, the hospital looks desolate and empty with no signs of activity. Much like any other government run hospital, the functioning of the centre is limited to very few hours in a day. When we had visited the hospital on Monday at about 4:30 pm, the doctors were already off-duty.

We were able to get in touch with the head nurse in the child-care unit who provided us with information on the functioning of the hospital. The schemes in place were being enforced (JSY, JSSK & PMMVY) but the facilities at the hospital were sub-par. The ward room and the labour room seemed under-furnished and unclean. The operation theatre was not in a working condition due to the lack of surgeons, though it was claimed that all the equipment was available. Through the hospital reports, we were able to identify that the majority of the women admitted were anaemic with a blood count of less than 9 (the normal level is 11), which was a major cause for malnourished nature of infants and complexions to both the mother and child during pregnancy.

The dietary standards were also not met as an in-house kitchen was unavailable and all food given to the patients was from the hotels outside. Facilities such as ultrasound scans were available without operation due to the lack of a trained sonologist.

Medical waste was being disposed of through the use of pits, in the campus of the hospital. Ambulance services were adequate and provided to all patients free of cost and at reasonable times of aid. Any cases of serious conditions were either directed to the Mahila hospital, or to the nearest district hospital with required facilities.

A common complaint amongst patients was that due to the ineptitude in the provision of services of the government hospitals, they are given no choice but to approach private hospitals to satisfy their requisite needs, which in fact ends up costing them more.

Primary Health Centre

The Jokaiya PHC was located about 10-15 km from the Mahila Hospital. As we had reached the centre in the wee hours of the day, the ward rooms were closed. But as it is the centre for 24x7 maternal health care assistance, the doctor on duty, as well as the head nurse, was available. Similar issues were raised including that of anaemia being omnipresent amongst most of the mothers in the village.

As they were a PHC, they were, limited to provide certain facilities and as such did not have an ultrasound machine and an operation theatre. Cases requiring these were referred to the closest district hospital for assistance.

The provision of iron folic tablets was done properly and for free, along with the approval and sanction of the schemes that pregnant and lactating women were entitled to. The vaccination room was also maintained quite well. However, the overall premise of the centre was shabby and unclean.

Ambulance services were provided largely free of cost to the majority of the population. The ASHA workers are responsible for bringing in pregnant women from their area to the hospital and taking care of them through the course of their pregnancy. In return, a commission is provided to the ASHA workers for their service (Rs. 500 for every referral to the hospital/centre).

Data relating to the number of births, no. of stillborn babies, and patients with anemia was also recorded. The roads leading to the PHC were highly inaccessible and it would be deemed impossible to travel during the night time as there were no lighting provisions throughout the area.

Community Health Centres

PACHPERWA

We had visited the Tulsipur Taluk which was about 30 km from the Balrampur *taluk* of Balrampur district. There, we were able to visit three CHCs functioning in the capacity of providing maternal healthcare for the women of the district.

The Pachperwa CHC was located about 5 km from the town centre of Tulsipur. The condition of the hospital was appalling. With waste disposed of hastily and shabbily, the hospital premise was a mess.

Inside the centre was no better. The toilets for the patients were in no way acceptable for any norm of hygiene as the water was clogged with fecal matter. The emergency and ward rooms were in a pathetic condition with torn beds and mattresses for the patients. We were able to find one pregnant woman lying outside the hospital as she claimed the rooms were claustrophobic without much air-circulation or sun-light. There was no ultrasound or pathology service provided by the Centre and thus patients had to obtain the same, from private parties on the outside.

The provision of schemes was positive as all the mothers were aware of their right and entitlements. The ambulance service was also operative at an efficient capacity. However, there was an evident lack of personnel to handle the hospital being largely understaffed.

Dietary provisions for the patients was also poor as there was no in-house kitchen available. All the food was to be ordered from nearby hotels. This would not guarantee safe and hygienic food being provided. Further, the disposal of bio-medical waste was a major concern.

Having interviewed the head nurse at the centre, she exclaimed that the pits designed for disposal of biomedical waste were built roughly above 10 feet from the ground water available to the district. She claimed that if there was to be a rise in the groundwater level due to rains, there would be a high chance of contamination of the drinking water available to the people as the medical waste would sync with the groundwater. This was a major concern. There was also no other agency or government body that was enabled for the collection and disposal of hospital waste. Evidently, there is also no sewer line throughout the entire district of Balrampur.

Apart from the bio-medical waste, general waste from the hospital was shabbily disposed throughout the premise including used syringes, blood stained clothes, etc. Cattle and other domesticated animals were found grazing over this waste.

GASEDI

The Gasedi Community Health Centre was roughly 10 km away from the one at Panchpadwa. Access to the CHC made the distance seem much longer as there were no proper roads laid to and from the centre.

Much like all the other centres and hospitals in Balrampur, Gasedy faced similar problems in terms of lack of personnel, improper disposal of bio-medical waste, lack of anesthetists, etc.

The hospital seemed active for a community centre with several patients flowing in and out. Compared to other hospitals, the centre recorded less number of stillborns and maternal deaths. We were also able to obtain data regarding the comparison of the number of home deliveries to that of institutional deliveries. It was recorded as at least twice as many of the former over the latter, which can be a primary reason for the high rate of infant mortality in the district. This would imply the same notion across all the hospitals in the districts, as the people are still reluctant to approach established health centres for aid due to an ever-present social stigma that has been deeply ingrained in the community.

There is no blood bank facility at the CHC, but other equipment are available without the requisite personnel to operate them (ultrasound, OT, etc.). The hospital premise is unhygienic and maintained very poorly.

The establishment seems like a half-done project as there is dirt throughout the building, bird nests in the hospital, shabby ward rooms, to name a few. Any serious cases requiring surgery must once again be transferred to the closest hospital with the adequate manpower and facilities, which is either Gonda (60 km) or Lucknow (4 hours away). Due to the large distance between hospitals, patients are forced to go to private centres to obtain facilities which are in fact supposed to be provided to them free of cost at government centres.

The disposal of biomedical waste is done through pits built for their storage. In terms of all other hospital waste, an agency works in the area for collection and disposal of the waste.

THULSIPUR

This was the third CHC during our visit to Balrampur, and the trip yielded results that were similar to the others we visited. Issues of inadequate personnel, lack of key medical facilities and improper disposal of bio-medical waste were rampant.

The hospital premises were not maintained and cleanliness was below par with animals grazing about the hospital area, both inside and outside. The road to the CHC was also substandard as no concrete pathway was made; just being mud roads throughout. The difficulty in commuting to and fro from the centre was thus a difficult task.

Ambulance services were however being provided. While engaging in a conversation with the head nurse, we had reiterated our observations regarding the anemic state of pregnant mothers and lactating women. To our surprise however, the nurse stated they had decided that the normal hemoglobin rate was 9 in the village, in contrast to the actual standard being 11. This was because women in the district are utterly unable to reach that mark. Even then, more than half the women had their levels below 9, which is appalling.

The dietary standards of the centre are not maintained as there is no in-house kitchen or laundry service meaning food was to be bought from the outside. The conditions of the medical rooms were also poor as they did not have personnel for its maintenance including sweepers, ward boys, etc. The women were however aware of their entitlements and benefits, according to the various government schemes.

Case Studies

Summary of the Findings

1. The hospitals are seriously understaffed. The entire district does not have a single anesthetist, no hospital offered ultrasound due to a lack of a sonologist, and the numbers general medical staff, nurses and support staff do not meet the IPHS Guidelines at all.
2. While iron and folic acid tablets are available at the Hospitals, many women are reluctant to take those, as they claim “not to feel sick” and therefore believe not to need the tablets, as they are not aware of its importance for the general health status, especially for pregnancies.
3. As a result, a lot of the women are anaemic, making the pregnancy dangerous for them and the child.
4. Some women are seriously underweight due to a lack of nutritional food.
5. The majority of women still preferred home deliveries as they do not seem to be aware about the importance and advantages of institutional deliveries. Further there are corruption by patients and ASHA workers towards the hospital administration, which might be another obstacle for pregnant women to opt for institutional delivery.
6. Neither of the health care facilities has a proper disposal mechanism for bio-medical waste. Instead, the waste is dumped on the hospital premises, sometimes even in the open. On several instances the team observed animals eating from the waste dumps. Therefore the risk of infection is enormous. Also there is the danger that, if the ground water level rises, the water will get contaminated by the waste.

Recommendations

1. Immediately hire at least one anesthetist and one sonographer in the district of Balrampur, to ensure that surgeries and ultrasound examination can be conducted in the district.
2. Raise the number of staff to the IPHS prescribed level as soon as possible.
3. Ensure proper implementation of all schemes promoting institutional delivery and raise awareness about the importance of nutritious food and IFA-Tablets among the pregnant women and lactating mothers.
4. Install incinerators or other equally effective measures for the disposal of bio-medical waste.
5. Ensure proper oversight over the facilities to prevent pollution of the premises and the environment.
6. Set up an investigative committee to look into the accusations of corruptions against the hospital personnel.