



# COMMUNITY MONITORING OF MATERNAL HEALTH

A Video Volunteers' Guide for Community Correspondents/Community Monitors



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## **INTRODUCTION**

Last year, 56,000 women in India died in childbirth. This is horrifying, because, given the state of health care today; no woman need die in childbirth. Nearly every single one of these deaths could have been prevented - had the women been getting the care they are entitled by law during their pregnancies through their Auxiliary Nurse Midwives; and by their doctors at the time of delivery. What changed because of all these deaths? Who went to jail? What new laws were passed? Which doctors were fired? What kind of a national emergency did the government declare regarding these deaths? Perhaps there were consequences in some of these cases, perhaps some people were held to account. From reading the news reports, you would never know. Because even when so many women die, none of them are a news story.

This is why we, as Community Correspondents, need to tell their stories; to help their families get justice. There is nothing we can do to bring the dead ones back but we can surely prevent more such cases from taking place. Because the key to preventing these deaths lies in our villages: it all starts by making our ANM's work better, by making sure the people in your village get the services they deserve, and this is something within our power as a CC.

### **What is maternal health?**

- It refers to the health of women during pregnancy, childbirth and the time immediately after the baby is born.
- Because women bear children, maternal health also includes things like women's education and financial situation, and things related to her empowerment in her family, like whether she makes decisions.
- Maternal health also includes child's health.

### **How serious is this issue?**

- Every ten minutes a woman dies in India from pregnancy and complications of child birth.
- 56,000 women die a year in childbirth.
- One in 70 Indian women who reach reproductive age may die during child birth or its related complications.
- India signed on to an important set of international guidelines called the Millennium Development Goal (MDG) in the year 2000, where it committed to cut the mortality rate a lot.
- **The MDG target is: less than 109 maternal deaths for every 100,000 deliveries.**
- In 2004-2006, 212 women died out of every 100,000. In 2010-2012, 178 women died out of every 100,000. We still have a long way to go.
- Sex ratio statistics – The country's sex ratio has shown some improvement in the last 10 years. It has gone up from 933 in 2001 to 940 in 2011 census of India.
- The Ministry of Health and Family Welfare and Ministry of Tribal Affairs are in the process of framing a bill jointly to look into tribal health. Among the conditions that it aims to focus on are maternal health, neonatal and infant health, and malnutrition. Such a bill will significantly impact health care systems in Odisha, MP, Chattisgarh, Jharkhand and West Bengal. This would be helpful as special attention would be paid to improving the poor health indicators of the tribal population.
- The government has launched an immunisation drive - Mission Indradhanush - to cover those children who are either unvaccinated or partially vaccinated by 2020 for 7 diseases- diphtheria, whooping cough, tetanus, polio, tuberculosis, measles and hepatitis

### **What are the phases of a woman's pregnancy?**

There are three phases of pregnancy and you could make videos on the challenges a woman would face in each of these phases

#### **Pre-conception Phase:**

- Women don't space their pregnancies enough. Women should wait at least 3-5 years between pregnancies. If they don't, they can face complications during child birth
- Often women get pregnant too young. If do get pregnant young, they can suffer from bleeding, eclampsia etc. Also, they are not mature enough to be able to assert themselves and take control of their body.

#### **Pregnancy (Pre-natal Phase)**

- Malnutrition. The cause of malnutrition is bad health services. Some conditions related to malnutrition are: Marasmus (wasting) and deficiency conditions like Osteoporosis (Calcium deficiency), Anaemia (Iron deficiency) and Goitre (Iodine deficiency), and prevalence of infectious diseases such as TB (Tuberculosis) and various sexually transmitted diseases (STDs like Syphilis and HIV) are some of the other conditions which pose difficulties to conception, in carrying pregnancies to term and in delivery.
- Failures of immunisation drives to vaccinate against some of the most commonly encountered diseases like Hepatitis, Tuberculosis and Rubella are yet another source of complications for maternal health. And are yet another area which could be avoided through better and more informed health care access and delivery.
- Sex Selective abortions and female infanticide
- Women are not allowed to make decisions about their own body- dietary restrictions, choice of health care providers etc

#### **Child Birth/ Delivery and Post Natal Phase.**

- Home Births: In some cases, women give birth at home in the absence of a trained medical professional. Even if there is a trained midwives, not always can they handle complications
- No Ambulances in many parts of the country
- Inadequate health staff results in women not getting the care they need. Providers stressed due to overburden of workload.
- Untouchability practiced by doctors and frontline workers
- Early Infections and and inadequate postnatal care especially after C sections
- Sterilisations: In about 40 lakh sterilisations that happen every year, men only account for 1 lakh of the total

### **What are some of the key challenges faced at the time of giving birth?**

Gaining medical access is one of the key challenges in India. The following issues may be focused on while monitoring the challenges:

- Do women have a say in where and under which conditions they are giving birth?
- Where are women giving birth: at home or in a hospital?
- Are hospitals/health care centres available nearby?
- How do women reach the location? e.g. Are ambulances available to take them to the hospital? What are the difficulties faced in reaching the hospital? How do they reach the hospital in the absence of ambulances? What are some of the commonly preferred methods?
- At the hospital, does the woman receive adequate medical attention and care? Are there clean beds available? Is the doctor(s) and nurse(s) available? Do they respond to the needs of the woman giving birth?

If for any of these questions, the answer is the absence or lack of such services and care, then investigate the reasons for the same through interviews and discussions with the people available.

### **Why do women die?**

Deaths are due to a number of factors which span the different phases of maternal health as well as different components of a woman's life. Some of them are:

- Infections due to non use a sterile kit during delivery
- Home Births without trained providers
- Post Partum Complications as a result of not seeking care from a trained provider
- Early Pregnancies
- Anemia
- Unsafe Abortions

## STRUCTURE OF GOVERNMENT HEALTH FACILITY

- A. *District Hospitals or General Hospitals*: are controlled by the state government and should have 100 to 300 beds.
- B. *Taluk Hospitals (Sub divisional/sub district)*: Taluk level hospitals are controlled by the state government and serves the people in respective taluks .
- C. *Community Health Centre CHCs*: Community Health Centres are available in basic health unit in the urban areas which has 30 to 50 beds and serves a population of 100,000 to 500,000 people.
- D. *Primary Health Centres*: The most basic units with the most basic facilities, and especially serving rural India. It is staffed by a medical officer or medical doctor, and generally serves a population of 30,000 to 50,000, with up to two beds
- E. *Sub-Centres* - First care centre that are staffed by Auxiliary Nurse Midwives (ANMs), and serve a population of approximately 5000 people. The ANM's work mostly with women, infants and children, and provide services to five or six villages in rural areas.

	<b>District Hospital</b>	<b>Sub Divisional Hospital</b>	<b>Community Health Centre</b>	<b>Primary Health Centre</b>	<b>Sub Centre</b>
How many Doctors?	29-50 depending on the number of beds	20-24	12	2	0
How many Nurses?	45-135	18-35	10	3	0
How many ANM/Asha?	0	0	0	0	1
How many Beds?	100-300	31-50/51-100	30	6	0
Any vaccination facilities?	Yes	Yes	Yes	Yes	No
Any surgical facilities?	Yes	Yes	Yes	No	No
What population or geographical area does it cover	32,000 to 30 lakhs	1,00,000 to 5,00,000	30,000 to 50,000	20,000 to 30,000	3000 to 5000
Who is head of facility and where do we file complaints if services are not in place?	Medical superintendent	Hospital superintendent	Block Medical Officer/Medical superintendent	Medical Officer	ANM

**Every pregnant woman has the following rights and entitlements during her pregnancy:**

- Free pregnancy testing using Nischay Kit with ANM at Sub Centre
- Free comprehensive abortion care at CHCs and District Hospitals
- Free ANC checkups (four) with ANM at sub centre which includes:
  - Blood screening for Blood Group, HIV (once) and Malaria
  - Urine, BP and Abdomen exam every ANC
  - Two TT (two for first pregnancy and one for others)
  - IFA (Iron Folic Acid) (100 tablets)
  - Tab Albendazole once
  - A birth preparedness plan to help the woman decide where she wants to deliver



## Anganwadi Centers

Anganwadi Centers were started by the Indian Government as part of the Integrated Child Development Services program to combat child hunger and malnutrition. **It is required to have one Anganwadi serve for every 1000 population**

### 1. What kind of nutritious food should be distributed and in what quantity?

**Children in the age group 6 months to 3 years:** are given Take Home Ration (THR) under the ICDS Scheme. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) which is often consumed by the entire family and not the child alone, THR should be given in the form that is palatable to the child instead of the entire family.

**Children in the age group 3 to 6 years:** are served Hot Cooked Meal in AWCs and mini-AWCs under the ICDS Scheme. Since the child of this age group is not capable of consuming a meal of 500 calories in one sitting, they are supposed to be served more than one meal if they come to AWCs. A morning snack in the form of milk/ banana/ egg/ seasonal fruits/ micronutrient fortified food is given etc.

**Pregnant women and Nursing mothers** should also be given meals that are 500 calories.

### 2. What vaccinations and medicines should be available in the Anganwadi Centre?

Six vaccinations to prevent the following should be available: -poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. Also simple medicines to prevent cough, cold and fever must be available.

### 3. Who is the head of Anganwadi and where can we file complaints if services are not in place?

The Anganwadi Worker is the head of the Anganwadi. If the services are not in place, one can file a complaint with the Mukhya Sevika who is the supervisor of the Anganwadi workers or higher up is the Child Development Project Officer CDPO.

**Role of Mukhya Sevika:** For every 10 Anganwadi workers, there is an Anganwadi Supervisor who is also known as Mukhya Sevika to provide on-the-job guidance,. Apart from the healthcare, nutrition and educational work, the following are the responsibilities of the Anganwadi Supervisor:

- Checks the list of beneficiaries from the low economic strata, who are severely malnourished
- Guides Anganwadi Workers in the assessment of correct ages of children, correct method of weighing the children, and plotting their weights on growth charts

- Demonstrates to the Anganwadi Workers the effective methods of providing health and nutrition education to mothers
- Maintains the statistics of the Anganwadi.

**Role of Asha worker: Accredited social health activists (ASHAs)** are community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM). She is selected from the village itself and trained to work as an interface between the community and the public health system. She functions with support from the Anganwadi Worker and other committees and her roles are:

- **Create awareness on** Health, Nutrition, basic sanitation, hygienic practices, healthy living and working conditions, information on existing health services and need for timely utilization of health, nutrition and family welfare services
- **Counseling** on Birth preparedness, importance of safe and institutional delivery, breast-feeding, immunization, contraception, prevention of RTI/STI. Nutrition and other health issues.
- **Mobilization:** Facilitate to access and avail the health services available in the public health system at Anganwadi Centers, Sub Center, PHC, CHC and district hospitals.
- **Village health plan:** Work with the village Health and sanitation Committee to develop the village health plan
- **Escorts/ Accompany:** the needy patients to the institution for care and treatment. She will accompany the woman in labor to the institution and promote institutional delivery
- **Provision of Primary Medical Health Care:** Minor ailments such as fever, first aid for minor injuries, diarrhea.
- **Inform** Births, deaths and unusual health problem or disease out break
- **Promote** Construction of household toilets

### **Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakaram (JSSK)**

**Background:** Both these schemes were launched under the National Rural Health Mission (NRHM). The objective of the schemes is to reduce maternal and neonatal deaths by providing free institutional care.

- These two schemes are available to all pregnant women who are 19 years and above, and belonging to the below poverty line (BPL) households
- JSY scheme is only applicable for up to two live births.
- Sick new born children for 30 days after their birth are eligible for JSSK scheme.

**Entitlements:** As a woman, you have rights! These are what they are under JSY and JSSK:

- 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

## Integrated Child Development Scheme

**Background:** This scheme runs to assist pregnant women, children between the age group of 0=6 years and nursing mothers. These services are provided at the village level through the Anganwadi workers who are associated with the Primary Health Centers (PHCs)

### **Entitlements:**

- Free health check ups (0=6 years)
- Antenatal care of expectant mothers and postnatal care of nursing mothers
- Recording of weight
- Immunization
- Supplementary nutrition for management of malnutrition
- Pre-school non-formal education
- Nutrition & health education
- Deworming

### **Solutions:**

If the above entitlements are not received then:

1. It should be informed to the Mukhya Sevika and the Village Health Sanitation and Nutrition Committee. The rationale for making these committees was for improving health awareness and access of community for health services. This committee also helps to address specific local needs and serve as a mechanism for community based planning and monitoring. In most places in India, these committees exist. If you come across a village/ area where it does not you can make a video exploring why.
2. Each Anganwadi should ideally have a 'Mata Samithi' where Anganwadi related issues can be discussed. This could be state specific. It exists in Jharkhand.
3. However, in reality most villages do not have such robust structures. So they will have to rely on reporting to Block officials - The Block Medical officer or the CDPO of that block/ district.

**Below are some of the kinds of problems you might find in the field. If you do it would be good to make a video on it:**

- 1) Irregular supply of iron folic acid (IFA) tabs
- 2) Lack of proper ambulance services to cater to the population due to which death of pregnant women takes place.
- 3) Services to be provided at ICDS centers lacking or incomplete. Full ANC not done especially abdomen check up, BP check up is not regular, weighing machines don't work properly.
- 4) Lack of facilities at PHCs and district hospital which forces the mothers to leave the hospital before the mandatory 48 hours of stay.

- 5) Absence of an ANM, nurses and doctors in facilities/ vacant posts
- 6) Lack of availability of essential medicines at the health centers.
- 7) Non functioning of Sub Centers, Primary Health Centers at the Community level.
- 8) Very poor governance and accountability as one of the main causes of the poor quality of health care
- 9) Indifference from professionals which results in services not being accessed by the target population
- 10) Absence of grievance redressal systems and Maternal/ infant death reviews
- 11) Corruption
- 12) Out of pocket expenditure
- 13) Inadequately trained staff
- 14) Unfriendly and even hostile environments
- 15) Check-ups that are often perfunctory and of poor clinical content
- 16) Poor inter-institutional arrangements for referral and care during complications
- 17) A lack of outreach and community awareness
- 18) Insufficient infection control measures

## CASE STORIES/EXAMPLES

This section of the manual will help you understand the kind of stories you may find in your field areas. These examples will also help you understand the various violations that a single story or case may have.

### **CASE STORY 1:** Early Marriage.

**Background:** Early marriage has been seen as a major problem affecting the health of women. Surveys show that 47% of women in the country were married by the age of 18. It is also known that women who have a pregnancy at a very young age face a high risk of morbidity and mortality.

**Story:** Mita is a 18 year old adivasi girl from Jharkhand who was married off early due to societal pressure. In her first pregnancy she had multiple problems - malaria, jaundice, swelling of feet and face, anaemia. Being an adivasi, and the ANM not visiting her part of the village she did not receive ANC. Her labour pains started at midnight and after visiting 3 facilities, Mita died of eclampsia.

**Gaps and Violations:** There are 2 violations that took place with Mita:

1. Inadequate ANC and access to care not available being her first pregnancy
2. No accountability during referral

**Tips to CC:** if you see the practice of early marriage or maternal deaths in their community in addition to ANC care not being available to certain parts of the community/ village, the following are the questions you should ask: Is early marriage very common in this village? Why does the ANM not provide ANC care in the ST hamlets? How long has this been happening for?

**Solutions:** Your Call to Action can be to the Village Health Sanitation and Nutrition Committee which should take action by writing to the Block Medical Officer BMO and demanding the ANM be dismissed for not doing her job. Also, the committee should motivate someone from the village to apply for the post and get trained.

**CASE STORY 2:** Village Health Sanitation Committees Initiative for delaying early marriage and first pregnancy.

**Background:** Apni Beti, Apna Dhan (ABAD), which translates to "My daughter, My wealth," is one of India's first conditional cash transfer programmes dedicated to delaying young marriages across the nation. "No other conditional cash transfer has this focus of delaying marriage. It's an incentive to encourage parents to value their daughters."

**Story:** Sabita Kumari, 16 years old lives in Hazaribagh District. She was in 10th standard when her mother arranged her marriage against her wishes as the family was facing economic difficulties and the groom's side had not demanded any money. As she was returning from school one day, she went to meet the Peer Educator of the village and shared her concerns. The peer educator reached out to Sahiya (the community mobilizer) and the VHSNC members (Village Health Sanitation and Nutrition Committee) and together, they organised a village level meeting. At the meeting, Sabita's mother was explained about the legal restriction of marrying girls below the age of 18 years and also discussed some of the problems which Sabita may face such as not being ready for marital role and responsibilities and for motherhood. Fearing legal repercussions, Sabita's mother changed her decision. To promote such a decision in the village, the VHSNC members pledged to contribute financially for Sabita's marriage once she reached legal age.

**Tips to CC:** If you come across such stories it will be good to make a "Success Video" and screen it back in other villages. This video will inspire communities to take similar positive actions which will help us achieve our goal of decreasing maternal mortality.

### **CASE STORY 3: Inability to make decisions regarding one's Bodies and Reproductive Health due to Patriarchal Norms & Gender Violence**

**Background:** Gender power inequalities between men and women are reflected in the roles the boys and girls are systematically taught to perform, their appearance and dress, activities and pastimes, behavior, emotions, responsibilities and intellectual pursuits.

**Story:** When Jhansi was 15, her parents arranged her marriage to Suresh, a 17-year-old boy. Suresh's mother began making Jhansi do all the housework - she had to cook, sweep, wash clothes and fetch water. She was not allowed to pursue her studies or work outside.

About 8 months after she got married, Jhansi became pregnant. One day, when Jhansi was returning home after fetching water, she met the Anganwadi worker. She asked her why she was looking so ill and weak. Jhansi told her about her pregnancy and said that she felt tired all the time. The Anganwadi worker gave her some Iron Folic Acid (IFA) to prevent Iron deficiency/ Anemia. When Suresh's mother found out that Jhansi had gone to the

Anganwadi Centre without her permission and started taking medicines, she was very angry and Suresh hit Jhansi.

**Gaps and Violations:** There are 2 violations that took place with Jhansi:

- 1) Not allowed to seek ANC care by her family members,
- 2) Gender violence in all forms; physical, psychological and emotional

**Tips to CC:** if you see situations such as the above you should ask the following questions to the community members. 1) What is the legal age of marriage? 2) Does early marriage happen in your community? 3) What about forcing a girl to get married when she doesn't want to, does that happen? 4) Are there differences in the way boys and girls are treated in this village with regards to work, diet, housework, marriage etc? 5) What are the factors influencing a woman's health? (*Answers: early marriage; early pregnancy, heavy workload, poor diet, not enough rest, lack of mobility & access to healthcare, lack of decision-making powers, myths about rest during pregnancy, domestic violence*)

In your closing P2C you should have answers to :

1. Is Jhansi's story the story of many girls in our society?
2. What does it tell us about women's place in society?

**Solutions:** Videos made on issues such as these should be shown to small groups of people within your community. It does not make sense to show this to any government officials. Also key stakeholders from the community can be brought together to discuss the matter so as to have consensus on the issue.

#### **CASE STORY 4: Out-of-pocket expenditure due to lack of facilities and personnel at the PHCs and District Hospital**

**Background:** Maternal health care services in public health facilities are supposed to be free, and with the launch of the Janani Sishu Suraksha Karyakram, free at the point-of-delivery services are guaranteed during pregnancy, delivery and post-partum period.

**Story:** Rita wanted to birth her child at the [PHC] but even a month after her due date she did not get any labor pain. So the PHC doctor asked her to go to [a tertiary care government hospital] in Bangalore. She went to Bangalore in a car hired by her family and was admitted there for 5 days. They gave her injections to induce pain and still did not have labour pain. The doctor said he may have to operate. After her family paid Rs. 20000 the provider conducted her



delivery. Rita's family spent a total of Rs. 70000 and now she is so fearful and wary that she says she will do her next birthing at home even if it took her life!

**Gaps and Violations:** There are 4 violations that took place with Rita:

1. Inadequate facilities and service providers at the District hospital to handle complications
2. No Free Ambulance services
3. No accountability during referral
4. Out of pocket expenditure for transport, health care, medicines and informal payments

**Tips to CC:** If you see that women are being referred to higher facilities for care due to complications or non availability of care in the area, the following are the questions you should ask the woman or her family: Was your planned choice of place for delivery different from actual and if yes, why? Why was the ambulance not available to transfer Rita from the PHC to the tertiary care hospital? Was a referral note sent with Rita that listed her history and complications? Was Rita contacted by the ANM after she returned home to make sure she received the appropriate postpartum care?

**Solutions:** If these violations have occurred then, the matter should be informed to the Village Health Sanitation and Nutrition Committee which each village is supposed to have. It is then upon this committee to enquire from the service provider and take the needed action. However, in reality most villages may not have such robust structures. If there is no VHSNC then your Call to Action should be to the Block Medical officer or the CDPO of that block/ district.

### **CASE STORY 5: Lack of facilities at PHCs and district hospital which forces mothers to leave the hospital before the mandatory 48 hours of stay**

**Background:** Since the majority of maternal deaths happen either during birth or in the first 24 hours after birth, it is important that after a normal delivery the mother and the baby are kept under a skilled attendant's observation for 24 to 48 hours. Advice on postpartum care for the woman and for the newborn is essential to the practice of good quality care, and rarely given.

**Case Study:** Meera lived in Bihar and belonged to a scheduled caste community. When Meera went into labour - she was taken to the PHC and had a normal delivery. The baby's birth weight was found to be low and after about 12 hours of treatment with oxygen, both Meera and her baby were discharged because there were no beds available in the PHC due to an increase in caseload. Once home, Meera developed fever - she was taken to the PHC

on the second day where she was given some medicines by the doctor and sent home. However, her condition kept worsening and a week later she died.

**Gaps and Violations:** 1. Meera was discharged before the stipulated 48 hours of stay especially in the case that her baby was Low Birth Weight (LBW, less than 2500 gms), 2. No advice about postpartum or newborn care was given.

**Tips to CC to document gaps:** If you observe that women are being discharged within 24 hours from a facility, the following are the questions you should ask: Was it your decision to get discharged before 24-48 hours? If not, why were you not kept in the facility for 48 hours of stay? Were there not enough beds or staff? Have you been asked to go back for a follow up visit or has the ANM been informed that you are back home?

**Solutions:** The Village Health Sanitation and Nutrition Committee which each village is supposed to have should inform the Block Level about the lack of beds in the PHCs and ask them to release funding for more beds or provide other options to solve this matter. In addition, compensation and the person accountable/ responsible for loss of life should be demanded by writing directly to the Medical Superintendent.

## **CASE STORY 6: Behaviour of frontline health workers and government hospital personnel.**

**Background:** Social support during birth is crucial for the physical and emotional needs of a woman. In most facility-based births in India women are not allowed a companion in the delivery room. The Yashodha Mamta programme, that is only operational in Madhya Pradesh, Odisha, Bihar and Rajasthan places a non-medical support worker in the hospital to provide labour support and counsel women on newborn care is an example of a programme that seeks to improve care and comfort to women during birth.

**Story:** Anjali started labour at midnight and went to the government hospital. There were two nurses there. Anjali's mother went to the nurse and asked if she could be with her daughter and they behaved disrespectfully simply ignoring her. Anjali was unable to bear the pain and the nurse slapped her cheeks saying can't you bear this little pain? Since they were not familiar with any other hospital and the nurse had made me very tired we stayed there and had the delivery done.

**Gaps and Violations:** 1. Lack of social support, 2. Disrespectful behaviour of frontline workers in the situation where they are the people we are supposed to trust

**Tips to CC to document gaps:** You will only come across situations like these if you talk to members of the community in whose homes deliveries have happened. When you see situations like these the questions that can be asked are: Why was there not a Yashoda

present for emotional support if you are in MP, Bihar, Orissa or Rajasthan? What are the emotions you felt when you were being treated this way?

**Solutions:** If these violations have occurred then, the rude and almost irresponsible behaviour should be informed to the Village Health Sanitation and Nutrition Committee. The matter should be addressed in a manner where the nurses are questioned about why they behaved so badly and a warning must be given. If the VHSNC is absent in that village your Call to Action should be to the Block Medical Officer or the CPDO of that district and you should ask for the suspension of the Yashoda worker.

### **CASE STORY 7: Services at ICDS centers to improve.**

**Background:** ICDS (Integrated Child Development Scheme) covers free health check ups and health care of children less than six years of age as well as antenatal care of expectant mothers and postnatal care of nursing mothers. Typically full pre delivery check ups are not done especially abdomen check up. Blood pressure check up is not done regularly and often weighing machines don't work properly.

**Story:** Geeta, a 21 year old adivasi woman in Chhattisgarh. Her family had been resettled because her village was in an area declared a tiger reserve. The resettlement village was 10 km away from the road and was inaccessible during the rains. There was a small ICDS centre in the village, the ANM did not visit there every day but visits only a few days a month and immunization was not regular. Geeta, pregnant with her first child, did not therefore have complete antenatal care.

**Gaps and Violations:** 1. ICDS semi functional and absence of ANM/ AWW, 2. Due to irregularity of staff, ANC irregular and sometimes completely absent, 3. Weighing machine and BP machine not working properly, 4) No Birth preparedness plan made in addition to counselling the woman and her family for place of delivery

**Tips to CC to document gaps:** If you see that women are not getting proper and needed care from the ICDS Center, the following are the questions you should ask: When was the last time the ICDS center was fully operational? Is the Anganwadi Worker/ ANM from this village? What are the reasons that nobody has taken this issue up with anybody for finding solutions? Is there a trained health care provider in this village- say midwife (Dai)? Is there anyone in this community who can be trained to fill the post?

**Solutions:** If these violations occur then maybe one can think about training someone from the community to run the Anganwadi center so that services can be given to the

people. Also from the cash pool that is with the VHSNC, the BP and weighing machine can be repaired.

### **CASE STORY 8: Sex selective abortion**

**Background:** It is estimated that around 1 crore female foetuses may have been aborted in India over the last two decades. Although prenatal sex detection and sex-selective abortion is illegal, the law is not being fully enforced. Doctors, nurses and other medical practitioners are routinely violating the ban, performing abortions of female foetuses and benefiting financially.

**Story:** Renu 25, and her husband are an educated couple. Renu already had a daughter when she became pregnant for the second time. She had an abortion after an ultrasound scan indicated the foetus was female. She later went on to have a son.

**Gaps and Violations:** The Prenatal Diagnostic Techniques Act and the Medical Termination of Pregnancy Act which prohibits sex-selective abortions are not being enforced and are instead routinely violated.

**Tips to document Gaps:** If you see more boys than girls in a village or you come to know of any abortion cases, you should follow this line of questioning: How come there are not many girls in this village? Are there any providers who perform abortion in the area? Which facilities do ultrasounds?

**Solutions:** Report these violations to the Block/ District level authorities in addition to the VHSNC. The providers carrying out these illegal activities of aborting female foetuses can be sent to jail and be given punishment. Also it is important to raise awareness of the impact of sex-selective abortions and neglect of girls through your videos.

### **CASE STORY 9: Sterilisation**

**Background:** State governments frequently organise mass sterilisation camps under a national programme whereby women are given Rs. 1,000 rupees and men Rs. 2,000 as an incentive to undergo the procedure. Government figures show 1,434 sterilisation deaths between 2003 and 2012, with 2009 being the worst year with 247 deaths. On an average, 12 deaths occurred every month over the last 10 years.

**Case Study:** About 83 women underwent a sterilisation procedure as part of an annual family planning camp. Even though this was a government run camp, they were sterilised

in the operation theatre of a private hospital, which was not yet fully functional. The operation theatre had not been used for the past four months.

**Gaps and Violations:** 1) Too many surgeries performed in one day to meet targets, 2) Negligence of doctors, 3) Quality of the medicines at the camp, standard of the surgery, post operative measures and others

**Tips to CC to document Gaps:** If you come across camps such as these or of failed sterilisation procedures, you have to ask: Were there enough providers at the camp? Was the procedure given enough time or was the provider in a rush? Were hygienic conditions maintained? Did you have enough time and space to recover after the procedure? Did your husband opt for the procedure or did you volunteer?

**Solutions:** Demanding “Strict action” against the guilty doctors and anyone involved. Your Call to Action will be to the medical Superintendent. It will be a good idea to interview the Medical Superintendent to get his answers and commitment to action.

### **CASE STORY 10: Lack of proper ambulance services**

**Background:** In addition to 108, a National Ambulance Service has been launched which has empanelled 4769 vehicles in some of the states. You should find out if this service exists in your state. These ambulances hope to provide timely transportation to pregnant women at the time of delivery and during emergencies.

**Case Study:** Neeta got her labour pains two weeks before her expected date and needed to be rushed to the hospital. The Mamta Vahan was called, but it took 6 hours to arrive. Once it arrived, the driver demanded money to take the woman. Neeta delivered her baby in the ambulance while she was on her way to the hospital.

**Gaps and Violations:** Delay in Mamta vahan/ambulance and demand for money

**Tips to CC to document gaps:** Why did the emergency transport/ ambulance take so long to come? Have there been other cases where the driver/ attendant of the ambulance have demanded money?

**Solutions:** The VHSNC along with members of the community must demand answers about the ambulance driver’s corrupt behaviour from the Block Medical Officer etc. In addition, if these problems have been faced often, the village should organise a vehicle that could take women in labour to a facility without delay.

### **Call to Action for Advocacy Campaigns:**

The following are some of the demands being made by health activists and NGOs to improve the situation of maternal health. When you make your issue video, see if you can incorporate any of these to support this larger advocacy purpose.

- Emergency transport services must be free of cost and arrive within the stipulated period of 30 minutes on receiving a call
- Fill Vacant posts across facilities (Sub Centre, PHC, CHC etc)
- Improvement of ANC and PNC Care (both in the facility and at the community level)
- Grievance redress mechanisms should be established. These need to be clearly communicated to families so that they have a forum to complain and get their complaints satisfactorily addressed.
- Medical records have to be maintained by all health institutions.

Mandatory Community Monitoring of health services is one of the demands made by the NGOs and experts working in the field of maternal health. Video Volunteers fully supports this demand. In fact, our work is exactly that! When you are out making videos that expose inefficient or inadequate health services and show the videos to the relevant government officials, we are in effect doing Community Monitoring. Community Monitoring using video.

The more we monitor health services and programs we are entitled to, the better our health services will become. This is one crucial way to prevent maternal deaths in our communities.

## FACT SHEET | BIHAR

The Total Fertility Rate of Bihar is 3.7. The Infant Mortality Rate is 44 and Maternal Mortality Ratio is 261 (SRS 2007 - 2009) which are higher than the National average. The Sex Ratio in the State is 916 (as compared to 914 for the country).

Indicator	Bihar	India
Maternal Mortality Rate (SRS 2007-09)	261	212

### Health Infrastructure of Bihar

Particulars	Required	In position	Shortfall
Sub-centre	18533	9696	8837
Primary Health Centre	3083	1863	1220
Community Health Centre	770	70	700
Health worker (Female)/ANM at Sub Centres & PHCs	11559	16943	*
Health Worker (Male) at Sub Centres	9696	1074	8622
Health Assistant (Female)/LHV at PHCs	1863	358	1505
Health Assistant (Male) at PHCs	1863	556	1307
Doctor at PHCs	1863	3532	*
*Obstetricians & Gynecologists at CHCs	70	39	31
Pediatricians at CHCs	70	43	27
Total specialists at CHCs	280	151	129
Radiographers at CHCs	70	13	57

<b>Pharmacist at PHCs &amp; CHCs</b>	<b>1933</b>	<b>439</b>	<b>1494</b>
<b>Laboratory Technicians at PHCs &amp; CHCs</b>	<b>1933</b>	<b>498</b>	<b>1435</b>
<b>Nursing Staff at PHCs &amp; CHCs</b>	<b>2353</b>	<b>1736</b>	<b>617</b>

**(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)**



## FACT SHEET | JHARKHAND

The Total Fertility Rate of the State is 3. The Infant Mortality Rate is 42 and Maternal Mortality Ratio is 261 (SRS 2007 - 2009) which are higher than the National average. The Sex Ratio in the State is 947 (as compared to 940 for the country).

Indicator	Jharkhand	India
Maternal Mortality Rate (SRS 2007-09)	261	212

### Health Infrastructure of Jharkhand

Particulars	Required	In position	Shortfall
Sub-centre	6043	3958	2085
Primary Health Centre	964	330	634
Community Health Centre	241	188	53
Health worker (Female)/ANM at Sub Centres & PHCs	4288	6574	*
Health Worker (Male) at Sub Centres	3958	957	3001
Health Assistant (Female)/LHV at PHCs	330	70	260
Health Assistant (Male) at PHCs	330	30	300
Doctor at PHCs	330	407	*
Obstetricians & Gynecologists at CHCs	188	30	26
Pediatricians at CHCs	188	16	172
Total specialists at CHCs	752	86	666

Radiographers at CHCs	188	58	130
Pharmacist at PHCs & CHCs	518	298	220
Laboratory Technicians at PHCs & CHCs	518	371	147
Nursing Staff at PHCs & CHCs	1646	976	774

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

## FACT SHEET | CHHATTISGARH

The Total Fertility Rate of the State is 3.0. The Infant Mortality Rate is 48 and Maternal Mortality Ratio is 335 (SRS 2004 - 2006) which are higher than the National average. The Sex Ratio in the State is 989 (as compared to 933 for the country). Comparative figures of major health and demographic indicators are as follows

Indicator	Chhattisgarh	India
Maternal Mortality Rate (SRS 2007-09)	269	212

### Health Infrastructure of Chhattisgarh

Particulars	Required	In position	Shortfall
Sub-centre	4904	5111	*
Primary Health Centre	776	755	21
Community Health Centre	194	149	45
Health worker (Female)/ANM at Sub Centres & PHCs	5866	16943	*
Health Worker (Male) at Sub Centres	5111	2514	2597
Health Assistant (Female)/LHV at PHCs	755	749	6
Health Assistant (Male) at PHCs	755	153	602
Doctor at PHCs	755	435	302
Obstetricians & Gynecologists at CHCs	149	18	131

Pediatricians at CHCs	149	19	130
Total Specialists at CHCs	596	71	525
Radiographers at CHCs	149	87	62
Pharmacist at PHCs & CHCs	904	611	293
Laboratory Technicians at PHCs & CHCs	904	444	460
Nursing Staff at PHCs & CHCs	1798	552	1246

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI) **State Profile -Odisha**

## FACT SHEET | ODHISA

The Total Fertility Rate of the State is 2.3. The Infant Mortality Rate is 61 and Maternal Mortality Ratio is 258 (SRS 2007 - 2009) which are higher than the National average. The Sex Ratio in the State is 978 (as compared to 940 for the country).

Item	Orissa	India
Maternal Mortality Rate (SRS 2007-09)	258	212

### Health Infrastructure of Odisha

Particulars	Required	In position	Shortfall
Sub-centre	8136	6688	1448
Primary Health Centre	1308	1226	82
Community Health Centre	327	377	*
Health worker (Female)/ANM at Sub Centres & PHCs	7914	8211	*
Health Worker (Male) at Sub Centres	6688	3827	2861
Health Assistant (Female)/LHV at PHCs	1226	629	597
Health Assistant (Male) at PHCs	1226	0	1226
Doctor at PHCs	1226	1069	157
Obstetricians & Gynecologists at CHCs	377	152	225
Pediatricians at CHCs	377	76	301
Total specialists at CHCs	1508	317	1191

<b>Radiographers at CHCs</b>	<b>377</b>	<b>55</b>	<b>322</b>
<b>Pharmacist at PHCs &amp; CHCs</b>	<b>1603</b>	<b>1515</b>	<b>88</b>
<b>Laboratory Technicians at PHCs &amp; CHCs</b>	<b>1603</b>	<b>371</b>	<b>1232</b>
<b>Nursing Staff at PHCs &amp; CHCs</b>	<b>3865</b>	<b>867</b>	<b>2998</b>

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)