“आखिरी छोर तक लाभ नहीं”
कार्यशाला में सरकारी स्वास्थ्य योजनाओं की जिमीनी हकीकत की साझा
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State Level
PUBLIC HEALTH DIALOGUE

Maternal Health and Health Rights in Madhya Pradesh

19 February 2014
Gandhi Bhavan, Bhopal (MP)

Hosted by
Maternal Health Rights Campaign- Madhya Pradesh

With Support from
Centre for Health and Social Justice, Delhi
CHSJ acknowledges the support of SATHI and SOCHARA and other member organizations of the Maternal Health Rights Campaign for contributing to the state level public health dialogue.
List of Acronyms

NRHM: NATIONAL RURAL HEALTH MISSION

CHSJ: CENTRE FOR HEALTH AND SOCIAL JUSTICE

SATHI: SUPPORT FOR ADVOCACY AND TRAINING OF HEALTH INITIATIVES

SOCHARA: SOCIETY FOR COMMUNITY HEALTH AWARENESS RESEARCH AND ACTION CBM-COMMUNITY BASED MONITORING

JSY: JANANI SURAKSHA YOJNA

JSSK: JANANI SHISHU SURAKSHA YOJNA

ANC &PNC: ANTE NATAL CARE & POST NATAL CARE

ANM: AUXILIARY NURSE MIDWIFE

JSA: JAN SWASTHYA ABHIYAN

MHRC: MATERNAL HEALTH RIGHTS CAMPAIGN

CHC: COMMUNITY HEALTH CENTRE

PHC: PRIMARY HEALTH CENTRE

VHND: VILLAGE HEALTH NUTRITION DAY

MO: MEDICAL OFFICER

RKS: ROGI KALYAN SAMITI

CBO: COMMUNITY BASED ORGANIZATION

NGO: NON GOVERNMENT ORGANIZATION

BMO: BLOCK MEDICAL OFFICER
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BACKGROUND AND CONTEXT

Community monitoring of health services started as a pilot project in Madhya Pradesh during 2008-09 under National Rural Health Mission (NRHM). During the pilot phase of community monitoring in NRHM, which took place across nine states including MP, organizations like CHSJ, SATHI and SOCHARA had played a greater role in facilitating the process of Community Monitoring (CM). Later the support and interest of the state government in the community monitoring process started declining in MP, though some civil society organizations continued the process in a few pockets including Badwani district.

The continued neglect of health services was being experienced in MP and the civil society groups, especially those with the leadership of some leading advocacy and policy were concerned about the deteriorating situation of health services in the state. Even with a strong health policy in place, the maternal health outcomes had remained elusive in the state. This dismal situation of the health services provided impetus to the civil society groups in continuing the monitoring of health services activities in their concern areas and carry out a collaborative advocacy on maternal health rights building upon earlier evidences around poor quality of care of maternal health services. Not funded by any donor agency or by the state government, the civil societies group initiated the process of autonomous community monitoring forward purely on a voluntary and collaborative basis, which led to the initiation of maternal health rights campaign and the immediate context now was the issue of maternal health rights.

To strengthen these CBM processes, a State health community enquiry data sharing and advocacy planning meeting was held during October 18-19, 2013 in Bhopal which helped in sharing the community monitoring data report and taking the advocacy plan forward. The data generated through the community monitoring processes on the overall state of maternal health services revealed:

- About 66% respondents only reportedly received JSY benefits.
- The state of JSSK and ANC services was found to be bad.
- It was reported that the services been provided under JSY and JSSK focused primarily on the monetary benefits.
• The qualitative component was lacking and the services like weight and height measurement, regular blood pressure recordings, blood, urine and abdominal examinations were not being adequately provided.
• Women had to pay informal fees for services that otherwise should have been available for free- ambulance services for transport, medicinal support during hospital stay and food.
• The provision of ANC services was also graded as poor in most of the districts.
• It was also reported that though ANM’s was visiting the villages, but their services were restricted to administering immunization only.

Based on the findings and data sharing the regional action plans and strategies were planned and strategies for preparation of action plans to be implemented at the block, district and state level were also deliberated.

**Some of the important points that emerged in the planning discussion are as follows:**

• Dialogues can be initiated at the block and district levels so that there is more clarity on how to take the campaign further. Several issues have already been identified in various districts; more information needs to be collected on it to further strengthen these findings.

• For effective support and monitoring it is important that the community is made aware about their rights and the condition they face due to lack of these. When this awareness is created then only they can effectively fight for claiming them.

• It is important to hold a dialogue with block and district level officials at the village level to identify issues. The officials should understand these issues and identify with them and take these forward to the state level. Advocacy is a challenging proposition and requires everybody’s cooperation.

• More than 150 committees have been formed primarily to ensure that the services and rights reach everyone adequately. However, most of them are non-functional. Requisite steps need to be taken to activate these committees at the Panchayat level.

• The community leaders of areas from where this data has been collected can be invited for a public dialogue along with representatives from Panchayati Raj Institutions (PRIs),
and the local people can be asked to take accountability. In view of the upcoming elections they can be asked as to what they plan to do if they come into power. They can be asked to sign a Shapathpatra or Ghoshnapatra. In addition, media can be effectively involved to highlight the specific issues.

- If public dialogues or meetings are not possible at present, the data collected so far can be strengthened by working with the community and collecting facts and statistics.

- If the CSOs come up as an alliance rather than working as individual organization, the campaign will be stronger. There can be a platform like the Janswasthyaabhiyan (JSA), for maternal and women’s health, where demands at the policy level can be listed down and evidence to support deficiencies in service delivery can be put forth.

- It is important that the platform defines its aims and limitations, issues that it will work on, in which districts it will be implemented directly, the challenges that could be faced and the strategies to overcome them.

One of the outcomes that emerged from all the action plans was that the movement should be given a name and hence it was called the Maternal Health Rights Campaign (MHRC). Besides this different tasks, teams and committees were decided upon, the details of which are outlined below:

- **Name of the movement**- Maternal Health Right Campaign (MHRC)
- **State coordination committee**- To comprise of Devender Singh (DHARTI), Ajay Shukla (Kalptaru), ArunTyagi (G.S.S.), Shushil Kumar (HARD), Savitari Singh (Ahsas), Prarthana (Sangini), Simariti (Shathiya), Manjiri (Pararth), Mahendra (CHSJ), Rakesh (SATHI)
- **Regional Coordinators**-Devender Singh (Chambal), ArunTyagi (Rewanchal), Prarthana (Bhopal)
- **Convening Team**- Prarthana (Sangini), Rakesh (SATHI), Mahendra (CHSJ)

It was decided to prepare a declaration note and an affidavit and it would be shared with the candidates to take the action plans forward
**Monitoring Process-2013**

After the action plan was drawn for MHRC, different monitoring processes were carried out in 2013, which included a range of components on how to proceed with the ongoing community mobilization, how strengthening of the civil society coalition should proceed, besides organizing state level consultations and carry on tasks of capacity building of the community based organizations. In addition, the monitoring process also focused on how the data should be gathered and aimed at the development and finalization of tools apart from preparing reports on it as well sharing it on the state level basis. Within the monitoring process the element of follow-up action was also charted which laid directions for sharing of data with the community as well officials in the health service system and for the interface of the community with the health service system in form of the public health dialogue.

**Components of Monitoring Process:**

1. Ongoing community mobilization
2. Civil Society Coalition Building
3. State Level Consultation
4. Development and Finalization of Tools
5. Capacity Building of Community Based Organizations
6. Data Collection
7. Data Compilation and Report
8. State Level Data Sharing with the Civil Society Organizations
9. Follow up Action:
   a. Data Sharing and Discussion with the Community
   b. District Level Submission of Memoranda and Share the Information with the Officials
   c. State Level Jansamvad (Public Dialogue)
The community monitoring process carried out in 2013 has been described below in detail:

1. **Ongoing Community Mobilization, Meetings with the Community:** Subsequent to the formally piloted community monitoring and planning of health services under NRHM during 2008-09, number of civil society organisations in Madhya Pradesh which are working with communities have continued working on accountability and health services. The continued engagement with the officials and health service providers have fore grounded many community issues especially issues of health services.

2. **Civil Society Coalition Building:** The civil society coalition in Madhya Pradesh took place through number of collaborative processes in which a number of organizations have been participating. Some of these are Responsible Fathercare Campaign, Men’s Action for Equity Jan Swasthya Abhiyan, Jagruth Dalit Adivasi Sanghatan (JADS) which has been facilitating accountability processes in health, Centre for Health and Social Justice (CHSJ) facilitated processes in 13 districts of Madhya Pradesh and intensive processes of health accountability in the districts of Morena and Sidhi. As maternal health services are a common concern, the idea of community monitoring as a tool was promoted as a strategy to engage with the public health system.

3. **State Level Consultation:**

SATHI in collaboration with CHSJ organized a state level consultation on March 20, 2013 at Bhopal and held a discussion with CSOs on health situation in Madhya Pradesh. The focus was on maternal health services which are being offered in different districts of Madhya Pradesh. The information was also shared which was collected with the help of *Jaankaari Prapatra* formats given in the meeting in February. 27 representatives from 16 districts participated in this consultation. Based on the discussions it was decided to undertake a community monitoring process to assess the situation of programmes and health services related to maternal health in 20 districts of Madhya Pradesh. During this discussion it was also decided to share the findings of this process with stakeholders and government officials through dialogue and collectively advocate for bringing about improvement in the quality of community health services.
Key Issues for Focus in Community Monitoring

- Janani Suraksha Yojana
- Janani Shishu Suraksha Karyakram
- Health services available under the Village Health and Nutrition Day (VHND)
- Condition of Rogi Kalyan Samiti
- Service delivery in health institutions

In the consultation process discussion was facilitated on various tools and formats to be developed for data collection. SATHI took up the responsibility for preparing formats for the community monitoring process. A plan of action was prepared for the monitoring process and the organisations were divided into three regions for the purpose of data collection. The need for capacity building of the organisations and need of volunteers was also emphasized. Some of the organizations CHSJ, SATHI, SOCHARA and Sangini Resource Centre took the responsibility to coordinate the processes further.

4. Development and Finalization of Tools

The tools that were discussed at the workshop were further developed for collecting data during the community monitoring process. A description of the tools used is as follows:

- Guide to record the information of the group discussion with women from marginalised communities
- Interview guide for interviewing pregnant women
- Interview guide with lactating women whose delivery occurred in government institutions in last 3 months
- Check list for observations of village health and nutrition day
- Format for interview with patients at the CHC and PHC level
- Format for interview of the medical officer at the level of CHC and PHC

The questions being asked during interview and group discussion was also developed in a pictorial format, so that respondents could easily understand and can easily reply
**Capacity Building of Community Based Organizations:**

Two day training on community monitoring tools and process for maternal health rights was undertaken in the three regions, viz. Rewanchal, Bhopal and Chambal. In each of these regions capacity building workshops were organized for the volunteers for data collection in different regions. The objectives of this workshop were:

a. To develop participants’ understanding on community monitoring (what and why)

b. To develop understanding on how to work on the grass roots level (tools, process, information collection)

c. To develop understanding in relation to health services (programmes, sub-centre, CHC, PHC)

d. To prepare action plans with organizations to take forward the community monitoring process (number of villages, PHC etc.)

The organization representatives were familiarised with the methods of data collection, were provided information on the various schemes of community health services (JSY, JSSK, and VHND), issues of community monitoring pertaining to JSY, JSSK, VHND and were provided an understanding on tools and formats for information collection and compilation of information and report card preparation. 19 organisations in 17 districts came forward to do the community monitoring processes and participated in the capacity building programme.

**5. Data Collection:** The community enquiry process was held from May 2013 to September 2013. Volunteers from various civil society organizations collected data from 102 villages. The districts and villages were selected purposively depending on the work areas of various organizations.

**6. Data Compilation and Reports:** The data collected was compiled by SATHI and district wise analysis of the data was prepared. The primary aim of discussing the findings emerging from the data collected was to identify issues for advocacy and prepare an action plan to be undertaken in different districts. The figure below shows a distribution of the districts and the numbers indicate the villages covered in each of these districts for data.
Figure 1: Districts of Madhya Pradesh from which data was collected for community monitoring process

The figure above outlines the 12 districts from which the data was collected for the community monitoring process which includes Anuppur, Ashokanagar, Bhind, Bhopal Chindwara, Hoshangabad, Sagar Satna, Sehore, Shivpuri, Shadol and Vidihsa.

The data collected from the different districts is enumerated below:

- Information sheet (Jaankariprapatra), which focused on the health services available at the village level and get an understanding of the services that are being offered in these districts. This was filled in 112 villages through group discussions with the people.

- Observation checklist and format for nurse’s interview to assess the type of services being provided under village health and nutrition day (VHND). These were filled by interviewing 92 respondents

- 224 women were interviewed for Jananishi Shishu Suraksha Karyakram (JSSK) and 212 women were interviewed for Janani Suraksha Yojna (JSY).
7. State Level Data Sharing with the Civil Society Organizations

Presentation of the Data & Report

From various districts of Madhya Pradesh data was collected for the following services:

- District wise analysis of Village level Maternal Health services
  - Group discussion (services by ANM, maternal health services and child immunization)
  - Interviews with women (JSY, JSSK, ANC)

- Health services provided in VHND
  - Observation
  - Interview of ANM

- Quality of health services in Health institutions, i.e., in primary health center (PHC) and community health center (CHC)
  - Exit Interview

- Functioning of Rogi Kalyan Samiti (RKS)
  - Observation and interview of MO

However, in the presentation only village level health services and health services provided under VHND were discussed as the data pertaining to quality of health services in health institutions and functioning of RKS did not reveal any significant findings.

8. Follow up Action:

a. Data sharing and discussion with the community

b. District level submission of memorandum and share information with the officials

c. State level Jansamvad
SECTION -II

This section provides a brief summary of the Community Monitoring data and situation of the Maternal Health Rights in Madhya Pradesh Data from 12 districts which was collected under the CBM process across 110 villages from February-September, 2013. The details of the analysis are given below.

Observations made in 92 villages on the status of services being provided under Village Health and Nutrition Day (VHND) and interviews with 112 pregnant women on antenatal care (ANC) services revealed:

- 46% of places do not have blood testing kits
- 82% centers do not conduct height measurements.
- Non availability of essential injections such as TT for pregnant women (82%), BCG (39%), and supplements of iron (12%), calcium (25%), zinc (65%), albendazole (40%) and ORS (13%).

Figure 2: Medicine availability in VHND
Interviews conducted with 215 pregnant women highlighted

- 36% women reported that blood pressure measurements were not being taken
- 24% women were not weighed even once
- 50% reported weight measurements are conducted on 1-2 occasions.
- For 40% women reported abdominal examination was not done, and 39% said that their abdominal examination was conducted only 1-2 times during pregnancy

**Figure 1: Free Services under JSSK Programme**

Interviews conducted with 208 women who are eligible under the JananiSurakshaYojana,

- 14% women did not receive any cheque
- 19% of those women who received the cheque reported that they paid money to get the cheques
The feedback from women on the ambulance services delineated that 36% women had to spend money for commuting to the hospital from their homes, while 75% bore expenses for travelling from hospitals to their homes. Similarly, 19% women had to pay for hospital admissions, 69% reported not receiving free check-up in hospital, 51% had to give money as donation to hospital staff at the time of delivery, 32% did not receive medicines and 37% reported not receiving food during hospital stay.
SECTION-III

Maternal Health Rights Campaign: District and State Jansamvads

With a view to strengthen the community interface with the public health service system, as well initiate a space for community voice over the demand of community for better health services, series of public health hearings (Jansamvads) were held at the district and state levels under the MHRC domain after gathering the data and the community perspective on the maternal health services through the community monitoring process. This section details out the processes, organizations involved, strength of people and officials present at the public hearings, memorandums submitted to the health authorities for better health services and findings of the district and the state level Jansamvads, carried out in Sehore, Chhindwara, Anuppur and Satna districts respectively besides the state level dialogue carried out in Bhopal.

Introduction

Maternal health refers to the health of women during pregnancy, child birth and the post partum period (41 days after delivery). While motherhood is often a positive and fulfilling experience for every woman, but for many it is associated with suffering, ill-health and even death. Maternal health also encompasses the health care dimensions of a country and state as well. According to the Annual Health Survey 2011-12; the Maternal Mortality Ratio (MMR) of Madhya Pradesh is 277. This shows the grim reality of maternal health status of the state. Seeking better maternal health status, a Maternal Health Rights Campaign is being carried out in 17 districts of Madhya Pradesh in which many grassroots organizations and CBOs are participating. In this campaign a survey was conducted to assess the ground realities of health and nutrition services like village health and nutrition day (VHND), availability of equipments and services at village level-immunization, antenatal & post-natal care (ANC & PNC), Janani Shishu Suraksha Karyakram (JSSK); Janani Suraksha Yojana (JSY) and Rogi Kalyan Samiti (RKS). Then the findings of this survey from village level were compiled and analyzed. The analysis sketched out the status of above mentioned services at field level. The analysed reports of the survey were shared with the community. It was decided that “Jansamvads” (public dialogue) would be organised at block/district and state level on the basis of the survey reports and demand of the community for better health services across districts of Madhya Pradesh. The issues that came forth through the
surveys and the analysis of the surveys would be discussed at the hearings and the community people will also submit memorandums to health functionaries to make the health services better.

**DISTRICT JANSAMVADS**

1. District Jansamvad: Sehore

**Process:** Under the MHRC campaign a public hearing was carried out in Ichawar block of Sehore district.

- The event was organized by Sathiya Welfare Society.
- Prior to the hearing, survey was conducted for 9 VHNDs, 18 beneficiaries of Janani Surkasha Yojna, 18 beneficiaries of Janani Shishu Suraksha Karyakram, 2 OPD patients and Rogi Kalyan Samiti.
- The findings that emerged from the survey were shared initially with community members and then a Public Dialogue was organized.

**Venue:** Community Health Centre of Ichawar

**Date:** February 7, 2014

**Participants:** The event witnessed presence of several government and health functionaries, representatives and people from diverse backgrounds including MLA Shailendra Patel, Block Medical Officer Dr. Sharma, Medical Officer, BCM Narendra Malviya, Supervisors (Health & WCD department) and other health department authorities, representatives from other CBOs & NGOs, media persons, and team member of Sathiya Welfare Society, Mahendra from CHSJ, Ajay from SATHI and different community members. In this public dialogue about 90 people were present out of which 47 were women.

**Findings and Issues that emerged in Public Dialogue**

- Unavailability of medicines at Sub-centre, PHC and CHC
- Unavailability of iron supplements to adolescent girls
- ANC’s are not done properly at village levels
- It was highlighted in the public hearing that discrimination in health is one of the major problems which hinders proper delivery of health services and among all women are the
most excluded and discriminated ones. This discrimination sometimes becomes life threatening especially when women are going through the motherhood.

**Official Response and Directives**

- MLA Patel outlined that he would raise the findings of survey in the District Planning Commission meeting and assured of his full support to make the health services better.
- The community members and the MLA submitted a memorandum to the BMO, Dr. Sharma
- Dr. Sharma said that he and his team were putting their best efforts to provide best health services in Ichawar. He assured of providing full support and said that he would try to resolve the issues falling in his jurisdiction or would raise the issues with district and state authorities whenever required.

**2. District Jansamvad: Chhindwada**

**Process:** This event of public hearing under the Maternal Health Rights Campaign was carried out in Tamiya block of Chhindwada district.

- The eharign was organized by ‘Paramarth Samiti’
- Under this survey process survey was conducted for 29 VHNDs, 53 beneficiaries of Janani Surkasha Yojna, 51 beneficiaries of Janani Shishu Suraksha Karyakram (JSSK).
- These findings were shared with community members and then a Public Dialogue was organized at the district level.

**Venue:** ParamarthSamiti’office hall

**Date:** 30 January, 2014

**Participants:** The hearing witnessed participants from diverse fields including Block Medical Officer, from Health & WCD department Sh. Gandewal and other Medical Officers, Supervisors of health department authorities, representatives from other CBOs & NGOs, media persons, team members of Parmarth Samiti, and women groups from 8 villages were present in this public dialogue.
The key Findings and Issues that Emerged in the Public Dialogue

- After institutional delivery, there is non-availability of government transport facility to take the mother and child back home from the health institution.
- No information is provided about health schemes and programmes by government health staff
- Non-availability of Iron tablets for adolescent
- No appointment of ASHA workers and ANM in the concerned villages.

Official Response and Directives

- Collective demand for better health services was pressed upon the district collector of Chhindwada.
- The Medical officer promised that he would take action on some issues and wants some time to work on long term issues.
- Action was taken on issues like of appointment of ASHA worker and ANM in district Jansamvad.
- Block Medical Officer promised that he would personally look into the matter of denial of transport facility from hospital to home.

3. District Jansamvad: Anuppur

Process: This event was carried out in Anuppur district and was organized by Holistic Action Research and Development (HARD) in association with other civil society organizations.

Prior to the public hearing, a research survey was conducted in 10 villages with beneficiaries of JSY, JSSK, OPD patients and Rogi Kalyan Samiti members. The findings were shared with community members and then presented in this Public Dialogue.

Anuppur is a tribal district of Madhya Pradesh and this district has high rates of infant and maternal mortality, besides high rates of malnutrition and there is high percentage of anemia among women. Sixty percent of population does not have direct access of government health services in this district.

Date: January 23, 2014
Participants: The event witnessed presence of functionaries from diverse backgrounds including local MLA, Ramlal Raotel; Medical Officer, Supervisors (Health & WCD department) and other health department authorities, representatives from other CBOs & NGOs, media persons, Sushil Sharma and team members of HARD organization, Rakesh from SATHI and community members.

The Findings and Issues that Emerged in Public Dialogue

- Major Data and findings were presented from 10 villages of Komta and Anuppur development blocks
- There is no ANC and PNC check-up at the village level.
- There is non-implementation of JSY and JSSK programme in these villages
  - No Transport (ambulance) facility is available to take back women home from the health institution after delivery
  - Money is charged for conducting delivery in government hospital by the hospital staff
  - No food facility available in hospital
- Government health call centers and referral centers are not functioning properly
- Collective demands
  - Dissemination of scheme information charts at all government health centre at all level
  - Female medical officers should be appointed in all the PHCs to conduct checkups of women
  - Representation of civil society, NGO’s, community member in grievance redressal cell

Official Response and Directives

- A memorandum was submitted to the government medical officer and the MLA Ramlal Raotel. He promised follow up of peoples health demands and promised to work towards fulfilling those demands
4. District Jansamvad : Satana

Under the MHRC campaign a district public hearing was also carried out in Satna district. This event was organized by Ahasas in association with other civil society organizations including Santosh Devi ManavVikas Sanstha, Gram Sudhar Samiti carried out this campaign in Satna District. Community based monitoring survey was conducted in Rampur, Nduond, Uchehara, Mazgavablock selected villages with beneficiaries of JSY and JSSK, OPD patients and Rogi Kalyan Samiti members. The findings that emerged were shared with community members and then presented in this Public Dialogue.

**Venue:** Hotel Siddhant, Semriya circle, Satna, Madaya Pradesh

**Date:** February 11, 2014

**Participants:** The event witnessed presence of local MLA, Shankarlal Tivari, representative of CMHO Satendra Singh, Medical Officer and other health department authorities, representatives from other CBOs & NGOs, media persons, team members of Ahsas organization, and community members. In this public dialogue about 103 people were present out of which 48 were women and 55 were men.

**Findings and Issues Emerge in Public Dialogue**

- Aganwadi and Sub centres not functioning at village level.
- Money charged for free government transport facility (Janani express)
- No residents staff at village and sub-centre level
- Government should take this community based monitoring process forward on issue of maternal health and other essential health services.
- Every government hospital should be well equipped for maternal and child health care
- Medical doctor should be appointed on vacant posts in government hospitals
- Sub-Centre should provide list of pregnant and lactating women in each village
- Special care should be given to high risk pregnant women and VHNSC should be functional
Official Response and Directives

- A Memorandum for better health services was accepted by representative CMHO, Satendra Singh

State Level Jansamvad (Public Dialogue): Bhopal

The findings through the community monitoring process and the district level public hearings on the situation of maternal and child health services as well the different gaps identified by the community in accessibility and availability of maternal health and related health services, charted out a way for a dialogue at a larger scale and higher level with the higher authorities in the state and as a result a state level public hearing was held in Bhopal in February, 2014

Place: Bhopal, Gandhi Bhavan

Date: 19 February, 2014

Time: 10.00 – 16.00 hrs

Process: A state level public dialogue on Maternal Health and Health Rights in Madhya Pradesh was held at Gandhi Bhawan, Bhopal on February 19, 2014 by the Maternal Health Rights Campaign, which is a coalition of civil society organizations working at the community level in different part of Madhya Pradesh and working across 18 districts.

Due to severe deficiencies in the public health delivery system and the reported inaccessibility of health services to communities in rural areas, people are deprived of the essential services. Women in need of maternal health services are still dependent on private institutions for these essential health services. The strengthening of the health services system is the need of the hour, as the essential health services have been reduced to a Village Health and Nutrition Day (VHND), which is one day per month in any given village.

In an effort to strengthen people’s access to health services, civil society organizations in 13 districts of Madhya Pradesh, undertook a community monitoring process on maternal health
services. This data was collected from 112 villages, through interviews conducted with 212 women on JananiSurakshaYojana (JSY) and 224 women for Janani Shishu Suraksha Karyakram (JSSK), and interview with 92 respondents on the status of services being provided under Village Health and Nutrition Day (VHND). This data was compiled and analysed and report cards were formed. The monitoring process was facilitated through a two-day orientation on the maternal health situation to the field workers of 12 organizations from 13 districts.

Sharing of the district-wise report cards and its analysis was organised for all the organisations and their field workers on October 18-19, 2013. A two day ‘Madhya Pradesh State Health Community Enquiry Data Sharing and Advocacy Planning Meeting’ was conducted on October 18-19, 2013 at All India Catholic University Federation (AICUF) Ashram, Bhopal by Centre for Health and Social Justice (CHSJ) and SATHI (Support for Advocacy and Training in Health Initiatives) with the support from Society for Community Health Awareness Research and Action (SOCHARA). The meeting aimed at data sharing and developing plans to ensure public accountability on maternal health rights.

Discussions were facilitated on district-wise report cards and regional action plans were drafted for Bhopal, Chambal and Rewanchal regions for advocacy on issues identified. A state coordination committee was also formed to take forward the “Maternal Health Right Campaign (MHRC)”. The key aim of this campaign is community monitoring and advocacy for maternal health rights to strengthen the public health system. 20 CSOs from 18 districts of Sidhi, Satna, Rewa, Shahdol, Anuppur, Morena, Tikamgarh, Bhind, Ashoknagar, Bhopal, Sagar, Vidisha, Raisen, Chhindwara, Betul, Hoshangabad, Guna, Sheopur of Madhya Pradesh are associated in the campaign.

As part of the process, the community monitoring information is shared with the communities in respective districts. In nine districts [Ichhawar (Sehore), Tamia (Chhindwara), Dhabora (Rewa), Gairatganj (Raisen), Aadhner (Betul), Anuppur, Shahdol, Satna and Sidhi] district health dialogues have already been held and the issues identified through the community monitoring process are being shared with health authorities for improving the quality of services. The authorities in the health department were told about the deficiencies identified during the community monitoring process and improvement in their delivery was demanded.
With the aim of presenting and discussing the findings from the monitoring process, and issues emerging out of the district level public dialogues with the state level senior health officials, a state level public health dialogue was organised at Gandhi Bhawan, Bhopal on February 19, 2014. The larger goal of the campaign is to improve the access of community to maternal health services by improving the public health services. The process is anticipated to create a space for community’s voice and premised upon it, CSOs can further work on this accountability process to realise health rights for the most vulnerable communities in the remotest parts of the state.
SECTION IV

CASE STUDIES AND ORAL TESTIMONIES

Through the community monitoring process and the MHRC initiative, written testimonials as well as oral narratives of the community were collated which reflect upon issues like how marginalized sections of the society are facing difficulties in realization of maternal health rights and how women of marginalized groups and their families face discrimination in accessing basic maternal health care and JSY benefits. The written narratives as case studies have been collected from nine districts of the state. There are 42 written case-studies which reflect thematically upon issues of maternal deaths (4 case studies), infant and child deaths (6), gaps in implementation of JSY and out of expenditure including corruption, payment of informal charges (8) and discrimination faced by marginalized women in accessing health services (10) and services at Anganwadis (15) respectively.

The objective of this collation, both written testimonials as well oral narratives was to capture the people’s perspective and their needs on maternal and child health care services and this perspective would enable a constructive dialogue of the community with the health service system. The case studies discern an array of viewpoints and experiences of the community in interaction with different units of health like ANM’s, ASHA’s, sub-centers, PHC’s and about the gaps in health infrastructure, disparities in health care provisioning at the health care centers, inaccessibility and inequities in ante-post natal care and absence of skilled expertise during delivery, besides problems of inaccessibility in JSY, social exclusion in JSY benefits.

1 The detailed narratives of written case stories have been appended in Annexure –I
CASE STORIES REPORT

Table 1: District and number of written Case Studies

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>District</th>
<th>Case Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Betul</td>
<td>02</td>
</tr>
<tr>
<td>2</td>
<td>Raisen</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>Chindwada</td>
<td>09</td>
</tr>
<tr>
<td>4</td>
<td>Morena</td>
<td>05</td>
</tr>
<tr>
<td>5</td>
<td>Sidhi</td>
<td>01</td>
</tr>
<tr>
<td>6</td>
<td>Anuppur</td>
<td>08</td>
</tr>
<tr>
<td>7</td>
<td>Shahdol</td>
<td>02</td>
</tr>
<tr>
<td>8</td>
<td>Satna</td>
<td>01</td>
</tr>
<tr>
<td>9</td>
<td>Bhind</td>
<td>02</td>
</tr>
</tbody>
</table>

The above table lists out the number of districts from which case studies have been obtained and the number of case studies from each district. The largest number of case studies, 12 has been obtained from Raisen district, followed by 9 from Chindwada, 8 from Anuppur district. Five case studies are from Morena district, and two each from Shahdol, Bhind and Betul district, whereas one each from Satna and Sidhi districts.

Table 2: Type of Case Studies

- Maternal Death
- Child Death
- Discrimination while accessing health services
- Lack of basic Infrastructures
- Informal payment during accessing free services
- Non-responsible behavior

Instructions for Case information and Testimonies collection

- Name and Identity of testimonies or victim should not revile
- Testimonies and case information will be used to get justice

The main purpose of this process is that, there will positive dialogue between health service system and community

The above table attempts to provide an indexical view of the type of case studies which the narratives from the field are giving an insight into and the purpose of their collection. The case studies focus on variety of issues including maternal and child health, the social exclusion and discrimination faced while accessing the services, the situation of the health infrastructure besides cases of informal payments in free services and the non responsible behaviour of health service providers.

**Table 3: Case studies on Maternal Deaths**

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Age</th>
<th>District, Block, PHC village</th>
<th>Circumstances and experiences</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>22</td>
<td>Betul, Multai, Pardhshigha</td>
<td>No timely care in PHC, Verbal abuse by ANM, Physical abuse by nurse</td>
<td>Died to due to negligence and lack of proper treatment in PHC</td>
</tr>
<tr>
<td>Case 2</td>
<td>21</td>
<td>Chindwada, Tamiya, Dhulniya (village)</td>
<td>Medical Officer was not present in CHC, Delivery was conducted by Nurse and Dai. No timely care in CHC, No PNC services provided</td>
<td>Both Mother and Child died in CHC due to negligence in CHC²</td>
</tr>
<tr>
<td>Case 3</td>
<td>24</td>
<td>Bhind, Bhind Mahavir Nagar,</td>
<td>Admitted in Bhind district hospital for delivery, Doctor demanded Rs.1000 before conducting the delivery, After delivery her health condition started deteriorating and referred to Gwalior. The patient died on the way to</td>
<td>Died to due to negligence</td>
</tr>
</tbody>
</table>

² Both mother and child died in the case
The case stories outlined in the above table suggest four cases of maternal deaths in districts of Betul, Chindwada, Bhind and Satna which occurred due to lack of timely interventions and lack of proper medical care. In one case from Chindwada both the mother and child died post delivery. The maternal deaths highlight that the mothers who died due to lack of proper intervening health services largely in the age group of early 20’s.

**Table 4: Case studies of Infant -Child Deaths**

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Age</th>
<th>District, Block</th>
<th>PHC village</th>
<th>Circumstances and experiences</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>NA</td>
<td>Chindwada, Mohkheda</td>
<td>Badgona</td>
<td>Patient could not get bed in hospital and was admitted on ground in hospital. No timely care in hospital.</td>
<td>Child Died due to negligence in government health institution and inadequate medical care</td>
</tr>
<tr>
<td>Case 2</td>
<td>NA</td>
<td>Chindwada, Mohkhed</td>
<td>Leelapur</td>
<td>Child couldn’t survive. After three days of delivery the child was dead. Patient was not aware about the health services offered in the village and was not taking nutrition from Anganwadi.</td>
<td>Child Died due to not having proper information of health services and services about food and nutrition from Anganwadi</td>
</tr>
<tr>
<td>Case 3</td>
<td>20</td>
<td>Bhind</td>
<td></td>
<td>Called Janani Express Service to</td>
<td>Child Died due to</td>
</tr>
<tr>
<td>Case</td>
<td>Village</td>
<td>Event</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
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<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-4</td>
<td>22</td>
<td>Sidhi Tarmani (village)</td>
<td>At the time of admission PHC was closed&lt;br&gt;No staff was available during night, suffered labor pain entire night, next morning ANM conducted delivery&lt;br&gt;ANM and birth attendant took money (Rs 150) from patient to conduct delivery and gave discharge after birth.&lt;br&gt;No PNC services provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-5</td>
<td>NA</td>
<td>Anuppur, Sohara (Village)</td>
<td>Delay in Janani express service, Neither ASHA nor Anganwadi worker accompanied the patient for delivery&lt;br&gt;No proper treatment and suggestion at PHC,&lt;br&gt;Had to make arrangements for private vehicle to take the patient to hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above outlines six child deaths due to inaccessibility of health services and lack of timely maternal health care. One case of infant death has been taken from Table 3 where both the
mother and child died, post delivery. The child death case studies in the above table are 3 from Chindwara, 2 from Bhind and one each from Sidhi and Anuppur.

Table 5: Gaps in implementation of JSY, out of pocket expenditure, informal demand of charges and corruption

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Age</th>
<th>District, Block</th>
<th>Circumstances and experiences</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case- 1</td>
<td>NA</td>
<td>Anuppur, Aambad, Paltola (village)</td>
<td>Did not get transport facility (Janani Express service), Hired private vehicle (Rs.800), Nurse demanded charge fee (Rs.1600) for conducting delivery</td>
<td>Huge out of pocket of expenditure and corruption</td>
</tr>
<tr>
<td>Case-2</td>
<td>NA</td>
<td>Anuppur, Mau Village</td>
<td>No ANC/PNC services being provided in village, charge money for medicines and injections</td>
<td>out of pocket of expenditure and corruption</td>
</tr>
<tr>
<td>Case-3</td>
<td>NA</td>
<td>Anuppur, Latgava (village)</td>
<td>ANC services not being provided ambulance driver charged fee for transportation, ANM charged fee for conducting delivery</td>
<td>out of pocket of expenditure and corruption</td>
</tr>
<tr>
<td>Case-4</td>
<td>NA</td>
<td>Anuppur, Murai (Village)</td>
<td>Not getting Janani Express service on time, Non availability of Blood in Dist. Hosp.</td>
<td>Suffered intense bleeding after delivery, No proper implementation of JSY services</td>
</tr>
<tr>
<td>Case-5</td>
<td>NA</td>
<td>Anuppur, Aambad, Bholapur</td>
<td>Abortion not conducted properly, Non availability of medicines,</td>
<td>Suffered for Intense bleeding, Out of expenditure on</td>
</tr>
<tr>
<td>Case</td>
<td>Village</td>
<td>Experience</td>
<td>Problem</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Case-6</td>
<td>NA Anuppur, Beragoan (Village)</td>
<td>needed to buy medicines from private store (Rs. 8000)</td>
<td>couldn’t get Janani express service due to heavy rain, PHC ANM demanded 500 rupees, Required Blood - Referred to Dist. Hospital</td>
<td>No proper implementation of JSY services, Corruption by ANM, condition of the mother started worsening due to intense bleeding</td>
</tr>
<tr>
<td>Case-7</td>
<td>NA Shadhol, Bughar, Mohkhan (village)</td>
<td>Because of remote location faced difficulties in accessing Janani Express Services, No timely transport services available</td>
<td>Patient faced difficulties in accessing transport facility in critical condition</td>
<td></td>
</tr>
<tr>
<td>Case-8</td>
<td>NA Shadhol, Revadi (village)</td>
<td>At the time of birth baby’s weight was relatively less and was very weak so referred to district hospital. After three days of treatment the infant died. After discharge no transport facility was provided to the mother to go back home. Had to access state transportation and had not money to buy the ticket</td>
<td>After delivery no proper PNC and transport facility was provided to the patient</td>
<td></td>
</tr>
</tbody>
</table>

The case stories in the table above, eight from different villages of Annuppur district and two from Shahdol district spell out details of difficult experiences in accessing ante- and post natal care as well as JSY benefits. With evidences of corruption prevalent across the case studies, the stories highlight that the JSY beneficiaries largely had to make out of pocket expenditure for
availing transport services and medicines which could have been free under the JSY scheme for the marginalized groups. The medicines had to be bought from the market and private vehicles had to be utilized for commuting to the health facility. Besides this the health service providers have been demanding money for conducting deliveries.

**Table 6: Discrimination and negligence experienced by Dalit Women in health services**

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Age</th>
<th>District, block PHC</th>
<th>Circumstances and experiences</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>22</td>
<td>Betul Amala, Pira,</td>
<td>No timely ANC and PNC Care to schedule caste community in village No registration by ANM or any health worker in village</td>
<td>Not eligible to get benefit of government health scheme such</td>
</tr>
<tr>
<td>Case 2</td>
<td>NA</td>
<td>Raisen Sonpur,</td>
<td>Faced lots of difficulties while accessing Janani Express service. She doesn’t have bank account and she didn’t receive any information about JSY scheme from the health workers.No information on opening bank account.</td>
<td>Delay in accessing health services The JSY could not be encashed</td>
</tr>
<tr>
<td>Case 3</td>
<td>NA</td>
<td>Raisen Ritapur,</td>
<td>The Village health committee sidelined the issues of health and sanitation of lower caste localities ASHA worker is from Dalit community but she doesn’t have any power and voice in village health committee.</td>
<td>Exclusion in health care access</td>
</tr>
<tr>
<td>Case 4</td>
<td>25</td>
<td>Raisen Aobedhullaganj, Riva</td>
<td>discrimination on the basis caste took place in her life while accessing ANC/PNC health services by ANM and Anganwadi worker</td>
<td>Exclusion in health care access at village and in public health institution Informal payment create burden on patient and</td>
</tr>
<tr>
<td>Case 5</td>
<td>NA</td>
<td>Raisen Aobedhullaganj, Sohalapur,</td>
<td>No ANM appointed for Sohalapur Sub-centre Anganwadi is running in sub-centre Dalit Community women no informed about immunization in village</td>
<td>Not appropriate use of infrastructure</td>
</tr>
<tr>
<td>Case 6</td>
<td>NA</td>
<td>Madhavpur, Amarwada Chindwada</td>
<td>Government trained Dai are not getting any financial benefit or incentives</td>
<td>Marginalisation of workforce</td>
</tr>
<tr>
<td>Case 7</td>
<td>NA</td>
<td>Chindwada Mohkhed Solapur (village),</td>
<td>No any services provided to SC, ST and Muslims on VHND programme</td>
<td>Exclusion in accessing health services</td>
</tr>
<tr>
<td>Case 8</td>
<td>NA</td>
<td>Chindwada Mohkhed Jameera (village),</td>
<td>Village people practice untouchability towards ASHA worker as she belong to SC Community</td>
<td>People do not take services from her</td>
</tr>
<tr>
<td>Case 9</td>
<td>21</td>
<td>Murena Samirabad Rasulpur (village)</td>
<td>PHC staff practice untouchability towards class four worker as she belong to SC</td>
<td>Exclusion in participation</td>
</tr>
</tbody>
</table>
Community

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Age</th>
<th>District, block, village</th>
<th>Circumstances and experiences</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>NA</td>
<td>Raisen, Gaeratganj Mira</td>
<td>No any service provider such ASHA worker or Anganwadi worker for there village. No Anganwadi in village. Other village Anganwadi worker discriminates to the Dalit children</td>
<td>Access of early education and nutritional food denial to schedule caste children</td>
</tr>
<tr>
<td>Case 2</td>
<td>28</td>
<td>Raisen, Aobedhullaganj, Poar</td>
<td>Anganwadi worker used Caste based remark when she asked about anganwadi services in her village</td>
<td>No Action</td>
</tr>
<tr>
<td>Case- 3</td>
<td>40</td>
<td>Raisen, Aobedhullaganj, Poar</td>
<td>Midday meal is served on paper to the child</td>
<td>After complaint to district CEO</td>
</tr>
<tr>
<td>Case</td>
<td>Age</td>
<td>Location</td>
<td>Anganwadi worker and ASHA worker do not provide information about any health programme to the community people ASHA worker doesn’t stay in village.</td>
<td>Affect health service delivery</td>
</tr>
<tr>
<td>------</td>
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<td>----------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Case 4</td>
<td>27</td>
<td>Raisen Gaeratganj Kathapur</td>
<td>Aaganwadi worker of Kathapur village do not give proper service and purposefully keeps away from accessing services to Dalit women and children.</td>
<td>Exclusion of dalit community from health services at village level</td>
</tr>
<tr>
<td>Case 5</td>
<td>27</td>
<td>Raisen, Gaeratganj Ravalpur</td>
<td>Anganwadi worker refused to give food because child did not come along with her mother.</td>
<td>Denial of health service entitlements</td>
</tr>
<tr>
<td>Case 6</td>
<td>NA</td>
<td>Raisen Hempur</td>
<td>the condition of Dalit and Muslim areas Anganwadis are appalling.</td>
<td>Complained to village panchayat but no action</td>
</tr>
<tr>
<td>Case 7</td>
<td>Raisen, Gaeratganj, Pampur</td>
<td>There is no Anaganwadi Centre in village Village Health and Nutrition Day (VHND) Programme has to be organized in open place There is no privacy in health check up due to which women and adolescent girl do not come for health check-up.</td>
<td>Lack of infrastructure Not men-tented right to privacy during women health check-up</td>
<td></td>
</tr>
<tr>
<td>Case 8</td>
<td>NA</td>
<td>Raisen Gaeratganj Jinaur,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case 9</td>
<td>32</td>
<td>Chindwada Amarwada Jokha</td>
<td>Anaganwadi worker made Caste based comment to Dalit women while bring food along with her child in Anganwadi. After that she stopped to go into the Anaganwadi Centre and she doesn’t send her children to the Anganwadi.</td>
<td>Untouchability practice denial access of government service</td>
</tr>
<tr>
<td>Case 10</td>
<td>NA</td>
<td>Jokha Amarwada – Chindwada</td>
<td>ASHA, Anaganwadi worker and panchayat members do not provide proper information to schedule tribe community.</td>
<td>Not getting benefit of services</td>
</tr>
<tr>
<td>Case 11</td>
<td>NA</td>
<td>Satna, Mohkhed Chindwada</td>
<td>In village so many children are suffering from malnutrition. There is a need to identify the category of malnutrition and urgently required health treatment.</td>
<td>Not having proper information</td>
</tr>
<tr>
<td>Case 12</td>
<td>NA</td>
<td>Morena Aambad Sohankapura (village)</td>
<td>Mid day meal is prepared by self help group of women who belong to Dalit community, Upper caste children do not eat food in the Anganwadi and in School.</td>
<td>Discrimination and practicing untouchability affecting the services</td>
</tr>
<tr>
<td>Case 13</td>
<td>NA</td>
<td>Morena Denapur (village)</td>
<td>Discriminatory practices in Anganwadi centre with Dalit community. No proper health services and health checkups.</td>
<td>Dalits are Excluded from accessing care in village and due to which they have</td>
</tr>
</tbody>
</table>
The above table briefly highlights 15 case stories, 8 from Raisen, 3 each from Morena and Chhindwara and 1 from Anuppur districts. It outlines the reduced access of the marginalized sections to health care and the harassment faced by these sections in availing the health services. It outlines experiences of how discriminatory practices limit sections of society from accessing the health care and services.
ORAL NARRATIVES OF CASE STUDIES

Apart from the written testimonies, nearly six oral narratives were also collected to further corroborate the community perspective and needs on the challenges faced in accessing maternal health care and related health services.

The overall issues put forwarded by analyzing different oral testimonies case stories:

All these case stories evidently show that, people are willing- to access public health services. It is the public health care system which failed to fulfill the basic health service needs and demands of the people. The failure has resulted to an extent that people are dying and it has been evident in Madhya Pradesh where maternal death, child death is being reported by different case stories, even though government introduced Janani Suraksha Yojna to tackle this problem. Under this new scheme government has introduced financial incentives to mother for promoting institutional deliveries, ambulance services for mother and child and call centre to facilitate these services. However, these initiatives are less people friendly as marginalized sections of the people and people who stay in geographically remote locations face lots of difficulties while accessing and utilizing these services. Large sections of the society mostly who belong to the lower social strata of society depend on these services. These case stories highlighted important issues of social discrimination in accessing public health services. Some major important issues are:-

- The public health infrastructure condition is very poor at all levels
- Rughna Kalayan Samiti (RKS) has important role to play for patient welfare but it functions only on paper not in practice.
- JSY beneficiaries not getting proper benefit under this scheme and had to spend more money on collecting documents for creating Bank account. There is also evidence that people had to pay informal charges to government staff
- Government ambulance drivers demanding money as a charge fee for using transportation facility to mother and child.
- People’s primary preference is to contact with Sub Centre but it is not functioning well and as always it’s been closed and in most basic facilities are not available.
- Medical Officers are not available at village level. They are not conducting visits to village.
Anganwadi centers are not functioning well as these centre’s does not even have basic equipments to measure height and weight.

- In many villages VHND programmes not organized properly. In many cases it is being reported that there is no regular ANC -PNC check-ups being conducted by ANM.
- There have been many vacant posts in primary health centre and sub-centre.
- There is no privacy being maintained while conducting female check-ups.
- Primary health centre OPD timing should be changed it not people friendly.
- People are not getting proper advice and suggestions from medical staff at the time of institutional delivery or ANC- PNC check-ups due to which people have to face several difficulties while accessing and utilizing government transport facility (Janani Express).
- People do not get proper response from government 108 call centre
- Many villages are situated in remote areas who needs special attention and care.
- Many villages ASHA worker is not appointed as well as no any home visits is being conducted by ANM
- In many villages there has been reported caste based discrimination while accessing and utilizing health services due to which people have suffered a lot and hence many times stopped accessing these services.
SECTION V

Responses from panelists and suggestions

The panelists from different civil society organizations (CSO’s) as well government functionaries discussed the issue of maternal health care and the different gaps in its accessibility and availability at the Jansamvads. This section surmises the responses, suggestions and views put forth by the CSO and Government representatives on the current situation and status of maternal health care in MP and different suggestions to reduce the gaps.


Y K Sandya, member of NAMHHR, which is a national network working for maternal rights, while addressing the panel stressed on the maternal health demands and needs of the people. She pointed out that one of the positive outcomes of National Rural Health Mission (NRHM) in Madhya Pradesh has been that the overall medicine availability has improved. However, while putting across her concern for maternal health situation in the state she pointed out some issues on maternal health like, hardly any ANC/PNC checkups are carried out at village level as well as at the PHC level. She added that, there has not been any significant change in the maternal death and care situation even after Badwani district fact finding report in 2010. Though efforts are being made to provide basic health care services to patients of lower income and lower caste group but unfortunately they are discriminated by health service system, she lamented. She highlighted that there are no free health services available as there has been an increase in the hidden informal payment system. While expressing her concerns, she stressed that the quality of iron tablet should improve. JSY beneficiaries do not get scheme reimbursement; they should get benefits on time without harassment. The levels of convergence with other health programme should be channelized properly and RKS is also not functioning well. RKS committees should be strengthened towards pro-community, pro- poor approach. Reflecting upon the inaccessibility problem in remote areas she suggested that Palkhi services can be started in such areas as these areas do not have ambulance accessibility. This will help to improve the 108 service.
2. Response and suggestions by government functionary: M Geeta- Director of NRHM, MP

While responding in the Jansamvad as a panelist, Director of National Rural Health Mission in MP, M Geeta outlined that Madhya Pradesh was pioneer state which initiated the RKS experiment; however not much documentation of the RKS experiment is available. “Though NRHM has increased availability of resources; however we do have problems in utilization pattern of resources,” she said. We need more community based counseling. The director NRHM added “We have developed quality check mechanism for medicine as well have developed software mechanism to trace individual maternal cases and their progress.” She said that letters had been already sent to various banks to open JSY beneficiaries bank account on zero balance.

3. Response of Consultant of MP Health TAST group: Dr Aboli Gore

Consultant of Madhya Pradesh Health TAST Group, Dr. Aboli Gore stressed on the need of people’s involvement in the health service delivery. She said, “Without people’s involvement health service delivery will be not succeeding, it always has to be associated with the people.” She highlighted that it was important to strengthen public health services delivery. “Community based monitoring of maternal health is a watchdog process and it has been instrumental in identifying the gaps and problems in services delivery,” she said. Though NRHM has provided space to the community to put forward their demands, however this initiative is in a developing stage, she added. Dr Gore stressed that MP TAST group realized and fully acknowledged people’s maternal health demands, which had been put forward by CSO representative Sandhya of NAMHHR and the organizations partnering in the campaign. “It has been a challenging task for us also, as we too face many difficulties in managing the health services system. We need support of the civil society support to overcome through these challenges,” she said.

At the end of session community representatives gave memorandum to mission director of National Rural Health Mission Madhya Pradesh and vote of thanks was given by Dr. H. B. Sen
SECTION VI

Campaign Forward

The participants discussed about the process so far and deliberated upon the future strategy and enumerated some points on how the campaign should be taken forward. The highlights of the discussion are as follows:

- The significance of collective campaigning was stressed upon to take the campaign forward.
- The significance of organizing women in a collective and creating awareness among them about their rights on health and monitoring of their rights was stressed upon as a way to take the campaign forward. The need of organizing women, especially the women from lower social strata of the society because they are the most marginalized and disadvantage sections of the society was also highlighted upon.
- The technical capacity building role of civil Society organizations and Non- Government Organizations was also stressed upon to take the campaign forward. Besides this the engagement of PRI members lath issues was suggested.
- Involvement of media to build lager pressure on health system was highlighted upon.
- The significance of case follow-up plan after Jansamvads was also suggested besides conducting district wise follow up meetings.
- Realizing the limited outreach of the current CBM of maternal health care processes, engagement and involvement of other civil society organizations and Non- Government Organizations from other districts of the state was significantly stressed upon.
- The significance of organizing district level meetings by all organizations to discuss village level plans was suggested.
- To facilitate sharing of experiences and learning from each other, arrangements of inter organization workshop were suggested.
The Annexure-I spells out the written narratives of the case stories that emerged from the field surveys in the community monitoring process.

### CASE 1
**Mother Name** - Sunanda Bokhade, **Age** - 22, **Date of Death** – 31/05/2013,
**Name of Husband** – Deventra Bokhade, **Village** – Pardhshigha, **Block** – Multai, **District** – Betul, **Case story taken by** : Ramlal on 7/8/2013.

**Description:** Sunanda passed away on 31/5/2013 in Multai CHC during her delivery. It was Sunanda’s first pregnancy. With the help of ASHA worker she accessed the Jannai express facility to reach the CHC in Multai. She was admitted in the CHC around 3:00 pm and went into labour around 6pm in the evening. The nurse and the medical officer at the CHC said that she would have a normal delivery. However, when Sunanda suffered intense labour pains, the ANM and the nurse misbehaved with her, the ANM used abusive language and the nurse slapped her. While in labour, half of the baby came out from the womb, but Sunanda couldn’t deliver the baby fully. During this period the nurse pulled out the baby forcibly which caused severe bleeding. Though the medical staff tried to stop the bleeding, however they couldn’t stop it and around 7.30pm Sunanda passed away. The Medical officer reported the Sunanda died due to lack of blood. But Sunanda’s family members pressed that she died due to occurred due to the negligence of the medical staff at the CHC. They said that she could have been saved had the medical staff provided timely intervention.

### CASE 2
**Mather Name** - Pujabai, **Age** - 22, **Village** – Pira, **Block** – Amala, **District** – Betul

**Description:**
Pujabai belongs to Dalit community; during her pregnancy she was administered immunization twice only however she is not aware about her registration. Not a single test was conducted during her pregnancy. She does not have a ration card and when asked about Gram Panchayat, she said “I don’t know anything about Gram Panchayat because nobody goes to the Panchayat from our family.”
### CASE 3
**Name**: Kamlabai, **Village**: Mira, **Block**: Gairatganj, **District**: Raisen

**Description**: Kamaltai is a Dalit community representative and narrated the major problems of the Dalit community. She said, “health services are not provided in our village as there is no Anganwadi and ASHA worker here. If people want to avail services of Anganwadi or ASHA they have to walk a distance of 3km, from the village. Moreover even if children go to the Anganwadi, the Anganwadi workers practice discrimination with the Dalit children.” They do not give food packets in the hands of Dalit children. They throw the food or roti as if it is given to the animals, she lamented. They do not even speak properly to the Dalit children. Kamlabai said that I have tried to raise these issues and bring them to notice of authorities however the service providers have scolded me for raising my voice. At the time of my delivery, the Janani Express didn’t trun up and I had to take a bus to the health facility, she said.

### CASE 4
**Name**: Lekhabai, **Village**: Sonpur, **District**: Raisen

**Description**: President of midday meal scheme of Sonpur village outlined an incident related to lekhabai. Lekhabai was pregnant and the Janani Express service was called for, during her delivery time to get her transported to the government hospital. Due to some reasons the ASHA worker couldn’t accompany her and hence the president of the midday meal scheme accompanied Lekhabai to the hospital. They faced lots of difficulties while accessing Janani Express service. Though Lekhabai was provided Rs.1400 cheque under JSY scheme for the institutional delivery, she couldn’t avail the financial benefit as she was not having a bank account. Information about the JSY scheme and bank account was not provided to Lekhabai by any of the health workers in the village.

### CASE 5
**Name**: Neemabai, **Village**: Ritapur, **District**: Raisen

**Description**: The Village Health Committee of Ritapur village constitutes mainly of upper caste representatives. There is no representation of Dalit community in the committee. Ramabai and , who belong to the Dalit Community tried to report the problems of the Dalit community regarding health and
sanitation issues, in the committee meeting. However, the committee members sidelined the issues of health and sanitation of Dalit community localities. The ASHA worker is from Dalit community and she too does not have any power or voice in village health committee.

CASE 6
Name- Sonabai, Age – 25, Village – Riva, Block – Aobedhullaganj, District – Raisen
Description: - Sonabai belongs to Dalit community and she explains the kind of exclusion Dalit community people face while accessing health services. She has four children. Her report card was not prepared by the ANM during pregnancy. She visited the PHC twice or thrice for pregnancy check up, but nobody examined her and she did not get any ANC and PNC check-ups. During her last pregnancy she was immunized twice. She didn’t get any nutrition supplements during her pregnancy from the Anganwadi Centre. Her children don’t go to Anganwadi.
While narrating her experience she said, “Once when my child was ill, I took him to the PHC for treatment. However, at the PHC no one touched and examined my child and just gave two tablets. The condition of my child did not improve with the medicine and he had to be taken to a private doctor who charged Rs.100 for check up.”
She said that her delivery happened at home with the help of Dai. After her delivery she became unconsciousness and her husband took her to PHC on bicycle in such condition. When she got Rs.1250 cheque under the JSY benefit, the staff at the PHC took Rs 400 from her on pretext of transport expenses. Other women of the village echoed similar views about difficulties in accessing JSY benefits and the levels of corruption in availing the health services and benefits.

CASE 7
Name- Medhabai, Age- 28, Village – Poar, Block – Aobedhullaganj, District – Raisen
Description: - Anganwadi worker used casteist remarks against Medhabai when she enquired about the Anganwadi services in her village
### CASE 8

**Name:** Radhabai, **Age:** 40, **Village:** Poar, **Block:** Aobedhullaganj, **District:** Raisen

**Description:** Radhabai belongs to the Dalit community and her children are studying in the government primary school, where mid day meals are served under the government mid day meal scheme. Radhabai’s children complained to her about the behavior of the school teacher and how they were being served food on paper. Radhabai complained about this to the district CEO. Though the school teacher started giving food to the Dalit children on plates, however her behaviour towards Dalit community children has not changed much and still practices discrimination.

### CASE 9

**Name:** Hetabai, **Age:** 27, **Village:** Kathapur, **Block:** Gaeratganj, **District:** Raisen

**Description:** Hetabai narrated that the Aaganwadi worker of Kathapur village does not provide services in the Dalit hamlets and the Anganwadi worker deliberately prevents the Dalit women and children from accessing the health services. She practices discrimination against people of the Dalit community.

### CASE 10

**Name:** Laximibai, **Age:** 27, **Village:** Ravalpur, **Block:** Gaeratganj, **District:** Raisen

**Description:** Laximibai narrated an incidence in the Community meeting held in Ravalpur village. She said, she had taken her grandson to the Anganwadi to avail the nutrition supplement. However the Anganwadi worker refused to give food to the child, stating that he was not accompanied by his mother.

### CASE 11

**Name:** Keshabai, **Village:** Hempur, **Block:** Gaeratganj, **District:** Raisen

**Description:** There are Anaganwadis in total in the village. Amongst these four, two Anganwadis are used by the people of Dalit community and Muslim communities and the condition of these Anganwadis
is quite appalling. The women have given application to the village Panchayat a number of times to develop the Anganwadi. However, there is no attempts have been made by the Panchayat to improvise the condition of the Anganwadis.

CASE 12
Name- Minaabai, Village – Pampur, Block – Gaeratganj, District – Raisen
Description:- The Pampur village is largely inhabited by people of the Dalit community and tribals. There is no Anganwadi Centre in village, due to which the Village Health and Nutrition Day (VHND) Programme has to be organized out in the open. There is no privacy during health checkups in the open and as a result women and adolescent girls do not come for health check-ups.

CASE 13
Name- Rekhaabai, Village – Jinapur, Block – Gaeratganj, District – Raisen
Description:- Feedback from the Dalit community members delineated that the Anganwadi worker and ASHA do not provide information about any health programme to the community people. ASHA worker doesn’t stay in village. When there is a delivery case then only the ASHA visits the village and takes a record of the case, otherwise no information is being provided by her on ANC and PNC

CASE 14
Name- Kusumlata, Village – Sohalapur, Block – Aobedhullaganj, District – Raisen
Description:- There is one sub-centre in Sohalapur Village however there is no ANM. Anganwadi is running in sub-centre. Dalit community women informed that whenever there is immunization is taking place they do not inform on time moreover even if Dalit women goes they give immunization at the end. Kusumlata told her incident that, she didn’t get JSY financial benefit after her delivery. Rather she was being demanded from health personnel’s for five hundred rupees to issue the JSY bank Check. She gave 700/- to Dai and Nurse during child delivery. Also she didn’t get Janani Express service form hospital to home after her institutional delivery.
CASE 15
Name- Mamta, Village – Badgona, Block – Mohkheda, District – Chindwada, Informant: - Hemraj

Description:- Mamta belongs to BPL family and her husband works as an agricultural worker in the village. When Mamta went into labour during night, the family members called for Janani Express service and she was taken to the Chindwada district hospital and was admitted there at around 1:30 am. However she couldn’t get a bed in the hospital and was admitted on the ground in the district health facility. Later on a doctor conducted her medical examination and administered her injections to increase the labor pain. The doctor told her family members that her condition was normal and she would have a normal delivery by the morning. Mamta suffered labor pain throughout the night and couldn’t deliver in the morning also. The family members made the doctor aware of her situation and the doctor examined her again and administered another injection to increase her labor pain. After suffering from labour pain during the entire night, she gave birth at 4.30 pm to a dead baby and it weighed 3.5kg. The doctor explained that baby had passed stools in the uterus so couldn’t survive. The doctor blamed Mamta, for the death of the baby and said that it was Mamta’s fault, as she couldn’t exert much pressure to push the baby out, due to which she lost the baby. After the delivery Mamta required blood, but her blood group didn’t match with other donors soon after that she also died due to lack of blood.

CASE 16
Name- Suman, Age- 32, Village – Jokha, Block – Amarwada, District – Chindwada

Description:- Suman belongs to Dalit community. While narrating her experience at the Anganwadi she said, “that once when I went to the Anganwadi to take nutrition supplements, the Anganwadi worker made casteist remarks against me” After the distasteful experience at the Anganwadi I have lost faith in the services and I never visit the Anaganwadi Centre and do not send my children also.” She said that she faces lots of difficulties in filling drinking water from the community well as upper caste people practice untouchability and do not allow them to fetch water from the community well.
CASE 17

Name- Prabhavati, Village – Jokha, Block – Amarwada, District – Chindwada

Description:- Prabhavati belongs to tribal community. According to Prabhavati, ASHA, Anaganwadi worker and Panchayat members do not provide proper information to her about different services. Being poor she gets subsidized grains and other items from the PDS shop, however due to non availability of ration card she cannot avail the facilities from the PDS shop. She was fleeced by the PDS shop keeper of Rs 500 on the pretext of fee charges for making the ration card.

CASE 18

Name- Jankibai, Village – Madhavpur, Block – Amarwada, District – Chindwada

Description:- Janakibai is traditional midwife and belongs to the Dalit community. Speaking about her profession she says, traditionally we have helped women to deliver children. Children borne due to our help even from upper caste used to respect us. Though Government has initiated trainings for Dais and this has helped us learn many new things. A new ASHA worker has been appointed under NRHM in the village she belongs to upper caste. The government gave us duty to work in the PHC. However there are many problems as many times we do not get money and the AHSA worker doesn’t even help at the time of delivery and government is giving money to her.

CASE 19

Name- Bhagvatibai, Village – Leelapur, Block – Mohkhed, District – Chindwada

Description:- Bhagvatibai is poor and belongs to Dalit community. Her child couldn’t survive after three days of delivery. She was not aware about the health services being offered in the village. She was not taking any nutrition supplements from the Anganwadi as she was not aware about it and no ASHA or ANM provided any information about the health services and the services at the Anganwadi to her.
CASE 20
Name: Sohana, Village – Sadana, Block – Mohkhed, District – Chindwada
Description: In our village many children are malnourished. There is an urgent need here to identify the category of malnutrition and the malnourished children require urgent health treatment.

CASE 21
Name: Kalabai, Village – Solapur, Block – Mohkhed, District – Chindwada
Description: In our village people from the Dalit community and those belonging to Schedule tribe and Muslim community are not getting health services related to VHND day and these services are being provided only to the upper caste influential people.

CASE 22
Name: Rupabai, Village – Jameera, Block – Mohkhed, District – Chindwada
Description: Rupabai is the ASHA worker for Jameera village and she belongs to a schedule caste Dalit community. She outlines that the higher caste people practice untouchability with her and do not co-operate with her. Upper caste people do not enter her house and refuse to take any services from her.

CASE 23
Name: Kavita, Age: 21, Village – Dhulniya, Block – Tamiya, District – Chindwada, Informant: Saroj
Description: Kavita belongs to tribal community and the village Dhulniya where she resides is largely dominated by ST people. When Kavita went into labor she was admitted in Tamiya CHC for delivery at 10 am in the morning. The Tamiya CHC is 8 km away from the Dhulniya village. At the time of admission there was no medical officer in the CHC to attend on her. A nurse and Dai attended Kavita at the CHC. Kavita started suffering intense labor pain around 2 pm, and the nurse administered an injection.
to her at that time. Kavita delivered her child around 6.30 pm and the delivery was conducted by the nurse and Dai without supervision of any medical officer. The baby was alive and the nurse kept the baby under light. The nurse went to attend another case in the CHC. In the meantime Kavita was not responding and her family members brought this matter into the notice of the nurse. After examining Kavita, the nurse declared that the patient had passed away. When the nurse examined the baby, she realized the baby was dead as well. Then nurse called up the medical officer (MO) and the MO declared that both the child and the mother were dead. Kavita’s family members said that Kavita and her child died due to lack of timely medical intervention as the medical officer was not present at the CHC during her delivery.

Kavita’s family members tried to register a police complaint against the doctor; however their complaint was not registered. They took the body of Kavita and her child from the CHC reluctantly. Next day nearly 25 village people went to the police station along with Kavita’s family members to register a complaint and a complaint was registered finally under pressure from village people. After four days of the complaint postmortem of Kavita’s body was conducted.

The Anaganwadi worker however said that she had done all the ANC checkups of Kavita and she had also completed her iron tablets course and after the completion of her nine months pregnancy her weight was 46.5kg and it was her first pregnancy. However the people in the village pressed that it was due to lack of timely medical intervention that both the child and mother had passed away.

CASE 24
Name- Minavati, Age- 21, Village – Rasulpur, Block – Samirabad, District – Morena, Informant: - Saroj
Description:-Meenavati works as class four worker in Rasulpur PHC. She says that the PHC staff and other high caste people practice untouchability and do not drink water touched by her as she because she belongs to the Dalit community.

CASE 25
Name- Rajpal, Village – Sohankapura, Block – Aambad, District – Morena, Informant: - Saroj
Description:- In the Anganwadi centre and primary school of Sohankapura the meals are prepared by women of SHG groups belonging to the Jatavs and Dalit community respectively. Upper caste children do not eat the food at the Anganwadi centre as it is prepared by women of the Dalit community.
CASE 26
Name- Rajgopak, Village – Sevasham, Block – Aambad, District – Morena
Description: - The VHND programme is conducted in an open ground in the village, due to which privacy cannot be maintained during health check-ups. As a result women and girls do not turn up for checkups during VHND. According to the village people, immunization is also not conducted properly in the village.

CASE 27
Name- Prem Prakash Valmiki, Village – Denapur, District – Morena
Description: - The Anganwadi worker in the Denapur village practices discrimination with the people of the Dalit community and they belong largely to Valmiki caste. No health services are provided to Dalit women nor are their health checkups conducted. As a result these women have to avail the health services from Abrah Hospital.

CASE 28
Name- Ramkumar, Village – Meva, District – Morena
Description: - Discriminatory practices are carried out with the people of Dalit community at the Anganwadi centre. No health services are provided to Dalit women nor are their health checkups conducted. As a result these women have to avail the health services from Abrah Hospital.

CASE 29
Name – Jayntibai, Age – 22, Village – Tarmani, District – Sidhi
Description: - Jayntibai started suffering labor pain in mid night at around 1:00 am. Jaynatibai was taken to the Jagirabad PHC by her relatives and ASHA worker via the Janani Express transport facility. The PHC was locked when Jayantibai and her relatives reached there and no medical staff was available,
except for an old watchman of the PHC. Though the watchman let Jaynatibai in the PHC but no one from the medical staff turned up to check her ion the PHC.

It was only in the morning at 7am that a ANM attended on her and administered an injection. Later in the day Jayantibai delivered a dead child. However the ANM and a traditional birth attendant took Rs. 100 and Rs. 50 respectively from Jayantibai to conduct the delivery. She was discharged from the PHC and was not provided with any transport facility to drop to her back home.

At home Jayantibai’s health condition started worsening and she became weak due to intense bleeding. Her family members called for 108 ambulance service to take her to the hospital however but they couldn’t get the ambulance timely and could avail it in the evening around 4pm. She was admitted to the CHC Mazoali for two days treatment. Gradually her health condition started improving and after being discharged from the CHC she again had to hire a private vehicle to reach back home.

CASE 30
Name- Leena Beaga, Village – Paltola, Block – Aambad, District – Anuppur
Description:-Leenabai did not get the facility of Janani Express during her delivery. She had to hire a private vehicle to reach CHC Kotma which cost her Rs. 800. The nurse demanded Rs. 1600 as charge for conducting the delivery and laid a condition that Leena would be discharged from the CHC only after she is provided with the money. Leena’s husband had to sell rice in market to get a charge fee demanded by the nurse and when he provided the money then only was Leena discharged from the public health facility.

CASE 31
Name- Ramkali, Village – Mau, District – Anuppur
Description:-Ramkali explains that no ANC & PNC services are provided in her village and the health service providers charge money for medicines and injections.
CASE 32
Name- Keshriya, Village – latgava, District – Anuppur
Description:- Keshriya Bai said that the Anganwadi was not functional in her village. No nutrition supplements and related health services are provided to the children. The ANM charges money to conduct deliveries.

CASE 33
Name- Miramati, Village – latgava, District – Anuppur
Description:- Miramati narrated that her daughter in law was not provided with any ANC services during her entire pregnancy period. Nor were any height-weight check-ups or urine tests, blood tests conducted and nor was immunization provided to her. The ANM also charged Rs. 400 for conducting delivery and the ambulance driver too charged Rs. 200 for transportation.

CASE 34
Name – Chunnibai, Village – Murai, District – Anuppur
Description:- Chunnibai recalled that during her daughter in law’s delivery they had called up for the government transport facility of Janani Express service to take her to the health institution for delivery. However the Janani Express did not turn up, however it didn’t turn up, and her daughter in law was transported by the 108 ambulance to the PHC. After being admitted at the PHC though she delivered a baby but suffered from intense bleeding after that. She required blood, thus the doctor referred her to the Anuppur District Hospital and blood was not available at the hospital also.

CASE 35
Name- Seeta, Village – Bholapur, Block – Aambad, District – Anuppur
Description:- Seeta had an abortion during six month of pregnancy. She suffered from intense bleeding after the abortion and her condition started deteriorating post abortion. She was later admitted to the Anuppur district hospital for treatment. At the district hospital she was provided proper treatment and her uterus was also cleaned by the doctor. Due to shortage of medicines in the hospital, Seeta had to buy medicines from private medical store which cost her nearly Rs.8000.
### CASE 36
**Name**- Champabai, **Village** – Beragoan, **District** – Anuppur  
**Description**:- Champabai started suffering labour pains during night at around 12:00 am. It being monsoon season she couldn’t access the Janani express. Heavy rains impeded plying of vehicles on the bridge at Kevai River which was the only main passage to the CHC. Thus she had to be admitted in Bijuri PHC where she delivered a baby girl. The ANM at the PHC demanded Rs. 500 for conducting the delivery. After the delivery Champabai’s condition worsened due to intense bleeding and she required blood. She was referred to Anuppur district improvised after the treatment at the hospital.

### CASE 37
**Name**- Kalavati, **Village** – Sohara, **District** – Anuppur  
**Description**:- The VHND village meeting was conducted on 01/10/13, in this meeting Kalavati narrated her difficult experiences of accessing public health services at the time of her delivery. Kalavati went into labour on 11.09.2013 and started with her labour pain around 9 am in the morning. Her husband called for the government transport facility of Janani express service to take her to the PHC and the express was available after one hour. Neither the ASHA nor the Anganwadi worker accompanied Kalavati to the PHC. At the PHC the medical officer examined Kalavati’s pregnancy status and after the examination the doctor declared that Kalavati’s delivery was due after 8-10 days and she was discharged from the hospital. They went home by a private vehicle. When they reached home she again started suffering labor pain and suffered the whole night. Next day in the morning she delivered a baby girl at home around 8am and the new born was very weak. The baby died after three days.

### CASE 38
**Name**- Kavita Singh, **Village** – Mohkhan, **Block** – Bughar, **District** – Shadhol  
**Description**:-Kavita started suffering labour pain at mid night around 12am. The village in which she resides is located in a remote area due to which she had difficulty in accessing the governments Janani express transport facility service. The ASHA worker was also not in the village as she was the nearly 45km way from Kavita’s village. A village member called up the 108 ambulance services and they could avail a 108 ambulance from Kotma. Though finally Kavita was taken to Anuppur district hospital for treatment but she faced lots of difficulties in accessing the government health transport services.
CASE 39

Name: Sumankali, Village – Revadi, District – Shadhol

Description: In a village meeting Sumankali narrated her difficult experience of accessing government health service transport during her delivery. Sumankali was taken to the Keshvahi PHC via the government health transport facility of Janani express by the village Anganwadi worker. She gave birth to a baby girl at the PHC and the newborn weighed less than normal. After examining the baby the PHC doctor referred the baby to the district hospital in Shahdol. The child underwent three days treatment at the Shahdol district hospital, however her condition did not improve and she passed away after three days of treatment. The hospital staff did not provide any transport facility to Sumankali to go back home. Sumankali’s husband didn’t have money to hire any private vehicle so they walked from hospital to the bus stand. From the bus stand they boarded a state transport bus. They didn’t had money to pay for the bus fare either, so Sumankali gave her ‘Payal’ (anklet) to bus conductor in lieu of the bus fare.

CASE 40

Name: Pooja, Village – Adivashi, Block – Shohaval, District – Satna

Description: Pooja was admitted for a family planning operation. The medical officer administered an anesthetic injection before conducting the operation. However she couldn’t get unconscious even after the anesthesia was administered to her, so the doctor again gave her an anesthetic injection. After second injection she became unconsciousness and the doctor conducted the operation. However after operation, Pooja couldn’t regain consciousness. Thus she was referred to the district hospital and in the hospital she was declared brought dead. The Medical officer pressurized Pooja’s husband to not make the matter a big issue and the doctor offered money to Pooja’s husband so that he did not report about the matter to anyone.

CASE 41

Name: Buri Devi, Age – 20, Village – Bhavashi, Block – Ater, District – Bhind

Description: Buri Devi went into labour on 15/06/12. Her husband called for Janani express service, to transport her to the PHC for delivery, but the government transport facility was not available. Alternatively, her husband had to hire a private tractor to transport his wife to the PHC in Khup. When
they reached PHC, the medical officer refused to admit her and asked the patient to be taken to the district hospital. Her husband asked to the doctor for referral papers and for ambulance service. Though the doctor provided the referral papers but didn’t provide any ambulance service from the PHC to the district hospital. Her husband took her to the district hospital in Bhind via the same tractor. After she was admitted at the Bhind district hospital, the doctors there examined her and she was again referred to hospital in Gwalior. The doctors told her husband that her condition was worsening and she required better medical expertise. She was taken to Gwalior and admitted in the Maheshawari Nursing Home. She gave birth to a baby girl after three hours of reaching Gwalior. The health condition of Buridevi had worsened in transit and she suffered due to intense bleeding and died soon after.

CASE 42

Name- Renu Devi, Age – 24, Village – Mahavir Nagar, Block – Bhind, District – Bhind

Description:- When Renu Devi went into labour her husband got her admitted to the district hospital in Bhind for delivery. After admitting her in hospital her husband enquired about her condition from the doctor and the doctor assured him of a normal delivery. The doctor demanded Rs.1000 before conducting the delivery. Around 5.00 pm in the evening Renu gave birth to a child. Post delivery her condition started deteriorating and the doctors held a discussion over her condition and she was referred to hospital in Gwalior. Her condition worsened on the way and she died in transit.
List of Organizations – Partners in MHRC

1. Gram Sudhar Samiti, Sidhi
2. Santoshi Devi Mahila Vikas Samiti, Satna
3. Ehsaas, Satna
4. Gram Seva samiti, Hoshangabad
5. Manav Vikas Sewa Samiti, Rewa
6. Srijan Seva Samiti, Rewa
7. HARD, Anuppur
8. HARD, Shahdol
9. Pararth Samiti, Chhindwara
10. Satyakam Jan Kalyan Samiti, Chhindwara
11. Krishak Sahyog Sansthan, Raisen
12. Life Line Service Society, Sagar
13. Sarvodaya Sant Lallu Dada Jan Seva Samiti, Bhind
14. Sathiya Welfare Society, Sehore
15. Prasoon, Vidisha
16. P.S.S. S, Shivpuri
17. Sangini, Bhopal
18. Samavesh, Bhopal
19. Pradeepan, Betul
20. Kalptaru Vikas Samiti, Guna

21. Parhit Samaj Sevi Samiti, Tikamgarh

22. Kalptaru Vikas Samiti, Ashoknagar

23. Swadhikar, Bhopal

24. SOCHARA, Bhopal

25. Centre for Health and Social Justice, Bhopal

26. SATHI, Bhopal

27. Dharti, Morena

28. Other district level organizations
Maternal Health Rights Charter

Adopted at the

Madhya Pradesh State Public Health Dialogue

On 19th February 2014

1. The attainment of the highest possible level of health and well-being is a fundamental human right. Being a woman, access to adequate and comprehensive reproductive health care services is the fundamental human right of every woman. It should be available irrespective of a person's religion, abilities, caste, or class. Accordingly, we declare that maternal health right is a fundamental human right of every woman.

2. Universal and comprehensive Primary Health Care (PHC) is essential for the realisation of maternal health rights, especially for the most marginalised and vulnerable women. To realise maternal health rights, primary health care should include all human and other resources including equipment and medicines and adequate referral services to all women.

3. Women live in an unequal and patriarchal society and are denied access to basic human services and opportunities and are subjected to physical, emotional and psychological violence. We declare that every woman has the right to enjoy violence free environment, to have access to adequate nutrition, rest and education to uphold women’s dignity.

4. Women from discriminated and socially excluded communities that of Dalits, Scheduled Tribes and Muslims, face discrimination at various levels of health care and also suffer due to the absence of healthcare. We assert that discrimination of any kind is violation of the maternal health rights of Dalit, Adivasi, Muslim women and women from other socially excluded communities.

5. It is Government’s fundamental responsibility to ensure universal access to quality health care for all women to uphold their dignity and well being. Government is accountable for every violation of the maternal health right and for every maternal death. It is the constitutional duty of the government to take every step to remove discrimination in accessing health services and to make comprehensive health services accessible to all women

Endorsed by all the people from 13 districts who participated in the public health dialogue at Bhopal on February 19, 2014
Maternal Health Right Campaign (MHRC)

State level public health dialogue (Madhya Pradesh)
Date: February 19, 2014,
Venue : Gandhi Bhawan, Bhopal

Programme Schedule

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<tr>
<th>Time</th>
<th>Session</th>
<th>Facilitator</th>
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<tr>
<td>10:00 – 10.30</td>
<td>Registration</td>
<td>Mahendra Kumar</td>
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<td>10.30- 11:00 AM</td>
<td>Welcome &amp; Introduction of the participants</td>
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<td>11:00 - 12:00 AM</td>
<td>Briefing on the objective of the <em>jan samvad</em></td>
<td>Madhavi</td>
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<td>Background to the campaign and community level processes of maternal health rights</td>
<td>Ajay Lal</td>
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<td>Campaign Song by Men for Gender Equality Group Leaders</td>
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<td>12:00 - 02:15 PM</td>
<td>Welcoming the guests and panelists</td>
<td>Mahendra Kumar</td>
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<td>Dr. M. Geeta Mission Director NRHM-MP</td>
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<td>Dr. Dr. Aboli Gore, Dept. Team Leader MPTAST</td>
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<td>Dr. Ravi Dishuja, SOCHARA</td>
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<td>Dr. Ajay Khare, JSA Bhopan</td>
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<td>Dr. Y.K. Sandhya, Member NAMHHR, New Delhi</td>
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**Plenary session 1 -**

- Sharing of Community Based Monitoring (CBM) data on Maternal Health
- Testimonies from community members
- Key recommendations emerging from CBM for the realization of maternal health rights
- Response from the Panel to the issues of maternal health rights and community experiences

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<tbody>
<tr>
<td>Rakesh Sahu</td>
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<td>Smriti</td>
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<td>Dr. H.B. Sen</td>
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Ragini Mishra
Suman Singh
August, 2014

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