Background:

Karnataka State Health Systems Resource Centre (KSHSRC) has analysed maternal deaths from email data obtained from the districts. According to the report by KSHSRC, the total number of maternal deaths reported in Karnataka for the year 2015-16 was 635 with Belgaum reporting 81 deaths and Udupi reporting 2 deaths. 81% of maternal deaths are of age group between 20 to 29 years. 150 maternal deaths were due to PPH, 111 due to CCF and other cardiovascular causes, 101 due to pre-eclampsia and PET, 78 due to sepsis, 16 due to APH and 13 due to severe anemia. 70% of the deaths of the women who died were handled by doctors. Five cases had delivered and died during transit on the way, 62 cases had delivered at government hospitals and died when they were being shifted to higher facilities, 4 cases had delivered at home and died when they were being shifted to hospitals, 23 cases delivered at private hospitals and died when they were shifted to higher care. 34 ANC cases died when they are being shifted to higher care. 85% of the women who died had anaemia (80% moderately anaemic and 5% with severe anaemia). For 31% of the women who died, it was the first pregnancy and for 24% the second pregnancy. Maximum deaths (148) occurred between 2 and 12 hours after delivery.

Analysis

The report by KSHSRC does not give a background of how reliable the data collected has been and why this method of self-reporting has been used. There is no mention in the report of whether maternal death audits have been conducted for the 635 reported deaths in Karnataka. It is not clear if all the deaths have been adequately included in this data and what efforts other than email enquiries have been done to ensure data quality. The report also wavers between using percentages and absolute numbers. The use of absolute numbers without a denominator is extremely problematic. For instance, the report mentions that Belgaum has the highest maternal death rate of 81 as opposed to 2 in Udupi. This gives a false sense of poor service delivery in Belgaum. In reality,
it is important to know the denominator and MMR is measured per 1 lakh live births.

According to the report, 85% of maternal deaths were associated with anemia and 80% of patients had moderate anemia (7-11 gms%). This means that patients have not been given iron and folic acid tablets, nutritional advice and nutrition support through ICDS and health system which is supposed to distribute iron and folic acid tablets to pregnant women and even adolescent girls. If the majority of deaths are in women less than 24 years, it means a programmatic failure. As per NFHS4 data, mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) was just 45.3% in Karnataka.

78 of the death recorded were due to sepsis. Why are deaths due to sepsis occurring? What is the quality of care provided to the patients? How many of them are being monitored post-partum? When patients are being asked to deliver at institutions and the institutional delivery is quoted to be high in Karnataka (94.3% NFHS4), it means that poor hygiene at the facilities are causing the sepsis. What are the monitoring mechanisms? Why is there no audit for cause of sepsis related deaths? If 70% of the deaths are conducted by doctors and specialists, why is sepsis so high?

89% of the CCF (Congestive cardiac failure) deaths were associated with anemia. It is known that anemia is one of the biggest causes of CCF in pregnant women, so in this instance it is anemia again that has likely to have contributed to CCF. While anemia can be easily picked up in the antenatal period through clinical examination and also basic blood tests, early signs of CCF can be picked up by a trained health staff. If the staff have not been able to diagnose and manage it shows that they have been inadequately or poorly trained to pick up danger signs. Even in the absence of diagnostics, both anemia and CCF can be picked up by a well trained staff – even an ANM or ASHA or staff nurse.

The report says that 247 delivered at government hospitals and died and 85 delivered in private hospitals and died. Without a denominator, how can this data make any sense? Out of how many is this? What kind of private hospital? Was it a clinic? Nursing home? Tertiary hospital? Why is there no record or audit of maternal deaths in private hospitals? When private hospitals are so unaccountable why is the government so ready to give them more funds and empanel them? Under the Universal Health Coverage scheme, there is a move to bring in private players even at the secondary level. What is the system in
place to ensure that they report deaths and become accountable? Is this not the duty of the government?

Data from the department of Health and Family Welfare shows poor performing PHCs to be well performing in most of the indicators other than service utilization. If this is true, then there would not be so many instances of women dying in transit and between hospitals. The in transit deaths mean that the facility that the woman approached first was not adequately equipped in terms of human resource or infrastructure to manage the emergency. It could also mean that her high risk status was not adequately picked up by the health care facility and referred in the antenatal period itself.

Most of the deaths occurred 2 hours to 12 hours after delivery. This means that there was adequate time to manage the patient for complications. Post-partum care and monitoring of patients for danger signs is poor and it means that these are mostly preventable causes of death.

According to the WHO, PPH is largely preventable and manageable. PPH accounts for 59 per cent of maternal deaths in Burkina Faso, 53 per cent in the Philippines, and 43 per cent in Indonesia. In Karnataka, as per this data, the contribution of PPH to maternal deaths is unacceptably high. WHO has continuously promoted active management of the third stage of labour as an intervention for the prevention of PPH. This intervention is a package comprising administration of an uterotonic drug to make the uterus contract after delivery of the baby, clamping and cutting the umbilical cord, and delivery of the placenta by controlled cord traction, followed by uterine massage. The high rates of PPH show that the staff, including doctors have not received adequate training in emergency obstetric care and active management of third stage of labour.

The State Institute of Health and Family Welfare, Karnataka had spent only 37% of their budget in the last financial year. In the last three months, a marathon spending was observed with some centres planning multiple training for multiple staff. During those last three months of the financial year – January, February, March, staff were busy with other programs, other trainings, end of year financial reporting and with pulse polio. There was therefore poor attendance both of resource persons as well as participants. The quality of training is poor and most often the trainees are left to themselves to practice on dummies. Expensive mannequins are purchased by SIHFW but trainees are left to learn on their own. This makes the entire training exercise a waste of time and resources. To ensure expenditure, SIHFW, Karnataka went on a marathon
spending spree organising a state level workshop with different mannequin and simulation companies showcasing their products, at a cost of approximately Rs. 12 lakhs for a single day. The workshop was held at an expensive hotel Capitol with food at the cost of Rs. 850/plate. In the last three months, vehicles were budgeted for the deputy directors at the rate of 90 lakhs for ten vehicles and high end laptops were procured at the rate of Rs. 60,000/ laptop for the deputy directors, most of whom are unable to even operate the laptops, leave alone use it for any productive activity.

Ten deputy directors are posted at the SIHFW along with one director. As per their responsibilities they are expected to monitor one district each. However, most of the DDs and the director are busy with their own private practice and are hardly available at the SIHFW headquarters. Neither are they available to monitor the quality of training or implementation at the district level. This attitude of just being on the payroll of the government while doing private practice is also carried out by many of the principals at the district training centres who are mostly unavailable during training programs. The responsibility is left to some non-clinical administrative staff who does not have the capacity to check for quality of trainings. The resource persons mentioned on training agenda for emergency obstetric care are mostly only available on paper and training is theoretical or demonstrated by staff who themselves do not follow any training protocols. In Vani Vilas hospital, training for staff nurse was done on Post partum Intra Uterine Device (PPIUCD) insertion. In theory the trainees were asked to take informed consent from patients well in advance during antenatal period. However in reality the patient was literally forced on the labour table to undergo the procedure.

As one of the trainees stated “the Group D of the hospital was on the labour table and literally pushing the baby out with extreme fundal pressure. The os was not even fully dilated. The lady was primigravida and the junior doctor doing the delivery was hitting the patient and cutting her. Episiotomy is supposed to be given when the os is thin and the baby’s head is pushing on it. Here the baby’s head was not even visible and the doctor was just cutting the woman. We never do deliveries like this in our hospital. We wait and give time for the woman to go into proper labour. Why this rush to force her to deliver.” This was the lady who was forcibly made to have a PPIUCD inserted. Her mother was concerned about the decision but the doctor in charge told her “This is the procedure. She HAS to get an IUD inserted. You cannot refuse.” When this is the nature of training at a tertiary hospital in Vani Vilas, one can only dread to imagine the nature of
training at the district level. During the two day training, there was only one obstetrician who was, in parallel, also busy managing many other emergencies. The trainees were given mannequins to practice on ‘their own’. The deputy directors in charge of these trainings should make sure that the necessary resource persons are available, and in their absence be ready to do the training herself or himself. How can the quality of training be ensured with the State institute is so uninvolved?

Instead of conducting trainings with qualified clinical resource persons, SIHFW is handing over training of newly recruited doctors (4000 in number) to NGOs like Institute of Public Health (IPH) which have no infrastructural or human resource backing without any due process of tendering and at a budget of Rs. 90,00,000/-. Fortunately, the central government did not approve this handing over of the training by SIHFW to IPH but has suggested that the state can do so under its own budget. The state cannot shy away from its responsibilities by handing over training to NGOs which have no established capacity in management of emergency obstetric care, administration or any form of capacity building. This responsibility lies with the SIHFW for which they receive salaries.

It is important that the people responsible for these deaths at all levels be held accountable. Usually the entire blame is placed on the patient or a few ASHA workers and ANMs are suspended or penalised. This is unfair. Changes have to be made at all levels of healthcare delivery.