

**Report to the National Human Rights Commission, New Delhi regarding death of children in Niloufer Hospital, Hyderabad dated the 12<sup>th</sup> June 2006**

**Sub: *Suo motu* cognizance by the National Human Rights Commission, New Delhi of report dated 11<sup>th</sup> August 2004 appearing in the newspaper “Eenadu” regarding death of children in Niloufer Hospital, Hyderabad.**

Ref: Letter of the National Human Rights Commission in NHRC Case No.405/1/2004-2005 (FC) NHRC (Law Division-IV) dated 17<sup>th</sup> March 2006 addressed to me.

In this case the National Human Rights Commission took *suo motu* cognizance of a news report dated the 11<sup>th</sup> August 2004 appearing in the Telugu news paper “Eenadu” alleging large numbers of deaths of infants in the Niloufer Hospital, Hyderabad in June and July 2004 and called for the comments of the Principal Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department on the contents of the report in that newspaper. The Commission in its proceedings dated the 30<sup>th</sup> August 2004 made the following observations:

“A news item clipping dated 11<sup>th</sup> August 2004 which appeared in the Telugu daily Eenadu states that in Niloufer Hospital at Hyderabad 227 children died in June of which 163 children were infants and in July 274 children died out of which 188 were infants.

If the contents of the report are true, it raises (the) issue of violation of human rights.

A copy of the news item may be sent to the Secretary, Health, Government of Andhra Pradesh and Medical Superintendent, Niloufer Hospital, Hyderabad for looking into the allegations and (to) submit their comments within three weeks.”

2. In response to the Commission’s proceedings the Principal Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department submitted a report dealing with the various issues raised in the news item to the Honourable Commission. The Commission thereafter forwarded a copy of the news item together with the proceedings of the Commission dated the 30<sup>th</sup> August 2004 and a copy of the report received from the

Principal Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department to me with the request that I visit the hospital and give a complete status report regarding the facilities and the present state of affairs at the hospital, keeping in view the report received from the State Government.

The following is the Report I sent to the National Human Rights Commission, New Delhi on the 12<sup>th</sup> June 2006 in ten sections under different headings, the last section being the Conclusions and Recommendations.

## **I. Report in the Eenadu**

The following are the main points made by the Telugu Daily “Eenadu”, a widely circulated newspaper in Andhra Pradesh in its issue of the 11<sup>th</sup> August 2004:

1. Between 5 and 13 deaths of children take place daily in the Niloufer hospital and in the months of June and July 2004, 227 and 274 children died respectively in this hospital. Of the 227 deaths in June 2004, 163 were below 1-month babies. Of the 274 deaths in July 2004, 188 were below 1-month babies.

2. Niloufer hospital is a 350-bed hospital. The available staff strength is also consistent only with the needs of a 350-bed hospital. However, more than 700 children are admitted into the hospital daily. In June 2005, as many as 3,170 pregnant women and children and in July 2004 as many as 3,580 pregnant women and children were admitted as inpatients. Two children are put in each single bed and several children are made to lie on the floor as well. Staff inadequacy has led to inadequate attention of the special needs of pre-mature babies.

3. The situation in regard to facilities and equipment is most deplorable. After the withdrawal of user charges of Rs.200/-, the ECG unit has been closed. This has forced the parents of the children to go to the market to get the ECG done. In the market each ECG costs Rs.400/- to Rs.450/-, which the poor can hardly afford. Any kind of diagnosis after 12 noon in the day has to be accessed only from the market outside. Even for blood test people have go to the market which means hundreds of patients have to go in search of privately run diagnostic centres. A Government doctor serving in the Government Niloufer hospital himself is running a diagnostic laboratory in the neighborhood of Niloufer hospital. The same position obtains in regard to supply of drugs and medicines to patients. Some medicines, which the hospital authorities themselves prescribe and which are not available and which are only slightly costlier than what the hospital itself would have incurred, have to be bought from the market putting the poor patients to expense.

4. Though the hospital has a lift, it has been under repairs from 2002 onwards till the period of report in 2004. This results in the children in distress and their parents having to walk up two floors. A child called Saidulu of Nomala village of Nalgonda District, who died

5. Corruption indulged in by the staff has been a source of great harassment to the poor patients depending upon this hospital. Gatemen, other class IV employees, ward boys, nurses and staff nurses, - all expect and receive bribes. In fact no admission is possible without payment of a bribe. Parents or guardians of little children necessarily have to have entry into the hospital as they have to attend on the little children who are inpatients, in order to take care of them including even changing of their clothes. If they cannot gain entry, even the changing of the clothes of the children will not take place. Even to go and see one's own child, a bribe has to be paid. There are different rates of bribe such as those for entry (Rs.2-10); shifting of patient from emergency to general ward (Rs.50/-); for a female child born at the maternity ward (Rs.300/-); for a male child born at the maternity ward (Rs.500/-); for the first birth of the child (Rs.100/-); stretcher for shifting the baby (Rs.250/-); sweeper on duty (Rs.10/-). Since a patient or the attendant has to go through several entrance gates, bribes have to be paid several times. The Eenadu reported that one person, by name Ramu, spent Rs.4000/- in this manner in Niloufer. Access at the main entrance in the hospital is extremely narrow and at the same time, thanks to the incompetence and indifference of the security staff, there is invariably jostling and pushing of the patients who are already ill and in distress.

6. The Infosys Foundation has given a donation of Rs.3 crores to create a 150-bed facility in the premises of the Niloufer hospital. The work on the construction of this facility has not been started because of the failure of the Municipal Corporation of Hyderabad (MCH) to give necessary permits, the inaction of MCH itself attributed to the expectation of bribes by the Corporation officials. This is a serious failure of the Government of Andhra Pradesh.

## II. Andhra Pradesh Government's Response

In response to the Commission's direction to offer his comments on the Eenadu report the Principal Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department submitted a report to the Commission on the 11<sup>th</sup> August 2004.

2. I summarize below his comments:

- i) A very large proportion of the deaths that occurred of 1-month-old babies has been of those referred from other hospitals. For example, out of the 163 deaths in June 2004, 136 had been referred from other hospitals and only 27 were born in the Niloufer hospital itself. Similarly of the 198 deaths in July 2004, 170 had been referred from other hospitals and only 28 were born in the Niloufer hospital itself.
- ii) Almost all the cases referred were in a very morbid and critical condition and brought from far off places with conditions relating to Asphyxia, Sepsis, HMD/MAS, ELBW, Malformations and others. Doctors were referring such cases to Niloufer only after realizing that the condition of the children was very critical. If only the children had been got stabilized and referred to Niloufer earlier, survival rate would have been much higher. Survival of babies of weight below 1 kg. is always very difficult. Niloufer is the only hospital, which admits such difficult cases. The number of newborn cases seeking admission has increased "tremendously" and because of the high-risk nature of these referred cases, mortality is high.
- iii) The number of children referred to Niloufer has been gradually and constantly increasing over the years, casting a "tremendous" burden on the human resource availability at the hospital, namely, Doctors, Nurses and Paramedical staff. At present Niloufer had 30 qualified Pediatricians in the form of Professors, Associate Professors and Assistant Professors. There is need to enhance and recruit more doctors in view of the workload. There was need to create 2 alternate Pediatrics and 1 Neonatology unit. The present qualified doctor patient ratio is 1:20 and this should be "doubled" if quality care has to be provided. The Government has provided 77 nurses and 16 head nurses and there were 14 nurses on deputation. The Indian Nursing Council norm for the

nursing staff is 1:3 and this means there was need to increase nursing staff at Niloufer by at least 4 times the present strength of 77 nurses. This was under Government's examination.

- iv) As regards the allegation about the closure of the ECG unit and the consequent need for patients to spend Rs.400 to 500 as the ECG test charges outside the hospital because of the abolition of the user charges, it was confirmed that the services of the ECG technician were terminated because of non-availability of funds and the ECG was being done by the Government's "own staff". Government has subsequently provided sufficient budget in lieu of cancellation of User Charges. The services of the ECG technical staff have been restored and therefore the allegation is false.
- v) As regards absence of repairs to the lift, "since the past 2 years, in spite of several repairs, the lift is not functioning as it has become very old. The team of engineers have come and inspected for providing the lift and work is likely to start once the sanctioned are made (sic)".
- vi) As regards patients being asked to purchase costly medicines outside the hospital and the non-starting of closed units, all medicines including costly life saving medicines are available in the hospital, having been provided by the APHMHIDC and all needy patients below the poverty line are provided required drugs free of cost. No unit of the hospital has been closed and all units such as the ESR (Emergency Service Room), Premature Intensive Care Unit (PICU), Post Operative Ward and operation theatres are all functioning.
- vii) As regards the allegation of not granting permission for starting the construction of the Infosys Foundation donated building, the work was likely to start shortly.
- viii) As regards bribes being collected by the hospital staff, a committee has been constituted consisting of the Civil Surgeon Resident Medical Officer, Deputy Civil Surgeon Resident Medical Officer, Nursing Superintendent Grade-I, Nursing Superintendent Grade-II and Health Inspector of the Hospital to probe into the allegation. The Committee's report on specific complaints is being acted upon, leading to suspensions and withholding of increments in some cases. The security personnel have been warned and new tenders are being called for fresh security appointments.

Nursing staff and all Class-IV staff have been warned sternly against collecting bribes and strict action will be taken against those found guilty.

3. The basic allegations contained in the Eenadu report about the Niloufer hospital pertain to the following issues:

- I. There are large-scale neo-natal deaths.
- II. There is gross inadequacy of staff and space.
- III. There is gross inadequacy in the availability and maintenance of diagnostic equipment and facilities and shortage in supply of drugs and medicines, driving the poor patients to the market to get the investigations done and buy the required medicines and drugs at great expense.
- IV. There is large-scale corruption among the Class IV staff.
- V. The lift in the hospital has been out of commission for years causing grave inconvenience to patients and even leading to fatality in one cardiac case.
- VI. There has been considerable delay in completing the construction of the building, which had been donated by the Infosys Foundation.

4. At the very outset it needs to be pointed out that that a mere reading of the reply of the Government of Andhra Pradesh shows that the Government of Andhra Pradesh has not seriously challenged any of the allegations made in the newspaper report. The basic facts mentioned in the newspaper report have been acknowledged as true excepting in regard to the supply of medicines and drugs and the availability and functioning of the diagnostic and other equipment. The report of the Principal Secretary, Health, Medical and Family Welfare of the Government of Andhra Pradesh has sought to explain the reasons for the situation in the Hospital and also enumerated certain steps that the Government intend taking to set matters right. Thus there is no disagreement as to the serious shortcomings reported about the conditions in the Niloufer hospital.

5. The only question that needs, therefore, to be examined is: how serious are these shortcomings and do they constitute negligence of an order and magnitude on the part of the authorities that would amount to the violation of Human Rights of the infants, children and the families who are entitled to care at the Niloufer hospital and who come to the Niloufer Hospital in search of and in the expectation of such care? I answer this question in the following pages based on the investigations made by me, discussions held by me with all

concerned and the material gathered by me. In pursuance of these efforts I have made four visits to the Government Niloufer Hospital for Children, Hyderabad on the 5<sup>th</sup> April 2006, 3<sup>rd</sup> May 2006, 29<sup>th</sup> May 2006 and 3<sup>rd</sup> June 2006. While during all these visits I have held discussions with Dr. N. C. K. Reddy, Medical Superintendent, Niloufer Hospital, Hyderabad I have also undertaken inspection of the hospital wards during my first, third and fourth visits accompanied by him, the Professor of Neonatology and the Resident Medical Officer-I. In addition to holding discussions with the Superintendent of the Hospital I have also held detailed discussions with several other Doctors of the Hospital including the Professor of Neonatology during my second, third and fourth visits. After completing my visits to the Niloufer hospital and my discussions with the authorities there, I have called on Dr. D. Sambasiva Rao IAS, Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department on the 9<sup>th</sup> June 2006 for a final wrap up discussion. Dr. D. Sambasiva Rao was kind enough to invite to this meeting Dr G. Sai Gopal, Director of Medical Education, Dr Muralimohan, Additional Director of Medical Education and Shri Raghuma Reddy of the Andhra Pradesh Health and Medical Housing and Infrastructure Development Corporation (APMHIDC). My findings, conclusions and recommendations in this Report are, therefore, based on all these inputs.

6. I would like to place on record my deep appreciation of and gratitude to Dr D Sambasiva Rao, IAS, Secretary to the Government of Andhra Pradesh, Health, Medical and Family Welfare Department for ensuring that I received all required cooperation from all concerned during my investigation. I am grateful to him for the meeting he convened at short notice on the 9<sup>th</sup> June 2006 to facilitate detailed discussions on my findings with the Director and Additional Director of Medical Education and the representative of the APMHIDC. **Dr N C K Reddy, Medical Superintendent, Niloufer Hospital spared a lot of his precious time most willingly to discuss with me sincerely all the issues raised by me, provided all the information sought by me and was always transparent during the discussions we had about all connected issues. My particular thanks go to him for his unstinted cooperation, including in facilitating my visits to the wards. I should place on record with gratitude the help I received from Dr Ravi Shankar, Professor of Neonatology, Niloufer hospital in understanding the problems of his division that are central to this Report of mine.**

### **III. Requirements of Staff as per norms, shortfalls as per norms, vacancies in sanctioned posts and the Actual Staff Position at Niloufer.**

That there is gross understaffing in Niloufer hospital with reference to the norms laid down is beyond doubt. This is the primary problem. The other problem, which compounds the primary problem in regard to staff, is that even the existing, sanctioned posts have been vacant over the past several years in a big way in crucial areas. The following is the position:

#### **1. Norms for Staff and Shortfalls therein.**

While discussing the staff needs of Niloufer Hospital, we are talking of a 500-bed hospital because though Niloufer hospital is a 350-bed hospital, in reality the occupancy in this hospital on any given day in the year, over several years, has been 175% to 200% of its original design. According to the data provided by the Medical Superintendent **the following are the shortfalls in the posts sanctioned against the yardstick prescribed by the Government of Andhra Pradesh, for a 500-bed hospital:**

Sl. No.	Category	Staff prescribed according to the Government yardstick for a 500-bed Hospital	Sanctioned.	Shortfall
1.	Medical Officers	81	55	16
2.	Head Nurses	23	16	7
3.	Staff Nurses	100	77	23
4.	Lab Technicians	23	11	12
5.	Pharmacists Gr. II	16	8	8
6.	Lab Attendants	23	8	15

**However, I find that there are flaws in the very yardstick adopted by the Government of Andhra Pradesh. For example, the accepted norm of nurses per doctor is 1:3, and by that reckoning the number of nurses should be 243 and not 123 as stated in the yardstick laid down by the Government of Andhra Pradesh. Therefore, clearly the standards the Government of Andhra Pradesh is observing are themselves seriously flawed and we cannot go by them. Still, the shortfalls are grave judged even by their own yardstick and far worse by any rationally accepted standards, as may be seen from the Table**

above. **The shortfalls are of an unacceptable order of 31% in posts that ought to have been sanctioned even according to the Government's own yardstick.**

## **2. Vacancies in the posts sanctioned.**

To make matters worse, **there have been serious shortfalls in the filling up of vacancies that have arisen even in the staff sanctioned for the Hospital, which itself is unrealistically low because of the yardstick adopted by the Government.** I have asked for and obtained the details in regard to the posts sanctioned under various categories of staff, the staff in position and vacancies over a period of 6 years starting from the year 2000 to the year 2005. I believe that it is important to examine this issue in the context of the position that has obtained over a period of time to assess the kind of commitment different Governments have brought to bear upon matters relating to health in this State. In doing so it is important for us to bear in mind that the existing vacancies are actually against the already grossly under-sanctioned staffing pattern at the Niloufer Hospital. **An examination of the vacancies position shows the following shortfalls over a period of 6 years:**

1. There are 21 posts of Assistant Professors of Pediatrics. In the year 2002 one of these posts was vacant. The vacancies rose to 3 in the years 2003 and 2004. In the year 2005 there were 2 vacancies. Vacancies of this order continuously for years together speak poorly of the Government's management of the hospital. As regards the post of Assistant Professor of Pediatric Surgery, against a sanction of 5 posts there was one vacancy in the year 2001 and the vacancies rose to 2 in the year 2003. Subsequently there have been no vacancies in this category. Nevertheless a vacancy position of 20% in the year 2001 and 40% in the year 2003 is extremely serious. One post of Assistant Professor of Obstetrics and Gynecology was vacant in the year 2003 against a sanctioned strength of 3. This again presented a serious situation. There is one sanctioned post of Assistant Professor of Pathology. This post was vacant in the year 2000. As for the posts of Assistant Professor of Neurology, against 2 sanctioned posts one continued to be vacant during the years 2003 and 2004, which is a very serious matter. In the year 2000 this hospital functioned without a Civil Surgeon RMO or a Deputy Civil Surgeon RMO though there is 1 sanctioned post against each of these categories. I shall revert to the theme of RMOs at the end of this chapter. In the year 2001, 1 sanctioned post of Civil Assistant Surgeon (Ophthalmology) was vacant. The single post of Civil Assistant Surgeon (Psychiatrist) was vacant in the year 2004.

2. Coming to the Nursing side, the situation has been very bad. Against 1 sanctioned post of Nursing Superintendent Grade-I, the post was vacant in the years 2001, 2004 and 2005. This is a deplorable situation. Against 16 sanctioned posts of Head Nurses, one post was vacant in the year 2005. While against a sanctioned strength of 77 Staff Nurses there were 7 vacancies in the year 2000, there were 5 vacancies in the year 2001, 2 vacancies in 2002 and 1 in 2003. As regards Public Health Nurses, against 6 sanctioned posts, there have been 2 vacancies during the years 2004 and 2005. Against 6 sanctioned posts of MPHS (F) there has been 1 vacancy in the years 2004 and 2005. Against 30 posts of MPHA (F), there were 3 vacancies in 2000; 2 in 2001, 2002 and 2003; and 1 in 2004. The single sanctioned post of the Sub-Health Inspector has remained vacant all through the past 6 years starting from the year 2000 to 2005. Also, there have been vacancies among the Nursing Orderlies. Against 39 sanctioned posts, the vacancies were as high as 3 in 2004; 4 in 2000 and 5 in 2005. This is a bad situation.
  
3. As for the important post of Lab Technician, against 11 sanctioned posts 2 were continuously vacant during the years 2000, 2001 and 2002 and again in 2005. In between, 1 of the posts was vacant in the years 2003 and 2004. This is a bad situation. As for the Lab Attendants, against 11 posts sanctioned there was 1 vacancy in 2000 and the vacancies rose sharply to 3 in 2001 before coming down to 2 in the years 2002, 2003 and 2004. The vacancies again rose very sharply to as many as 4 in the year 2005. This is an extremely bad situation. The vacancies in the categories of Lab Technician and Lab Attendants taken together, the Laboratory could be taken as having functioned very poorly indeed. The number of posts sanctioned for the category Dark Room Attendant is 3. One of these posts has consistently remained vacant all through the last 5 years starting from the year 2001 to the year 2005. We can quite imagine how they X-ray Department would have functioned. **In other words, the investigation side of the hospital was in a state of disarray and near collapse.** That this situation would have forced the poor patients to get their investigations done outside the hospital in private facilities is obvious. That in turn would have put them to enormous expense is beyond question, the patients being very poor. The single post of the Biochemist has remained consistently vacant all through these 6 years starting from the year 2000 to 2005.

4. The important posts of Electrician and Boiler Attendant also remained vacant frequently. The single post of Electrician Grade-II remained vacant throughout the last 6 years starting from the year 2000 right up to the year 2005. As for the Boiler Attendant, a very crucial post, the same has been the case all through these 6 years. The single post of a Carpenter that is so crucial for the general upkeep of the basic and essential hospital furniture like cots remained similarly vacant all through the past 6 years. There are 2 posts of Tailor. One of them has been continuously vacant during all the last 6 years starting from the year 2000. One of the 7 posts of Driver was continuously vacant during the period 2002 to 2003. That this would affect the operations of the hospital Ambulance is beyond doubt, affecting the emergency needs of the children at risk.
5. Against 30 sanctioned posts of sweepers, the vacancies were 11 in 2000; 7 in 2001; 4 in 2002, 2003 and 2004. The vacancies were 3 in the year 2005. In addition, the “outsourcing” of the sanitation work destroyed the sanitation environment thoroughly as pointed out by me elsewhere in this report.
6. Some of the other essential services that affect the patients and their attendants were poorly manned because of vacancies. There is 1 post of Lift Attendant. This has been vacant during the last 3 years, from the year 2004. In any case, the APHMHIDC never repaired the lift itself, obviating probably the need for a lift attendant altogether! Also, of the 4 sanctioned posts of Telephone Attendants there has been 1 vacancy in the years 2000 and 2001; and 2 vacancies during the last 4 years starting from the year 2002 till 2005. There are 4 sanctioned posts of Gate Porters. Two of these posts were vacant during the years 2003 and 2004. Similarly, 2 of the 8 sanctioned posts of Attendants have been vacant for the past 3 years starting from the year 2003.
7. On the Diet Services side, things cannot be worse. The single sanctioned post of Senior Cook has been vacant throughout these last 6 years, starting from the year 2000. As for the 5 sanctioned posts of Junior Cooks, 3 of them have been vacant through these 6 years, starting from the year 2000.
8. The all important post of Occupational Therapist – 1 sanctioned post – has been consistently kept vacant all through these 6 years starting from the year 2000 to 2005. Given the load of prematurely born babies coming into the hospital as also babies with birth defects, and potential for birth defects in LBW children, how poorly the vital need

for an Occupational Therapist has been understood by the authorities in the Government can be easily gauged.

2. To sum up, the shortfall in providing the sanctioned strength with reference to staff norms of all categories taken together, for years on end, has been 31%. This serious original handicap has been further compounded by the overall vacancy position, which of all the staff taken together has hovered between 14% and 18% during these 6 years and has been 15, 17 and 17 percent respectively during the years 2003, 2004 and 2005. The latest vacancy position at Niloufer as of May 2006 shows 6 vacant posts of Professors - 1 in the areas of Pediatrics, 2 in the area of Obstetrics and Gynecology and 1 each in the areas of Cardiology, Neurology and Dental Surgery. There are 6 vacancies of Lab Technicians and 2 of Lab Attendants. The vacancies in other areas remain more or less the same as in 2005. **The two viewed together - the original inadequacy of the number of posts sanctioned themselves as against norms and bare needs on the one hand and the vacancies in even the truncated sanctioned posts on the other, gives us a clear understanding of the chronically parlous situation this hospital has functioned in, for years together because of lack of personnel. The ban on recruitment of personnel and resort to “contract” appointments has also adversely affected the staff availability and morale in the health sector in general, with Niloufer Hospital being no exception. That there has been unconscionable numbers of deaths in this hospital should, therefore, surprise nobody.**

3. All this has affected the morale of the existing Staff in Niloufer. The staff of this hospital is working under extreme stress for the following reasons:

- i) Overload of patients.
- ii) Gross under-staffing in all areas and more especially in the area of nursing, equipment and technical investigations.
- iii) Grossly inadequate infrastructure for neonatal care (not enough even for Level II care) and
- iv) Grossly inadequate Lab support, medicines and disposables.

These greatly demoralize patients who come with a lot of expectations from the city of Hyderabad and the neighbouring districts. As for the Doctors themselves, there does not appear to be any job satisfaction among most of them. The reason why many are still sticking to their jobs is the expectation that good days would eventually come; and perhaps, even

more importantly, the teaching experience and updating of theoretical knowledge and the availability of extensive resource material for learning about diseases the sheer patient load a Hospital of this kind provides.

### **3. The problem of Contract Jobs in the Health Sector – a defect in Policy**

The main reason for staff shortage is the ban the Government of Andhra Pradesh has imposed on recruitment of medical and health personnel as part of its personnel policy. In my considered opinion there has been a perceptible deterioration in the health care scenario in the State of Andhra Pradesh during the past 5 to 6 years. One of the chief reasons for this is the so-called “reforming” Governments of Andhra Pradesh have persisted with the ill-informed idea of a ban on recruitment of medical and health staff and seeking to fill the arising vacancies by offering jobs on “contract” basis to health personnel of all categories. I have touched upon this subject in my August, 2005 Report on the Deaths of Tribals in the Paderu Agency Area of the Visakhapatnam District of Andhra Pradesh submitted to the National Human Rights Commission. I have now studied a typical case of an Assistant Professor of Neonatology in Niloufer Hospital, Hyderabad to understand what this untenable policy has done to doctors and childcare in Andhra Pradesh. This bright doctor was a school topper from class 1 to class 10 and topped the State Entrance examination while passing his Intermediate examination at one of the prestigious residential schools of Andhra Pradesh. He obtained 10<sup>th</sup> rank in the EAMCET examinations. He later graduated as a Gold Medallist in MBBS from one of the most prestigious medical institutions, JIPMER. He went on to top the Postgraduate Entrance Examination at PGIMER, Chandigarh. He is a university topper in MD Pediatrics and also a topper in DM, Neonatology. He was given the best researcher award in DM at the PGIMER. With such outstanding qualifications he came to Hyderabad expecting to join a medical institute to serve the people of Andhra Pradesh. To his surprise he found that his qualifications did not carry any weight with the recruiting authority, thanks to Government policy. He was refused a post of Assistant Professor that he sought and was asked to wait for vacancies to arise so he may get a “contract” job. Eventually he obtained a “contract” job in a vacancy that arose in the Niloufer Hospital. In this post, his salary is Rs.12, 000 per month, which is some times paid once in 3 months! There are echoes here of the fate of the much trumpeted Andhra Pradesh Government’s World Bank-inspired Community Health Workers (CHW) of the Paderu Tribal Area, who receive their monthly honorarium of Rs.400/- once in six months, as shown by me in my August, 2005 Report on

the Deaths of Tribals in the Paderu Agency Area of the Visakhapatnam District of Andhra Pradesh submitted to the National Human Rights Commission. His working hours are 9 AM to 2 PM and he has night duties every fortnight in the Pediatric Department along with another Assistant Professor. He has teaching responsibilities for under graduate and postgraduate students. He compares his fate with that of the other Assistant Professors who had been recruited earlier and therefore have regular jobs and finds that he has no job security since his contract is renewed from a minimum of 3 months to a maximum of 1 year! He thus has no future at all and can look forward to no progress in his career, as he is only a “contract” employee. There is no guarantee that he would get his pay every month. Since he is a contract employee he is not entitled to sick leave or earned leave nor would he be entitled to certain special benefits that his other regular service colleagues have. Since he is a contract employee he cannot be a member of the Doctors’ Association, which means he cannot even consider himself to be part of a group of professionals who can collectively bargain and seek redress of grievances, consistent with their rights. He now keeps wondering as to why he did not flee the country like many of his friends have done, to the United States or Canada or Australia. He is a thoroughly de-moralized professional today. I am certain that he will any time now go away from the Andhra Pradesh Government service and join a private corporate hospital as he will have better emoluments and better quality of work life there since, unlike in Niloufer, he would have good health and medical infrastructure environment to work with and thus provide quality service to children and in the process derive his own job satisfaction. Only, the children from the poor classes of our society who come to the Niloufer Government Hospital will have one service provider less.

2. It is clear from the study of this case that employing health personnel on contract jobs can never be an answer at least in Indian conditions, either for credible provision of health and medical care or for fulfilling the job needs of qualified medical personnel or for satisfying the legitimate expectations of the faculty in a teaching hospital. It is unlikely that any qualified medical officer will care to face the kind of hardship narrated above and continue in a “contract” job of this kind. The Government of Andhra Pradesh has singularly failed to understand even the fundamentals of human psychology and motivation in resorting to such a counter productive “contract” appointment policy in regard to recruitment of personnel in the health sector. **This ill-advised ban on recruitment of health and medical staff and resort to contract appointments have together fundamentally affected adversely the right to health of the poorer section of the people of Andhra Pradesh.**

3. An appendage to this policy is the currently fashionable philosophy of “outsourcing” essential services. In Niloufer, services usually rendered by Class IV staff have been “outsourced”. The policy is that to the extent of the funds saved by not recruiting Class IV staff, outsiders will be engaged on “contract” basis. The self-serving argument is that it is cost effective and therefore a rational arrangement. The result is that the services of all Security and Sanitation staff have been outsourced. The consequence is that Security in the Niloufer hospital is in a total mess. All the allegations made in the Eenadu report in this regard are true. **I spoke to a number of parents sitting outside the hospital premises at the Niloufer hospital during my visit to the Hospital on the morning of the 3<sup>rd</sup> May 2006 and they all confirmed that they have to pay bribes to the Security personnel to gain admission into the hospital when they bring their children or wives.** I am satisfied, on the basis of my personal discussions with the authorities, that the private agencies with whom the hospital has had to enter into contract for supply of Security personnel on the basis of tenders called for, send absolutely undisciplined, untrained and generally characterless individuals as security personnel to the hospital. The result is that they, the Security personnel, are a law unto themselves with no body in the hospital having any control over them. Consequently, there is corruption, indiscipline and obvious harassment to the hapless patients.

**4. By far the most serious shortcoming in regard to staff at Niloufer is the total absence of the concept of a proper functioning of the Resident Medical Officer (RMO) System. According to the staffing pattern we have for this hospital 1 RMO designated as RMO-I in the cadre of Civil Surgeon and another RMO designated as RMO-II in the cadre of Deputy Civil Surgeon. It is with the utmost shock that I record that though we have two Resident Medical Officers for Niloufer, none of them lives on the premises as required under the Rules. The reason given in regard to RMO-I is that the residential quarters meant for him were demolished 3 years ago and not reconstructed again. As for the RMO-II, he has quarters in the hospital premises but he has not chosen to live there. Because the RMO-II has chosen not to live in these quarters, it is in a state of disrepair. The RMO-II explained to me during my inspection that he was not living in these quarters because electricity had been disconnected to the quarters since a couple of years as the former occupant had not paid the electricity charges due from him to the**

State electricity authority, the APCPDCL. It is indeed most deplorable that a senior medical officer of a premier Government hospital could advance such an untenable excuse for such a serious lapse. An investigation should be started immediately by the Government as to why a small amount of a few thousand rupees could not have been paid by the Government to one of its own organizations or the matter sorted out by discussions and how this gross neglect has been used as an excuse for the RMO-II not residing on the hospital premises. This is by far the grossest example of complete absence of discipline at Niloufer and responsibility and accountability on the part of senior medical officers who ought to observe a certain sense of professional ethics on their own. That such ethics are a personal imperative is one thing. The other aspect, however, is that it is equally important that the State Government should enforce these ethics under the rules and the disciplinary powers that it undoubtedly possesses. This, the Government of Andhra Pradesh has failed to do. That the Government has failed to ensure this minimum requirement speaks very poorly of the way it is looking at its responsibilities towards the rights of the children in the context of the functioning of the Niloufer Hospital. The Government should investigate at once as to why the quarters of the RMO-I have not been reconstructed for years and make the RMO-I take up his residence. The investigation should establish whether due diligence has been shown by every one directly and indirectly responsible for the proper administration of this hospital to ensure that the quarters were reconstructed by the APHMHIDC at the utmost speed to get the RMO-I back to full time work as per the rules and to ensure that the RMO-II did not have excuses for not residing on the premises of the hospital as expected under the rules. The accountability of the APHMHIDC should be established in this case. The Chief Secretary to the Government of Andhra Pradesh should himself look at this scam of non-resident RMOs at the Niloufer Hospital personally and report to the National Human Rights Commission, having fixed responsibility for negligence on those responsible.

5. Based on all the points made by me above, I conclude that there is palpable negligence on the part of the Government of Andhra Pradesh in regard to matters relating to essential staff requirements both in policy and implementation terms. However, an emerging good sign is that the present Government of Andhra Pradesh has started recruiting doctors and nurses. It remains to be seen nevertheless whether this recruitment would be better than a mere half-hearted measure in the sense that the

Government of Andhra Pradesh should go for recruitment of all categories of personnel needed according to recognized norms instead of doing something cosmetic that is too little and too late.

#### **IV. Large Scale Neo-natal Deaths.**

By far the most distressing aspect of the functioning of the Niloufer Hospital is the very large number of deaths that regularly takes place of infants below 1 month. The number of these deaths has been simply stunning, continuously over the past several years. They were an unacceptable 1,389 of a total number of admissions of 6, 252 in 2001 or 22% of all babies admitted. These deaths rose to 1,528 in 2002 out of total admissions of 6,434 babies, a percentage of 22.7%. The number of deaths climbed sharply to 1, 884 in 2003 though the admissions in that year were only 4,282. The number of deaths in 2003 constituted a huge 44% of all babies admitted! In 2004 the number of deaths rose to 1,895 against 8, 163 admissions, the deaths being 23.2% of admissions. In 2005 the deaths were 1,970 against an overall admission of 8,573 or 22.9%. **This is a story of a continuing holocaust.**

2. The specific issues that relate to under -1 babies that have caused these deaths are:

**a. Premature birth and low and very low birth weight (VLBW).** Because of premature birth organ functions are problematic, organs having not matured. Premature births are caused by poor antenatal care, poor maternal nutrition, maternal hypertension and infections in pregnancy, vaginal bleeding in pregnancy etc., As for low birth weight, maternal nutrition and other maternal risk factors are the main cause.

**b. Asphyxia.** This means deficient oxygenation of the fetus and also deficient blood supply to the fetus. This leads to the baby breathing poorly. Maternal malnutrition, other maternal illnesses, TB and hypertension are generally the cause of these. Therefore, obstetric follow up is the most important element in dealing with this problem. Also crucial are the timing and place of delivery.

**c. Septicemia.** This is also a problem of premature birth of babies as prematurely born babies are especially vulnerable to infection. Over crowding in wards where they are nursed leads to cross-infection. This means that **there is very little immunity for premature babies, the situation compounded by the kind of conditions witnessed in Niloufer.**

**d. Respiratory problems.** This accounts for 5% of all deaths of babies under 1. HMD and MAS represent these. The need here is for respiratory support to babies through essential equipment like ventilators in regard to which Niloufer is poorly equipped.

3. Given the magnitude of mortality of below 4-week babies, it is essential to examine the environment in which the neo-natal cases are dealt with in the Hospital in terms of staff strength, space in the patient care area, equipment and supply of drugs and medicines. I have already referred in detail to the general shortage of staff at Niloufer in the previous chapter. I may add here specifically in the neonatal context that there are mandatory norms laid down by the National Neonatology Forum of India in regard to staff, physical facilities, nutrition, feeding and other connected needs, infection control, special monitoring and therapeutic facilities, investigation facilities, mothers' education and neonatal follow up. Some of these are discussed below in the Niloufer Hospital context:

4. The Neonatal Unit of the Niloufer hospital consists of a Premature Babies Ward and a Sick Nursery. The newborn babies are also admitted into the Emergency Neonatal Intensive Care Unit (NICU), which is kept in this hospital as a component of the Pediatric Emergency Services Room (ESR). Of the total admission to the hospital, 15% are admitted to the Premature Babies Ward, 20% to the Sick Nursery and about 65% remain in ESR NICU. I have visited these units on two occasions on two different days to observe the actual conditions obtaining there and have held extensive discussions with the Professor of Neonatology and the Medical Superintendent of the Hospital about them.

#### **A. PREMATURE BABIES WARD**

A critical care unit like this should have, given the patient load here, at least 6 nurses per shift, which means a total requirement of 20 nurses; 1 Resident (a Trainee Post Graduate) per shift; and 1 Assistant Professor to be available at all times – day and night – to handle the emergencies. However, in reality we just have 1 head nurse and 7 nurses against the 20 needed; 1 resident against the 3 required; and no Assistant Professor after 2 P.M. This represents a gross inadequacy of staff.

2. The space situation in the Premature Baby Unit is a matter of great concern. This is primarily a NICU for admission of sick inborn babies. The bed strength is only 20, considered adequate by the doctors, but the space available is inadequate with a requirement of at least double the present space. We have around 400 here sq.ft. here as against a need of 1, 200 sq.ft.

3. As for the essential Equipment required, the following is the position:
- i) We need 20 radiant warmers. The need for heat and for warmth for the just born, premature babies in distress needs no emphasis. There are, however, only 5 fully functional radiant warmers here, which are recent donations. **The general point about donated equipment that needs to be made here in this Report is that the Government of Andhra Pradesh never provides the budget required for maintaining the equipment received by it as donation.** In addition, there are 8 “partially working” radiant warmers.
  - ii) There is need for 3 incubators but there are only 2, which are both non-functioning incubators.
  - iii) There are 5 Phototherapy beds of which one is a double surface blue light one and 4 are white light. Ideally, all should be blue light phototherapy ones, considering the requirements to deal with jaundice, very common in the newborns.
  - iv) Against a requirement of 20 Syringe Infusion Pumps, there are only 2 infusion pumps. These are also non-functional, being 8 years old.
  - v) We need 10 pulse-oxymetres. We have 6 and all the 6 are non-functional at present for want of disposables or spare parts.
  - vi) We have 3 ventilators of which 1 is functional but 2 are non-functional at present for want of servicing and spare parts.
  - vii) Of the 3 air conditioners, only 1 is functional.
  - viii) There are 4 washbasins and though all of them should be elbow-operable as recommended, only 1 is elbow-operable.
  - ix) One C - PAP machine (this is a respirator device needed by newborns) and 1 electronic weighing scale are available, which are a recent donation from the manufacturing company concerned.

**4. Thus it would be seen that in the Premature Babies Unit most of the equipment is either in short supply or non-functional for want of spares or servicing or just partially functional. This represents a desperate situation for the newborns admitted here.**

## **B. SICK NURSERY**

Newborn care is critical care and staff standards must be according to the recommended norms but the staff here is hardly adequate. There is 1 Head Nurse here but only 4 nurses

against a required number of at least 15 nurses. In other words, when we have only 4 nurses it means that we have 1 nurse per shift against a requirement of at least 4 nurses per shift! We have only 1 Resident, a trainee postgraduate for morning, afternoon and night shifts. The Resident in charge of the Premature Ward is on call duty here. The Assistant Professor is available only during the morning hours from 9 AM to 2 P.M. and after that, available only on call. The Professor in charge takes rounds once a day on working days.

2. Sick Nursery is the area meant for admission of “out born” babies, that is, babies born outside the hospital in neighbouring rural areas or even in the city of Hyderabad, who require prolonged hospitalization. The bed strength here is 20 but the care area available is totally inadequate. We now have here 400 sq. ft. of space but we require triple the space presently available, say, 1200 sq. ft. to make any meaningful difference to the babies admitted here.

3. As far as equipment is concerned, there are 15 radiant warmers available here, received as donation recently. We have 3 phototherapy beds of which 2 are double surface blue light, received as donation and 1 white light. **Against a requirement of 20 infusion pumps, there is not even a single infusion pump in this sector. Against a requirement of 6 pulse oximeters, we have only 1, a donated one. Against a requirement of 3 ventilators, we have none. There are no air conditioners here. Of the two washbasins, none is elbow-operable.**

4. The grave risks the babies face here need no further comment.

### **C. THE EMERGENCY NEONATAL INTENSIVE CARE UNIT (NICU)**

This unit is run as a part of Pediatric Emergency, which is headed by a Pediatric Professor. **The bed strength here is 20 but on almost all occasions several babies are kept in each cradle. On an average there are 80 newborns on any given day at the NICU. During my visit on the 29<sup>th</sup> May 06, I actually found 80 babies there. This meant that in each cradle or crib there were 2 to 3 babies! Any comment on the cross infection that will result from this situation and complete absence of comfort to the babies is superfluous. In such a situation administration of oxygen, IV fluids, phototherapy and the basic well-directed warmth required by the babies, – they all get jeopardized. During my visit again to this ward on the 3<sup>rd</sup> June 2006 I counted 60 babies and 45 women (mothers and patient**

**attendants) in this ward, that is, a total of 105 in an area that may be about 400 sq. ft. That we need more space here is obvious, - perhaps 3,000 sq ft. The situation is so heart-rending that words can do no justice to the picture of veritable horror obtaining here.**

2. As for staffing at the NICU, there is no separate head nurse with the result that the Emergency-in-charge has to take care of her work. Against a requirement of at least 10 nurses per shift, we have here a total of 4 nurses, that is, 1 nurse per shift! Against a requirement of 4 residents for each shift, we have only 2 residents who are trainee postgraduates. We have 2 Assistant Professors who, however, are available only during the morning hours from 9 AM to 2 P.M. and after that available only on call. The Professor In-charge takes rounds once a day on working days.

3. As for the facilities here, there are no radiant warmers or any kind of warming devices whatsoever. It is reported that “indigenous warming devices” were being made use of but in one such case, due to an accident, a baby was charred to death. This has resulted in “discouraging” the use of these indigenous warming devices. In other words, there are no warming devices here. The 2-phototherapy beds here are both white light beds. The NICU has no other equipment worth mentioning.

#### **D. Supply and availability of Medicines, Disposables and Consumables.**

It has been mentioned to me by the hospital authorities that emergency medicines and disposable like adrenaline, bicarbonate, calcium, vitamin K, phenobarbitone, phenytoin, aminophylline, dopamine, bronchodilators and first line antibiotics such as ampicillin, gentamicin, cephalosporins are always available and are adequate. Intravenous fluids of all types are reported by the authorities to be always available. So is the case reportedly with intravenous canulas in required number as also functioning laryngoscopes, bag and mask equipment. **However, pediatric drip sets are not available in adequate numbers, which means that frequent change of drip sets is not followed. Similarly, the all-important endotracheal tubes of various sizes are not available in required numbers. Higher antibiotics and other drugs like dobutamine and alcohol rubs are often prescribed for the patients since many are referral patients and are very sick at admission. These are not available or supplied by the hospital and the patients have to buy them from the medical shops outside. Discussions suggest that while for most emergencies drugs may**

**be available, and administered at admission time, for subsequent management the patients themselves have to buy the medicines and disposables.** One of the reasons for this, I reckon, is that no worthwhile staff is available after 2 P.M. to dispense the medicines required by the patients, forcing them to obtain them from the market.

**2. the overall position is that although most things appear as available on paper, most of the times supply is inconsistent and intermittent resulting in frequent occurrence of shortages.**

**3. as for the all-important disinfectants, alcohol rubs for hand disinfection and glutaraldehyde for disinfecting of wards and equipment are often not available.**

#### **E. INVESTIGATIONS**

**Blood counts, electrolytes, renal functions, liver functions and coagulation profile are possible only during working hours. Many routine reports are available the next day only. As for sugar, no bedside monitoring is possible. Cultures are not available to the extent required even during working hours. There is a basic blood bank but patients have often to go out to get blood, though it is claimed that the cost is reimbursed. The inconvenience in this regard is quite obvious. Niloufer has 2 ABG units but neither of them is functional. Neither a portable X-Ray machine nor a portable ultrasound is available in the hospital. Routine investigations like viral markers and metabolic workup and tissue cultures are not available. In this hospital neither CT nor MRI is available. No Echocardiography is available nor EEG, EMG or ECG.**

**2. This is a frightening scenario.**

#### **F. INFECTION CONTROL**

I specifically asked in the meeting I held with the senior Doctors about the infection situation in the hospital, given the very large number of deaths occurring from Sepsis. I sought information on whether the hospital has an Infection Control Committee, whether it meets every week and discusses the urgent issues regarding emerging causes of infection and whether swabs and cultures are taken from operation theatres and wards to determine

infection load in specific areas. **It emerged from the discussions that there is no specific Infection Control Committee in existence in this Hospital.** Discussions, if any, in regard to infection load take place only in the usual monthly meeting of the faculty of the hospital that takes place on the 2<sup>nd</sup> Wednesday of each month to “discuss the statistics of the previous month”. In these meetings the causes of death are reportedly discussed in detail. **No routine surveillance cultures are done in the Neonatal unit.** It was explained that the neonatal unit department takes the following steps to fight infection:

- (a) Alcohol rubs are used routinely in premature and sick nursery wards. **The individual patients, however, have to buy these rubs and not the hospital!**
- (b) Monthly teaching sessions are held for the resident doctors and nurses on hand washing and disinfection of the ward and equipment.
- (c) Research projects are given to postgraduates to study the profile of micro-organisms; antibiotics sensitivity patterns etc., **The investigations for these studies are, however, done from other institutions or private labs on personal request!**
- (d) Baby diapers are made from sanitary pads as sanitary pads cost 1/5 of baby diapers.

**2. The conclusion is that the high standards of infection control that need to be observed are not observed in the hospital.**

### **G. Patient Load And Levels of Care.**

The Premature Unit and the Sick Nursery admissions are restricted to the bed strength. However, **the admissions in the ESR NICU are always 4 or 5 times higher than the capacity. Each cradle is occupied by at least 2 and sometimes by 3 babies.** Nearly 50% of the babies arrive here very sick having been referred for advanced neonatal care. Advanced neonatal care is not available anywhere else in the State at “affordable cost by the poor”. Most babies are from families below poverty line and come to Niloufer hospital, as it is believed that there “treatment is free of cost”. The irony of all these can however be seen from the fact that practically every investigation has got to be done outside the hospital at the patients’ expense and practically all essential drugs have to be bought from outside shops at the patients’ expense, making a mockery of the claim that advanced neonatal care is available at Niloufer at “affordable cost by the poor” or “treatment is free of cost at Niloufer hospital.”

2. During my discussions with the Professor of Neonatology and the Hospital Superintendent the point was frequently made about the majority of the deaths of the newborns at Niloufer being those of babies born outside the hospital and brought for treatment at a critical and often hopeless stage. One of the reasons for this is that the newborns are not managed properly at the periphery. There is considerable force in this argument. The care that is needed for a newborn is 24 hours, round the clock. For this the District Level hospitals, the Primary Health Centres or the Sub-Health Centres in Andhra Pradesh are not adequately equipped or oriented. They are essentially adult-oriented facilities. This is true again of private hospitals in the rural areas also. This is why referrals on a large scale take place from “outside” to Niloufer. These transfers result in big delays because of transportation over long distances. The private hospitals in the rural areas collect huge sums of money for treatment and when the money paid is not considered adequate by them to complete the treatment, they transfer the cases to Niloufer resulting in the patients reaching Niloufer late and meeting certain death.

3. There are 3 levels of care that we need to provide for a newborn, especially to one born with low birth weight (LBW). Level-I is to ensure the simple warmth needed from the mother; breast-feeding; preventing infection; and immunization. All these things can be done at home and at the nearby Sub Health Centre if they are properly oriented and equipped. Level-II care is for moderately sick babies with respiratory issues, jaundice, infections or where the baby has had low APGAR counts (without Asphyxia) etc., All this can be attended to at the Primary Health Centres (PHC) and Community Health Centres (CHC) and in the private hospitals if they are properly oriented and equipped. Level-III care is highly advanced care where tiny babies, that is, preemies and VLBW babies with complications need to be dealt with through the use of equipment like ventilators and close monitoring. **Because of patient over-load Niloufer hospital has been unable to deliver even Level-II care. Niloufer is not equipped to deal with Level-II needs also because of absence of adequate nursing and medical staff and equipment and of maintenance of even the available equipment.** There is urgent need for a variety of warming, monitoring and life saving equipment. All these grave shortcomings need to be rectified on priority. At the periphery the health system has to be improved at all levels - at the Sub Health Centre (SHC) level, the Primary Health Centre (PHC) level and the District level hospitals in the surrounding rural areas. Such improvement is called for even in the hospitals in the city of Hyderabad, including in the private sector hospitals. In the city jaundice, for example, is a

serious problem. **The problems we are witnessing at Niloufer are the result of a combination of the problems that are there in Niloufer as well as those that exist in the catchments area of the Hospital.** Therefore, the health problems of women and children of the rural poor families especially should be adequately addressed at the earliest stages at the Anganwadi level in the Integrated Child Development Services (ICDS) programme and through the system of referrals provided for in the ICDS programme at the SHCs, PHCs and the District Level Headquarters Hospitals. This means that the basic solutions that we need to provide should include a well-coordinated outreach programme which extends right down to the ICDS Anganwadis, SHCs, PHCS and District Hospitals backed by sound health education efforts that would comprise education, training and facilities in areas like the warmth required by the baby, minimal resuscitation measures, oxygen and transport so that the baby gets quick initial attention and does not get destabilized *en route* to the tertiary hospital, which is what causes mortality most of the time. All these can be achieved only if Niloufer is made an APEX Institute, equipped to provide complete Level II care to all inpatients and Level III care to the most needy of the patients backed up by a large Outreach Programme.

#### **4. Specifically, we should ask ourselves: What should be done to improve the neonatal services in Niloufer Hospital?**

Based on my inspections and discussions, I have the following recommendations to make for the consideration of the Government of Andhra Pradesh:

- a) **Integrate the neonatal services into a single separate Department** with adequate personnel the minimum being, for the entire cycle of 24 hours that make a full day, at least 100 nurses against the 18-20 we now have; 20 residents against the 9 available now; and 10 Assistant Professors against the 4 available now. In this connection the most important reform we need in Niloufer is to de-link the Emergency Neonatal Intensive Care Unit (ENICU), which is presently kept as a part of the Pediatrics Department from that Department and bring it under the undivided control of the professor of Neonatology. **Having done this the entire neonatology Unit should be relocated in the newly constructed Infosys Millennium Block**, with care taken not to jeopardize the interests of the newborns born within the Niloufer Hospital and who constitute about 10% of all the newborns present in the hospital, the other 90% being babies born outside the hospital. There is need to increase the patient care area to at least about 10000 s.ft. from the present 3000 s.ft.

b) The basic approach to the reforms we need in Niloufer should be the understanding that at least 80% of the patients admitted into Niloufer would certainly be requiring Level II Care while at least 20% of them would definitely require Level III care. Therefore, **the Government should install all the equipment required in adequate numbers** as discussed in this Report and as shown below, ensuring they are bought backed up by 5 years of annual maintenance contract:

- i) Radiant Warmers - 80.
- ii) Pulse Oxymeters - 40.
- iii) Infusion Pumps - 40.
- iv) Ventilators - 10.
- v) Multi-channel Monitors - 10
- vi) Portable Ultra Sonographic machine – 1
- vii) Portable X-Ray machine - 1
- viii) One CT Scan Machine, which would be useful for the entire hospital

**These are merely illustrations and the actual equipment and numbers required would obviously have to be determined by changing circumstances depending on maintenance etc.**

- c) **Set up a Hospital Infection Control Committee** headed by the Medical Superintendent consisting of doctor members, some of whom should be drawn from other leading hospitals of the city to determine and ensure the implementation of the required infection surveillance and control measures and
- d) **Establish an Outreach Prenatal Education Program** to decentralize and make available credible health care in the neighbouring rural areas and thus ease the admissions into the Niloufer Hospital. As part of this effort, strengthen the ICDS programme in rural Andhra Pradesh and the city of Hyderabad in regard to all 6 services that programme is expected to deliver.

## **V. Conditions in the Wards relating to Inadequacy of Staff and Equipment, Poor Maintenance of Equipment and Sanitation.**

I personally inspected the Niloufer Hospital premises in the company of the Superintendent Dr. N. C. K. Reddy twice during this investigation, once on the 5<sup>th</sup> April 2006 and again on the 29<sup>th</sup> May 2006 and once with the Professor of Neonatology on the 3<sup>rd</sup> June 2006. I must say that these visits have left me deeply disappointed if not thoroughly depressed. To begin with the patient load is admittedly very heavy. However, it cannot be the Government's case that they do not know this. What is clear is that the Government has simply failed to deal with the problem over a long period. The children arrive at the Pediatric Emergency in very poor shape and need to be stabilized at the Resuscitation Ward. This ward has very little space and with the hospital having very little nursing staff, parents themselves attend on their gravely ill infants along side the nursing staff, thus crowding the little space available. As for the Neonatal Emergency ward to where these babies will move next and which is part of the Pediatric Department, I have already discussed the hear-rending conditions obtaining there in Chapter IV. As already pointed out, this NICU area should altogether be de-linked and the Neonatal Sick Nursery expanded. From here the more serious cases needing intensive care are moved to the Pediatric Intensive Care Unit (PICU), through a connecting ramp. This ramp is pretty congested and narrow and on arrival at the PICU we find an even more depressing scenario. The capacity of this PICU is 8 beds. It would be important for us to remember at this stage that Niloufer is a Tertiary Care hospital. We should have equipment like Ventilators, Infusion pumps, Pulse-oxymeters etc., as the basic equipment for each bed and most important of all Multi-channel monitors for each bed to monitor the functioning of all these so as to see whether the baby is getting oxygen, IV fluids, drugs, nutrition etc. We have a few multi-channel monitors here but the only problem with them is that not one of them is functional. We need more of all these and we need them to be maintained properly so they are actually functional. Discussions with the doctors at the PICU revealed that 5% of all admitted cases are such as need emergency, intensive care at Level-III. That means 5% of 500 cases or 25 cases a day. However, the bed strength is 8! This means that every day there are always going to be a very large number of babies who would not get the immediate intensive care they should receive if their lives have to be saved. If the capacity of the PICU is a third of the minimum need, so is the availability of the staff here. According to norms we need 1 nurse for each bed which means 8 nurses per shift here or 24 nurses a day. As for doctors, we need 1 senior doctor and 2 junior doctors per shift or 9 doctors during a day of 24

hours. However, what we have is 1 Associate Professor, 1 head nurse in the morning and 2 staff nurses each for the 3 shifts. I noticed during my visit that the patients and their attendants were in great discomfort because of heat and even some of the doctors were perspiring. The windows in the PICU were open. Discussions with the doctors showed that this was because all the 8 window air conditioners were non-functional. Actually, these air conditioners had been donated by a philanthropic trust and the donors had even maintained those air conditioners for 2 years initially. Obviously, they were not going to maintain them for all time and it was the responsibility of the Government to do that. The hospital, however, is unable to do so as the Government has not provided any maintenance budget for this vital, donated equipment. **It was clarified to me by the doctors present that any donated equipment at all time goes with out maintenance.** Any comment on this attitude of the Government is again superfluous. Discussions with the doctors further showed that there are no facilities for diagnostic investigations needed in the PICU. Thus, while ABG Analysis equipment was available at one time, it is no more functional. **There is a basic lab for testing blood urea and sugar levels but no ABG. Other investigation facilities are not available either. Therefore, the patients have to go outside the hospital to have their investigations done. That means expenditure for the patients, who are almost all of them invariably poor. I was shocked to learn from the doctors that one patient, who was currently in the PICU, had so far incurred an expenditure of Rs. 100, 000. This child had been brought here from a private hospital where she had been admitted earlier. At this stage I should make a reference to my witnessing an ambulance form a private “Super Specialty” hospital unloading a baby at the Emergency reception at Niloufer, which raises the question of what a privately-run “super specialty” hospital in the city of Hyderabad means if they have to bring their patients to an already over-stretched Government hospital! Obviously, health care for the infants is in serious jeopardy even in the private sector here in the State of Andhra Pradesh including in the city of Hyderabad. Returning to the PICU, discussions with the doctors showed that almost all the time equipment at the PICU, for the supply of which the APHMHIDC is responsible, as a rule went out of commission very soon after its installation and also, as a rule, was never repaired by the suppliers of the equipment. This situation calls for an investigation into the functioning of the APHMHIDC by the Government. Another situation of very serious magnitude noticed by me is the frequent power failures at the PICU. The lady Resident who was in charge at the time of my inspection around 12 noon told me in response to my inquiry that she had been on duty since the evening the**

**previous day and that during her duty period power had failed at least on 10 occasions! And the Niloufer hospital has no stand by generator! This means that important equipment in use at the PICU like the ventilators and infusion pumps would stop functioning, even to the extent they are available, and they have to be manually operated to keep the patient going, a feat well-nigh impossible given the effort required and staff shortage. The results are not difficult to contemplate.** The lady Resident also certified that there was recently an incident when the sudden burn out of an air conditioner had led to the release of dangerous gases from it in the PICU. **Obviously, a hospital needs to have unfailing supply of power backed by the availability of a generator. That the Government of Andhra Pradesh has failed to ensure this means that it has exposed infant lives to acute danger on a continuous basis.** One of the doctors present at the PICU told me that the electricians at the hospital do not respond to any need in any worthwhile manner. In this context attention needs to be drawn to the charring to death of an infant at this hospital in the neonatal ward owing to the malfunctioning of an electric lamp. I may, for good measure, add that during the closing stages of my visit on the 29<sup>th</sup> May 06, electricity went off throwing the hospital into darkness.

2. We next come to the question of Sanitation in the Hospital. During my visit on the 5<sup>th</sup> April 2006 I had found the toilet in one of the general pediatric wards under repairs and out of commission and locked and, therefore, unavailable for use for the mothers attending on their babies. This meant that they had to go in search of an available toilet, leaving their babies in distress unattended. Though I had noticed this in the presence of the Medical Superintendent and the Resident Medical Officer (RMO) on the 5<sup>th</sup> April 2006 and had expressed my feelings about the situation, I regret to record that the toilet had remained with out being repaired and with out being restored to use even by the time of my subsequent visit 1 ½ months later. This toilet had gone out of commission about 6 months earlier. The Superintendent, in response to my enquiry informed me that he had indeed taken up the matter with the APHMHIDC that smaller repairs were within the competence of the Superintendent himself to rectify but repairs to clogging and blockage that had occurred in this toilet came with in the purview of the APHMHIDC. Obviously, the APHMHIDC does not think that toilets in a top hospital are important enough for its attention, even if they had been in a state of disrepair for all of 6 months and their condition had even attracted the attention of the National Human Rights Commission of India. The point about this particular toilet having been out of commission for several months on end is not confined to the absence

of a fundamental sanitation need and gross inconvenience to the patients and their attendants alone but goes far beyond that. This ward and the toilet are in the first floor and the water seepage that is continuously occurring from the floor of this decrepit toilet has affected the walls below in the ground floor leading to the Obstetrics ward. The walls there are moist, dank and musty. However, to return to the Pediatric wards itself again, the bathroom in the next ward I inspected was wet and slippery, a condition to be avoided at all times for obvious reasons. In the wards the heat was oppressive because of absence of ventilation and over crowding and the doctors complained of these conditions that affected their work. When I discussed the inadequacy of space in the wards the doctors pointed out that in summer months the admission of inpatients in the pediatric sector was about 50-60 per day. The cases discharged were also 50-60 per day since the incoming patients had to be found accommodation in the wards. The result was that because of patient load, patients were discharged regardless of their having received adequate care or relief. In other words, there were large-scale cases of premature discharge. Answering a specific question from me the doctors said that this kind of unjustified and premature discharge was of the order of 40% to 60% of all admitted patients. The admission of inpatients went up drastically in the peak monsoon months of August/September to 150, the dominant complaints being gastro enteritis, pneumonia and various kinds of infections. In November, Encephalitis was a common complaint. Premature discharge of patients was greater in these peak months. The doctors explained that human considerations did postpone and delay this kind of premature discharges but any such humanitarian action had also its flip side in that in such an event the load in the wards in the peak season rose drastically from the normal 200% to 300%, leading to poor quality of medical attention and relief. I visited the Treatment Rooms for sick babies for infusion of fluids and oxygen. In one of the rooms I visited, there was zero ventilation with all the exhaust fans closed and missing. The room itself was in a state of very poor maintenance. Doctors said that any number of representations made about this had gone unheeded.

**3.** Niloufer hospital is also a hospital that provides Obstetric and Gynecological services. The normal admission per day in this sector is 20 of which 15 would be pregnant women for deliveries and another 5 for attention on the gynecological side. I inspected one obstetric ward where women who had undergone C- section deliveries are kept. The upper parts of the walls of the room were covered with fungus resulting from prolonged seepage of water from the first floor, a condition I have referred to earlier, and the atmosphere, therefore, was pretty

depressive here. The average number of C-sections per day at the Hospital is 10 and the average stay for this purpose or for the first delivery is 5-6 days, while for a normal delivery it is 4 days. I next visited one of the wards where post-natal cases are accommodated and found garbage littered in the corners of the ward and also blood-stained gauze pads lying on the floor in the bath room attached to it. The room was over crowded with patients and their attendants and then I found several women who had just delivered lying on mattresses in the corridors of the Obstetric area! It was a scene too shocking to be believed but then seeing *is* believing! My next visit was to the antenatal ward where the available accommodation was so little that the accompanying lady doctor explained that more than 2 pregnant women waiting to deliver and in labour were often put in one cot! The doctor also explained that absence of a blood bank was a serious issue for obstetrics as there have been serious reactions including fatal episodes caused by blood brought from outside.

**4. The Eenadu report has made a specific reference to the lift in the Niloufer Hospital having been out of commission over a long period. I inspected the lift area personally and found the complaint to be true. Discussions with the Medical Superintendent confirmed that the lift in the hospital has been totally out of order for a long time, nearly 2 ½ years. Even prior to that it was going out of order repeatedly. The Government of Andhra Pradesh also in its comments to the National Human Rights Commission has acknowledged this fact. According to the Superintendent a request to repair the lift was made which is still pending with the APHMHIDC, Hyderabad. Repairs to the toilets, electrical repairs and a ramp around the lift have all been “sanctioned”, which the APHMHIDC is, however, still to carryout. For these works the estimates are ready and tenders have been called for. However, I saw no sign of the work starting. In fact a lot of garbage was dumped in the lift area. Either this hospital does not get even the minimum budget required for meeting its basic needs thus exposing the patients and, in fact, the service providers themselves to serious suffering or there is some thing seriously wrong in the way the APHMHIDC is functioning. In response to my concerns, the Superintendent pointed out that the State Government have provided the hospital with state of art equipment in Intensive Care areas, diagnostics, operation theatre complex and specialties worth Rs.3.5 crores in the year 2003. However, to me the flip side of this is that much of it is not operable for want of sanction of staff. For example, the Superintendent has also issued circular instructions to all concerned not to prescribe for the patients either in the general wards or for emergency patients any medicines that**

**need to be purchased from outside. It is, however, clear that this well-intentioned circular would have no effect if after 2 P.M. every day adequate staff is not available to dispense the medicines required by the patients, driving them to the market and huge expenses for buying drugs and disposables.**

5. All this brings us to the functioning of the society called Andhra Pradesh Health and Medical Housing and Infrastructure Development Corporation (APMHIDC) set up by the Andhra Pradesh Government. Amongst its functions are those relating to acquisition of medical equipment and procurement, storage and distribution of drugs and medical supplies. Discussions with the Medical Superintendent of the Niloufer hospital also show that this organization is responsible maintenance of hospital buildings. During discussions on the 9<sup>th</sup> June 2006 the Director of Medical Education also confirmed that for maintenance of buildings the Government provides a budget to the APMHIDC. However, while it appears clear that the APMHIDC is responsible for maintenance of the Niloufer hospital buildings, the representative of the APMHIDC him self did not appear convinced that such a responsibility rested with the organization. He gave me the impression during the discussions that due to a number of reasons this organization was only doing original construction work and was not undertaking any maintenance work. I even got the impression that this organization was concentrating more on building residential schools rather than attending to work connected with Medical and Health infrastructure. Therefore, **there seems to be a big gap in understanding between the officers of the Medical and Health Department on the one hand and the authorities of the APMHIDC as to what the responsibilities of the APMHIDC are and who is responsible for maintenance of the hospital building. This fundamental lack of understanding is obviously the cause of the toilet and lift not being repaired over a long time and walls in maternity wards being overgrown with fungus or the residential quarters of RMOs not being rebuilt. That such a lack of understanding exists within the Medical and Health Department is a very serious matter that gravely affects maternal and child health. It is an urgent imperative, therefore, that the Government of Andhra Pradesh immediately addresses this issue pertaining to the role and responsibility of the APMHIDC, brings into existence, and places in position a credible and accountable system under which responsibilities relating to budget and outcomes could be assigned to specific individuals and Departments. The State Government should also investigate and fix accountability for the shabby sanitation and the poor up keep and maintenance of the Niloufer hospital detailed in this Report and**

**take suitable action against those responsible. This investigation and fixing of responsibility should cover the state of disrepair and non-functioning of all medical equipment and other equipment like the lift, the air conditioners and electrical facilities as well.**

## **VI. Discussions with Senior Doctors at Niloufer Hospital on the 3<sup>rd</sup> May 2006 on their view of the problems at the Hospital.**

As part of my efforts to understand the way the senior doctors working at Niloufer appreciate their own work environment, I held detailed discussions with several of them on the 3<sup>rd</sup> May 2006 in the chambers of the Medical Superintendent. The doctors highlighted the following issues during these discussions as causing the problems in the functioning of the Niloufer hospital:

1. There is tremendous constraint of staff strength. Over a period of 20 years there has been very little change in the staffing pattern, though the workload has increased five fold during this period and repeated representations have been made to the Government. Stopping the recruitment of staff by the Government has meant that there is no inflow of supporting staff at the junior level to assist the senior doctors. One lady doctor pointed out how unrealistic it is to expect a 55-year-old lady doctor to keep standing over long stretches of time and deliver at-risk babies, without expert staff support. In the Intensive Care and Anesthetic Care units, there has been no worthwhile change in the staff for the past 18 years. Repeated representations to Government all these years have had no effect.

2. Space is another great constraint at Niloufer. The rush at the OPD in Niloufer is always very heavy and the resultant pressure is enormous. As for inpatients, the number of beds in the maternity wards is 120 but at any given time there would be very many more in these 120 beds. This leads to early discharge of the patients even when it is medically unjustified. As many as 1/3 of all admissions in Niloufer are critical cases. The number of inpatients on any given day in Niloufer is 700 of whom 600 are children born outside, that is, brought for admission from the districts neighbouring Hyderabad. At least 250 cases of these would be critical, not to mention the critical state of some of the babies born in the hospital itself. However, the critical care unit has only 20 beds. That means 20 beds are available for dealing with 250 critical cases.

3. There are only 5 ventilators in the hospital. They go under repair often. As for surgical staff, at least 7 surgeons are required with all necessary support staff and equipment to deal with emergencies of the magnitude faced in the hospital. As far as care is concerned, depending on the seriousness of the condition of the baby, minimal or intensive care has to

be determined and provided. This would require, given the conditions, strengthening of the Pre-mature Baby Unit (chiefly for the inborn), the Sick Nursery and Emergency NICU (chiefly for the out born) by way of staff, equipment and more monitoring. There are only 4 Professors in Pediatrics here.

4. Even with regard to basic facilities there is great shortage. The hospital does not have a proper blood bank. The blood bank has serious problems. **There is need for an Obstetric Intensive Care Unit (ICU).** Laboratory facilities are of fundamental importance to a hospital, especially one dealing with infants and pregnant women at risk. These are totally inadequate at Niloufer. **Patients, therefore, have to be compulsorily sent out for getting the investigations done.** This casts an intolerable physical, psychological and financial burden on the poor, who flock to the Hospital. **The same goes for ECG and the related technicians and technical staff. The EEG equipment has been under repair since a long time and, in any case, there has been no one to operate it.**

5. One of the major problems faced in regard to staff is absence of job satisfaction. Several categories like Radiologist and Anesthesiologist go away to foreign countries after getting trained in institutions like Niloufer. There are other man-made problems like the short sighted policy of ban on recruitment and outsourcing that the Government has introduced in the recent past and which is being carried forward by the current Government as well with bad results for the hospital and the poor who have come to depend on it.

The doctors made certain suggestions for improvements, which have been referred to in various parts of this Report.

## VII. Facts about Niloufer and Budget Expenditure Details.

All the issues discussed in the previous chapters lead us to the question: is the budget provided to the Niloufer Hospital adequate to meet the patient load and to provide the services a tertiary hospital is expected to provide?

2. Niloufer Hospital and Institute of Child Health is a 350-bed teaching specialty for women and children with the exclusive aim of tertiary care of the child starting from the intra-uterine period. The occupancy in the hospital has been consistently 175% to 200% of its capacity with Intensive Care Component of a minimum of 100 to 125 beds. Niloufer, has 4 major departments: pediatrics, pediatric surgery, obstetrics and gynecology and anesthesiology with post graduate training in 3 specialties and higher specialty training in maternity and child care and pediatric surgery. The other specialties here are child psychiatry, school health clinic, cardiology, neurology, radiology, microbiology, pathology, biochemistry and a basic blood bank. Children who are ill are referred to this institute from the twin cities of Hyderabad, neighbouring districts and some times from the neighbouring states also. Many seriously ill cases are referred from the private sector hospitals also to Niloufer. The policy of the hospital is to accept every case. According to the Superintendent of the hospital the cases that come to Niloufer have been increasingly of the high-risk category with potential for high mortality.

3. To handle 200% occupancy and to manage 100 to 125 ICU cases in a 350-bed facility, the available staff is grossly inadequate and is, therefore, under constant pressure. Representations have been frequently made to the Government to increase bed strength with additional budgetary provision and increase the posts of medical officers, nursing staff, paramedical staff etc, the latest proposal being one that was made in October 2005. **The Medical Superintendent himself made a proposal for additional provision of Rs. 2.5 crores in October 2005 for the additional staff required and for diet charges etc., and another Rs. 2.5 crores for purchase of new equipment and their maintenance. I should point out that these proposal do not in fact cover the actual needs of even the needs of a 500 bed hospital in full as the proposals, as is usual in Government, have been watered down against actual needs.** The actual need would be somewhere in the region of an additional one time capital expenditure of about Rs. 5 crores and a recurring annual staff and maintenance expenditure of about Rs. 5 crores. **The position, however, is that even the**

**watered down proposal has not been sanctioned by the Government of Andhra Pradesh at the time of my writing this Report. It is most urgent and important that the State Government calls a meeting of the Director of Medical Services, the Medical Superintendent and senior doctors of Niloufer and takes a realistic view of the true requirements, as against diluted requirements, and provides the needs of the Hospital in full.** Else, the Government of Andhra Pradesh has to be deemed guilty of continuing violation of the Human Rights of the children of Andhra Pradesh who are dying in large numbers in the Niloufer Hospital, the state's premier Children's Hospital. Against this background, I am unable to accept the stand taken by the authorities that though the budgetary provision is only for 350 beds, the State Illness Assistance Fund (SIAF) along with an amount Rs.4.56 lakhs provided each quarter by the Government in lieu of abolishing the user charges adequately compensates the short fall required to meet the needs of a 500-bed hospital.

4. During discussions the hospital authorities themselves acknowledged that a serious problem in Niloufer is extreme inadequacy of staff and also all the needs relating to diagnostics and the ICUs. This is by itself an acknowledgement of the inadequacy of budget.

5. This apart, an analysis of receipt and expenditure in recent years shows that even the existing budget made available to the hospital is not being fully utilized. Under the head 212-D&M- Drugs, in the year 2003-04 against a total receipt of Rs.30.29 lakhs the expenditure was only 23.74 lakhs, leaving a balance of 6.55 lakhs. This is a huge shortfall in expenditure on drugs of 22%. In the following year 2004-05 this unspent balance was brought forward. The total receipts for the year 2004-05 were Rs.29.87 lakhs but the expenditure was only Rs.22.77 lakhs, leaving a balance of Rs.7.10 lakhs. Thus in the year 2004-05 the shortfall in expenditure on drugs was even more than in the previous year, at 24%. At an average unspent balance of Rs.7.0 lakhs a year, the Niloufer hospital was falling short of utilization of the available budget by as much as one fourth of the provision. Therefore, the claim that there is no problem of supply of drugs is not substantiated. **At this level of un utilized budget, which it self is under provided to begin with considering the numbers of patients involved, the obvious conclusion is that the patients in Niloufer are going without being provided their minimum drugs and medicines requirements.** It is significant that the large number of deaths reported in Eenadu pertain to the year 2004-05. The expenditure under the head 211-M&S, that is disposables, is no better. Though the total receipts are small, the expenditure is even smaller leaving balances of the order of 80% of receipts. **By**

far the most shocking state of affairs is seen in the budget relating to the maintenance grant. In the year 2000-01 against Rs.68.12 lakhs, the expenditure was only Rs.28.08 lakhs, leaving a huge balance of Rs.40.03 lakhs. The shortfall was 59%! In the year 2001-02 though the expenditure was much better, there still was a balance of Rs.4.28 lakhs at the end of the year. In the next year the balance was Rs.4.61 lakhs against a lower availability of Rs.21.50 lakhs. A short fall of a little above 21%. In the year 2004-05, against a budget available of Rs.16.98 lakhs the expenditure was only Rs.12.18 lakhs, the balance left being 4.80 lakhs. The short fall was a little above 28%. In the year 2005-06 the situation was as bad it was in the year 2000-01, the total receipts being Rs.60.09 lakhs, the expenditure being Rs.30.31 lakhs and the unspent balance being 29.78 lakhs. That is a short fall of 50%! Naturally, it should not come as a surprise to us that even the lift and the toilet do not function at Niloufer nor are walls free from water seepage and fungus.

6. It was mentioned to me that because of the allotment of the SIAF to the hospital by the State Government, there exists no problem in relation to the budget. While this is a claim that cannot be taken seriously as already pointed out above, what is most distressing is that even the receipts under the SIAF were never fully spent leaving huge unspent balances. The following are the details:

In the year 2002-03, expenditure was only 9.71 lakhs against a receipt of Rs.17.50 lakhs, the balance being 7.79 lakhs. This represents a shortfall of 44.5%. The next year 2003-04 saw a big receipt of Rs.30.0 lakhs taking the total available budget under this head to 37.99 lakhs. However, the expenditure was a meager Rs.9.47 lakhs only. The balance left behind unspent was 28.51 lakhs. The shortfall was 75% of the resources available. The situation was even worse in the next year 2004-05. With the budget received being Rs.55 lakhs and the total availability raising to Rs.83.57 lakhs, the expenditure was again meager being Rs.22.38 lakhs leaving behind an unspent balance of Rs.61.19 lakhs. This huge unspent balance represents a shortfall in utilization of a little over 73%. In the year 2005-06 no budget was received under this head probably because of poor expenditure. However, the total amount available was as much as Rs.62.72 lakhs and expenditure during the year was just about half the budget at Rs.32.85 lakhs. The balance that remained unspent at the end of the financial year 2005-06 was Rs.28.86 lakhs. The shortfall in expenditure was 46%.

**7. These figures tell their own tragic story.**

**8. The Government of Andhra Pradesh needs to review the adequacy of the budget for Niloufer Hospital on the one hand and the way the allocated budget is being currently utilized on the other.**

## **VIII. Corruption among the Security Staff.**

**In regard to the allegations about corruption at the level of the Class IV staff and nursing staff mentioned in the Eenadu report, the Superintendent has pointed out that the administration has warned, counseled and punished a number of persons. I have seen some of these orders and find them vague and too soft on the delinquents. In any case the security and sanitation services have been outsourced according to Government policy on contract basis. The Superintendent confirmed that the security arrangements had to be changed a number of times because of complaints. He also felt that “outsourcing” is an unsatisfactory arrangement and that the situation has been brought to the notice of the Government suggesting a better alternative of either directly engaging security personnel from recognized security agencies (rather than obtaining them on the basis of floating tenders) or to fill security posts through regularly recruited Class IV employees. There is no doubt that the Government’s policy of “out sourcing” essential services are affecting their delivery to the poor patients and the Government of Andhra Pradesh should reconsider this policy.**

**2. As regards the specific charges of corruption against the Security staff I have already mentioned in Chapter III that these are true, as personally verified by me by talking to a number of parents coming to attend on their wards at Niloufer.**

## **IX. The New Infosys Millennium Block**

The Eenadu Report has written about the failure of State Government to take timely advantage of the munificence of the Infosys Foundation, which has sanctioned a building costing Rs.3.5 crores. This report is substantially correct. Though the foundation stone was laid on the 7<sup>th</sup> November 2003 the actual construction of this facility was started only on the 1<sup>st</sup> October 2004 after a delay of one year. **It needs to be acknowledged that thanks to the efforts made by the Superintendent Dr. N.C.K. Reddy, the pace of construction of the Infosys Building was stepped up.** The major part of the civil works was completed within a year and the Chief Minister of Andhra Pradesh also inaugurated the block on the 26<sup>th</sup> October 2005. The building cost about Rs.3 crores and has a built-up area of 30,000 sft. in 4 floors. It is planned to have diagnostics and specialty units, a twin operation theatre complex with post operative ICU and Neonatal Surgical ICU and an Advanced Learning Centre to accommodate 250 persons for continuing medical education. This can be a state of art facility. The implication of this block coming up is that the existing 350-bed Niloufer hospital can be upgraded to a 500-bed hospital, with newly created bed strength of 150. This is an extremely good development. However, though the Chief Minister of Andhra Pradesh actually formally inaugurated this building on the 16<sup>th</sup> October 2005, because of further delays in completing certain basic works, this building was not occupied even partially till the 17<sup>th</sup> April 2006. Obviously, the up-gradation of the hospital from a 350 to 500-bed facility would call for additional staff, equipment and facilities to meet the increased demand and patient care. Proposals to cover such increased need had been submitted by the Superintendent in February 2002 itself. The proposals included creation of the posts of 24 Medical Officers, 120 Staff Nurses, 18 Paramedical Staff and 60 Class IV staff. As for equipment, a spiral CT scan, operation theatre equipment, ICU cots and monitoring equipment including diagnostics equipment at a cost of Rs.2.40 crores towards capital costs and about 10 to 15 % of the capital costs towards maintenance were proposed. Through the efforts of the Medical Superintendent Dr. N. C. K. Reddy and the intervention of the office of the Chief Minister, approval for 24 Medical officers, 60 staff nurses against the 120 proposed and the 172 actually required and equipment and power connection expenditure as proposed was obtained in October 2005.

2. I have inspected this new building on the 5th April 2006 and again on the 29th May 2006. Thanks to the efforts of the Superintendent about 50 cots have been put in the wards, and the OPD for pediatric surgery started here. **However, the operation theatres are not ready even now.** This means the building will be occupied in phases over a period of time. My own estimate is that it will be another 4 months before it would be put to full use though the Superintendent feels that the Infosys wing will be operational by the end of June 2006. **Even though the Government has “deputed” 30 staff nurses to this new facility, it is seen that only 17 of them have actually reported to work. The word “deputation” indicates that the Government has not recruited any new staff for this new facility but has diverted staff from elsewhere. This means some other health area has been deprived of this staff. This is not the way to improve health care in the tertiary sector. My inspection also shows that the full operationalization of the Infosys building in phases would really depend on the APHMHIDC delivering the required equipment in time and the Government providing the necessary paramedical staff. All this clearly shows that staff and equipment are not ready and that the Government, despite the facility coming up, has not properly planned for these essentials in advance.** The result is the building donated by the Infosys Foundation did not come up within the time frame in which it could and should have and, what is more, today even after it has become largely ready it is lying mostly vacant and unutilized and will continue to lie un-utilized for quite some time to come. **I am also convinced that the staff provided for this new facility is inadequate. It would be seen, for example, that in the matter of the staff nurses required, the number actually approved is so low that the norm of 1:1 for newborns and 1:3 for children in the Intensive Care unit and even the 1:5 ratio for semi ICU beds would never be achieved. In other words, while the Infosys building may be a new one, the facilities there in terms of actual childcare could continue to be as primitive as now. It is not too late for the Government even now to take a fresh look at the total requirements of the Niloufer hospital in the context of the Infosys block having come up and eased the space constraints in a big way, and provide all the staff and equipment that a Level III Tertiary Hospital would require. The Government of Andhra Pradesh should not allow this opportunity to be lost to the mothers and children of the State.**

## **X. Conclusions and Recommendations**

**A reading of the forgoing pages of this Report based on as many as four visits made by me to the Niloufer Hospital, Hyderabad which included detailed visits to the wards and wide ranging discussion with the Medical Superintendent, the Professor of Neonatology and senior doctors and attendants accompanying patients to the Hospital would show that the conditions obtaining in the Niloufer Hospital, Hyderabad are most unsatisfactory and indeed deplorable. In every aspect of health care, the conditions in this hospital leave a great deal to be desired. On all fronts of health need, be it staffing adequacy, adequacy of space, basic, routine or life-saving equipment or investigation facilities, or supply of drugs and medicines or sanitation or security, – there are gross shortages and shortcomings. For example, the overall vacancy position of all the staff taken together has hovered between 14% and 18% during these 6 years and has been 15, 17 and 17 percent respectively during the years 2003, 2004 and 2005. Viewed against the thorough inadequacy of the number of posts sanctioned themselves to the extent of 31% against norms and bare needs as shown earlier, it can be easily seen in what a parlous situation this hospital has been placed because of lack of personnel.**

**2. I am convinced as a result of all the information I have gathered and all that I have seen at this hospital that all these inadequacies and shortages have been contributing to avoidable loss of infant and child life over the last several years. The loss of these lives in five years from 2001 to 2005 is of the order of 14, 692. Of these neonatal deaths alone are 8,666. I have analyzed these neonatal deaths in the body of this Report in year-wise detail. The loss of infant lives and children's lives and the mind-boggling number of neonatal deaths in particular were not exceptions that happened in an exceptional year. They have been occurring every year and the neonatal deaths in fact have been going up every year maintaining a level of around 23% of all admitted babies and such deaths reaching a benumbing level of 40% of all admitted babies in the year 2003. Pediatric deaths, apart from neonatal deaths, have hovered around 5 to 7% during these years. After a careful examination and analysis of all the facts and circumstances relating to this Hospital I come to the conclusion that there has been grave negligence in regard to the needs of new-borns, infants and children at the Niloufer Hospital, Hyderabad. This**

**grave negligence has resulted in the violation of the Human Rights of these babies, - if not of all of them, at least of a very large number of them - and also of the human rights of the families of these children.**

3. Having come to this conclusion it is necessary for me to determine who is responsible for this negligence and, therefore, the violation of the Human Rights of these children. **Since these deaths occur and have occurred at the Hospital, it would be easy enough to hold the hospital authorities and the doctors responsible for this. However, that would be wrong. In my view it is the Government of Andhra Pradesh as a whole who should be held responsible for this negligence and the consequent violation of the human rights of the children whose parents trustingly flock to the Government Niloufer Hospital in the expectation of all possible care for their children.** It is not my argument that every single case of a child that was brought to Niloufer can be or could have been saved. If all efforts are made to save a child's life and if all the conditions required to save a child's life are available and provided for and, based on such conditions such efforts have been facilitated and made, then no negligence can be attributed even if a life is lost. **However, if these basic conditions are not met and minimum facilities are not provided in the hospital by a Government which ought to know and does know what these minimum requirements and facilities are, then that failure constitutes negligence and leads to the violation of the child's fundamental right to life, guaranteed under Article 21 of the Constitution of India. In my considered opinion, the Government of Andhra Pradesh ought to have known the seriousness of the situation obtaining at the Niloufer Hospital over a period of time stretching over several years and taken steps to deal with and minimize the sort of mortality that was being witnessed at the Niloufer Hospital, year after year. Having neglected its responsibility in this regard, the Government of Andhra Pradesh is guilty of the violation of the Right to Life of a very large number of babies at the Niloufer Hospital, Hyderabad. This continuing negligence on the part of the Government of Andhra Pradesh over the past several years attracts Section 12 (a) (ii) of the Protection of Human Rights Act, 1993. This negligence has been fully and conclusively brought out in this Report here.**

4. Having established the responsibility of the Government of Andhra Pradesh, the next question that needs to be raised is: **how should the Government of Andhra Pradesh be**

**made to make amends for this lapse and ensure that such gross violations are not allowed to recur in the future?**

The best way the Government of Andhra Pradesh can make amends for its lapses over a number of years is to immediately direct its Chief Secretary to personally take cognizance of the unacceptable situation obtaining at the Niloufer Hospital, study all aspects of the health, medical and administrative needs of this hospital and fill in all the gaps in regard to the needs relating to the crucial areas of staff, space, equipment, annual budget, laboratory facilities and accountability. The availability to the Government of Andhra Pradesh of the Infosys Millennium Block that has newly come up will be a great help in setting matters right over all at Niloufer. The revamping of the entire functioning of Niloufer Hospital should be informed by the realization that what is happening at Niloufer is essentially only the reflection of the situation obtaining in rural Andhra Pradesh in regard to maternal malnutrition, maternal ill health, neglected load of infection, absence of proper community health services including sanitation, infant and child malnutrition, the failure of the implementation of the ICDS programme in letter and spirit relating to all the 6 services it offers and the non-existence of the linkages that ought to exist between the Anganwadi Centres on the one hand and the Rural Public Health Institutions such as the Sub Health Centres, Primary Health Centres and the Government District Headquarters Hospitals on the other. The poor conditions that obtain in these institutions in regard to the same questions as raised at Niloufer should all be studied and action taken to rectify them. The conditions at the Niloufer Hospital are but the tip of the enormous iceberg that is the failure of the public health and nutrition related programmes of the Government of Andhra Pradesh. This failure also includes the lack of regulation and monitoring by the Government of Andhra Pradesh of what is happening in the private sector in the areas of health and medical care in rural Andhra Pradesh. **Failure to monitor and regulate the private sector in the health care area also constitutes negligence, leading to violation of human rights, the defence of which is ultimately the responsibility of the Government.**

5. In taking action as indicated above, certain specific recommendations related to the Niloufer Hospital may be considered by the Government of Andhra Pradesh as suggested below:

1. Neonatal services in Niloufer Hospital must get priority attention since almost  $\frac{1}{4}$  th of all neonatal cases admitted into this hospital result in death.

The following are some of the steps required:

- i) Integrate the neonatal services into a single separate Department with adequate personnel. The minimum nurses required here would be 100; Assistant Professors 10; and 20 postgraduate residents. Their availability needs to be ensured at all times. The patient care area requires to be increased to about 10, 000 s.ft. from the present 3000 s.ft. The Emergency Neonatal Intensive Care Unit (ENICU), which is presently kept as a part of the Pediatrics Department should be de-linked from that Department and brought under the unified control of the Professor of Neonatology. Having done this, the entire Neonatology Unit should be relocated in the newly constructed Infosys Millennium Block. While this arrangement is absolutely essential, a desirable measure would also be to move the maternity wards to the new millennium block so that maternity and child care are managed together.
- ii) Bearing in mind that at least 80% of the patients admitted into Niloufer would certainly be requiring Level II Care while at least 20% of them would definitely require Level III care, install all the equipment required as discussed in the body of this Report in chapter IV and elsewhere, ensuring they are bought with 5 years of annual maintenance contract.
- iii) Set up a Hospital Infection Control Committee headed by the Medical Superintendent and consisting of doctor-members, some of whom should be drawn from other leading hospitals of the city to determine and ensure the implementation of the required infection surveillance and control measures.
- iv) Establish a decentralized, well-coordinated Outreach Prenatal Education Programme to make available credible health care in the neighbouring rural areas and thus ease the admissions into the Niloufer Hospital. As part of this effort, strengthen the ICDS programme in rural Andhra Pradesh and the city of Hyderabad in regard to all 6 services, which that programme is expected to deliver. This Outreach Programme should be backed by sound health education efforts, which should include training in subjects like the importance of warmth required by the baby, minimal resuscitation procedures, use of oxygen and safe methods of transport so that the baby does not get destabilized *en route*

from outlying areas to the next level hospital, which is what causes mortality most of the time. All these can be achieved only if Niloufer itself is made an APEX Institute with a large Outreach Programme that gets guidance from it in various levels of care.

2. The over all staff strength in Niloufer Hospital needs to be enhanced to cope with the patient load. Nursing strength in particular is of the most fundamental importance and the total nursing strength should at least be about 250 nurses for this hospital, which will mean an addition of about 175 nurses. It is self-defeating for the Government of Andhra Pradesh to increase staff strength in dribbles. The medical fraternity should on their part give up the prevailing tendency to minimize the demands for nursing staff out of “consideration” for economy that the Government wrongly expects from them and thus settle for lower standards.

3. Government should do every thing to enhance the morale of the medical personnel and senior doctors, which is now low on account of poor job satisfaction resulting from overload of patients, gross under-staffing especially in the area of nursing, inadequacy of patient care area, grossly inadequate and poor maintenance of infrastructure and Lab support, short supply and poor management of medicines and disposables. To enhance morale Government also needs to introduce higher pay scales while simultaneously enhancing the working hours from 9 AM to 4 P.M. The importance and requirement of discipline should be fully recognized by the Government and its enforcement ensured by full powers and backing being given to the Medical Superintendent and to the heads of various units in the hospital. In regard to staff recruitment, the existing ban should forthwith be removed and the required staff recruited as per the Indian Medical Council norms. Health being a human right cannot be “out sourced” and, therefore, the principle of public recruitment that can demand accountability from medical and health personnel should be followed uniformly in regard to all categories of staff – medical, para-medical and services like sanitation and security.

4. The facilities mentioned here in terms of infrastructure and equipment should be created and provided forthwith, because job satisfaction is not only a matter of higher pay but also the desire associated with the pride to produce results, for which basic infrastructure and facilities are a *sine qua non*. The Government must also have a policy in regard to equipment maintenance so that no equipment remains out of commission, as is largely the case at Niloufer. We can illustrate the importance of this by pointing out that one ventilator under repairs for one month could conceivably cause deaths of several infants.

**5.** The Government of Andhra Pradesh should restore at once fully the sanctity of the concept of a proper functioning of the Resident Medical Officer (RMO) System in Niloufer Hospital. The Government should initiate action against the violations that have occurred in regard to this as discussed in the body of this Report.

**6.** The Government of Andhra Pradesh should thoroughly review the role of the APMHIDC in regard to budget allotments made to it under various heads relating to construction and maintenance of buildings, procurement and maintenance of equipment and procurement of drugs and consumables and its performance in relation to the responsibilities assigned to it. The State Government should also investigate and fix accountability for the shabby sanitation and the poor upkeep and maintenance of the Niloufer hospital detailed in this Report. This investigation and fixing of responsibility should cover the state of disrepair and non-functioning of all medical equipment and other equipment like the lift, the air conditioners and electrical facilities.

**7.** Autonomy based on accountability needs to be provided to the Niloufer Hospital. However, autonomy should not mean imposing unaffordable user charges or this hospital behaving like a corporate hospital. Autonomy should mean functional and financial autonomy to enhance excellence in delivery of service to the poor and nothing more. There should be no service charges of any kind in the future since Niloufer should continue to take care of the requirements of the poor.

**8.** The Medical Superintendent at Niloufer Hospital should be clothed with adequate powers for enforcing discipline against all levels of erring staff and given at the same time an unambiguous mandate and responsibility and accountability to ensure that the Government's policies regarding "treatment free of cost" for the poor are translated into an actuality in every detail at the Niloufer Hospital.

**9.** The Government of Andhra Pradesh should put in place an enlightened regulatory mechanism to watch over the role and performance of the private sector in the neonatal, pediatric and maternal health sectors in the whole of Andhra Pradesh.

**10.** The Government of Andhra Pradesh should consider all the other recommendations made in the body of this Report for implementation, in addition to the specific ones listed above.

The above Report may please be considered by the Honourable Chairperson, the National Human Rights Commission and the Commission for issuing appropriate directions to the Government of Andhra Pradesh in the light of my findings. I recommend to the Honourable Commission that this Report of mine may please be forwarded in full through a D.O. letter to the Chief Secretary to the Government of Andhra Pradesh with a request to him to place this Report before the Honourable Chief Minister of Andhra Pradesh so that the status of health and medical care obtaining in the State's premier Children's Hospital may be understood at the highest level and remedial measures initiated without delay in defence of the Right to Life of the children of the State of Andhra Pradesh.

K R VENUGOPAL

The latest status of the case  
as ascertained from the NHRC is:

**Comments of the Chief Secretary, A.P. on the report of  
Shri Venugopal, Spl. Rapporteur are still awaited.**