INFANT DEATH IN JAGDALPUR, BASTAR

Fact-Finding Mission to Bastar District, Chhattisgarh (April 2016)

Human Rights Law Network
Reproductive Rights Initiative
576 Masjid Road, Jungpura
New Delhi, India 110014

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BACKGROUND

INTRODUCTION

India has the highest number of child deaths in the world, with an estimated 1.2 million deaths in 2015 — 20 per cent of the 5.9 million global deaths. Other countries in the top five for number of deaths included: Nigeria (7,50,000), Pakistan (4,31,000), Democratic Republic of the Congo (3,05,000) and Ethiopia (1,84,000). Surveys and findings by the Registrar General of India's office showed in 2013 that from 1990, when the under-five mortality per 1,000 live births was 126, it has declined to 49 per 1,000 live births in 2013.

The relatively new state of Chhattisgarh was formed in 2000 by carving out 16 Chhattisgarhi-speaking south-eastern districts from the state of Madhya Pradesh. Chhattisgarh is the 10th largest state in terms of geographical area, the third largest in terms of forest area and has the second largest mineral reserves.

The state has a population of 26 million, more than three-quarters of whom live in rural and remote areas. The population density is 189 people per kilometre lower than the national density rate of 382 per sq km , making it one of least densely populated states in India, ranking 26th.

The sex ratio of 964 females for 1000 males is higher than the all-India sex ratio of 914. The literacy rate in Chhattisgarh has improved steadily from 42.91 per cent in 1991 to 64.7 per cent in 2001, to 71 per cent in 2011. The state has experienced a modest, but consistently positive growth in Gross State Domestic Product (GsDP). Chhattisgarh ranks 23rd in Human Development Index 2007-08 (HDI) out of 23.

Of the total population of 26 million, 43.4 per cent represent scheduled castes and scheduled tribes, who live mostly in the thickly forested areas in the north and south of the state, and are largely involved in small-scale farming. As most of Chhattisgarh's disadvantaged people live in remote forested districts, they remain poorly served and show lower levels of development.

Chhattisgarh is identified as one of the richest biodiversity habitats in India and has one of the most dense forest covers in the country. Rich in wildlife, the state is home to several species of exotic flora and fauna and abundant non-timber forest products, with tremendous potential for value addition. Chhattisgarh is endowed with a rich cultural heritage that includes its varied crafts, folk dances, food, theatre and natural diversity. Many of the tribal groups are known for their ancient traditions and intricate handicrafts.

The greatest challenges for Chhattisgarh are wide disparities in terms of gender, geographical location, civil strife, rural-urban and a widening gap in the availability of human resources. According to recent health statistics, the infant mortality rate is 46 deaths per 1000 live births, the maternal mortality rate is 269, and the total fertility rate is 2.7.

There is need to scale up efforts to achieve development goals by putting efforts using the strategies in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A). Malnutrition in the state has been a concern as the recent NFHS-3 data shows that the prevalence of stunting at 53 per cent, underweight at 48 per cent and wasting at 24 per cent.

The quality of education is also a concern. National Council for Educational Research and Training data for 2014 revealed that performance of children in both language and mathematics is lowest in the country. There is also low enrolment and school completion in children from disadvantaged groups and not enough effort is being made towards multilingual education.

According to District Information System for Education (DISE) data analysis undertaken by UNICEF for 2012-13, there is high Gender Parity Index (GPI) at the primary level (0.96), and (0.97) at the upper primary level. Chhattisgarh's all India Early Development Index (EDI) rank at the primary level is an impressive eighth, but at the upper primary level the state ranks a low 25th.

Significant challenges also exist in the civil-strife affected districts of Bijapur, Narayanpur, Dantewada, Bastar and Kanker, which account for about nine per cent of the total population in the state and where the outreach and provision of social services is extremely difficult.

Communities in most of regions still need to be informed about and have made social programmes and services made more accessible. The lack of avenues for the families and children to express fears and concerns related to the provision of essential services, integration with families and communities, and livelihoods – especially in hard to reach areas – has been a challenge.

Key facts

- Nearly 15,000 children in Chhattisgarh die annually within the first week of their lives and one in every four children under three years of age suffer from wasting due to acute under nutrition.
- About 178,000 children in the 6-14 age group are out of school, with half of these children coming from the five districts of the Bastar region.
- Open defecation is still practiced by 80 per cent of rural households.
- Two thirds of adolescent girls suffer from anaemia.

Infant mortality refers to deaths of young children, typically those less than one year of age. It is measured by the infant mortality rate (IMR), which is the number of deaths of children under one year of age per 1000 live births. The leading causes of infant mortality are birth asphyxia, pneumonia, term birth complications neonatal infection, diarrhea, malaria, measles and malnutrition. Many factors contribute to infant mortality, such as the mother's level of education, environmental conditions, and political and medical infrastructure. Improving sanitation, access to clean drinking water, immunization against infectious diseases, and other public health measures can help reduce high rates of infant mortality. Child mortality is the death of a child

before the child's fifth birthday, measures as the Under-5 Child Mortality Rate (U5MR). National statistics sometimes group these two mortality rates together. Globally, ten million infants and children die each year before their fifth birthday; 99% of these deaths occur in developing nations. Infant mortality rate was an indicator used to monitor progress towards the Fourth Goal of the Millennium Development Goals of the United Nations for the year 2015. It is now a target in the Sustainable Development Goals for Goal Number 3 ("Ensure healthy lives and promote well-being for all at all ages").

Leading causes of congenital infant mortality are malformations, sudden infant death syndrome, maternal complications during pregnancy, and accidents and unintentional injuries. Environmental and social barriers prevent access to basic medical resources and thus contribute to an increasing infant mortality rate; 99% of infant deaths occur in developing countries, and 86% of these deaths are due to infections, premature births, complications during delivery, and perinatal asphyxia and birth injuries. Greatest percentage reduction of infant mortality occurs in countries that already have low rates of infant mortality. Common causes are preventable with low-cost measures. In the United States, a primary determinant of infant mortality risk is infant birth weight with lower birth weights increasing the risk of infant mortality. The determinants of low birth weight include socio-economic, psychological, behavioral and environmental factors.

INVESTIGATION INTO INFANT DEATH IN JAGDALPUR, BASTAR

There have been reports of infant death and rampant corruption and inhumane treatment of women at the Gynaecology Department in the Maharani Hospital in Jagdalpur, Bastar. In order to understand this issue better and investigate the infant death a team of activists and lawyers from Human Rights Law Network undertook a visit to the Maharani Hospital as well as interviewed the parents of the dead infant in the last week of April 2016**.** The team visited the village where the family lived and interacted with the family members of the new born, the Mitanin and other community members. Additionally, newspaper reports and affidavits submitted by the family members were reviewed.

BACKGROUND TO THE GOVERNMENT MEDICAL COLLEGE & MAHARANI HOSPITAL, JAGDALPUR, BASTAR

The Government Medical College & Maharani Hospital, Jagdalpur is one of the bigger hospitals in the state of Chhattisgarh. It caters to the people of the southern districts of Bastar, Dantewada, Kondagaon, Sukma, Bijapur, Narayanpur which are fifth scheduled areas, inhabited predominantly by Scheduled Tribes.

The importance of this hospital lies in the fact that it is the highest referral centre in the region providing specialty services. There are very few private hospitals in the region making the government insurance scheme (RSBY) redundant in the region and making the Maharani Hospital an extremely important health facility for the people of the region. The referral unit after the Maharani Hospital is the Medical College in Raipur which is about 284 kms and takes close to 7 hours by road.

BACKGROUND OF THE FAMILY

Soni Baghel (24 years) and her husband Kadiram Baghel are residents of village Bilori in Bilori Panchayat, Block Jagdalpur, District Bastar. They belong to the Mahra caste which is recognized as a Scheduled Caste in Maharashtra, though in Chhattisgarh this community is in the general category. People from this community settled in the Bastar region, two to three generations earlier. Kadiram Baghel is a construction worker and Soni Baghel works at home and in the fields.

Bilori is about 10 kilometres away from Jagdalpur. The population of the village is 3275. The sub center nearest to the village is the Adaval sub centre which is about 3 kilometres from the village.

Soni Baghel has two daughters, aged seven and two years. The older daughter was born at home, and the second daughter was born at the Maharani Hospital. Both earlier deliveries were normal and there were no complications.

Details of the Incident

Soni Baghel became pregnant with her third child. During her third pregnancy, she went to Maharani Hospital for her ANC. The mitanin of the village always accompanied her. She was a little weak so they decided to go to Maharani Hospital for delivery as well.

On 20th March 2016, when her labour pain began, the family went to the Adaval Sub Center, however there was no ANM present there. They called the 108 Ambulance which took them to Maharani Hospital. They reached the Maharani Hospital at about 8:30 in the morning. The doctors were told that she was in labour. She was shifted to the delivery room. The delivery room has three delivery tables. There were two other women in the room as well. At that time there were two doctors and one nurse on duty. The mitanin was inside the delivery room as well. Soni's mother in law was asked to leave the room.

Soon after, the doctor left Soni unattended on the table and left the room. There was no ayah or nurse attending to Soni or the other two women. Within five minutes after the doctor left Soni, was in tremendous pain. The mitanin went out to call the doctors but they did not listen and continued talking on the phone. Meanwhile the baby was born, the umbilical cord broke and the baby fell into the dustbin with a loud thud. The mitanin complained to the doctors about their negligence but they shouted at her. The doctor picked up the baby from the dustbin and took it away.

The Ayahs told Soni and the mitanin to clean the blood stains. Soni herself right after delivery was made to clean the delivery table and the floor and wear her clothes. She was weak and collapsed on the table right after completing the cleaning. She was in the delivery room till 12

noon. Thereafter she was taken to the ward. No doctor came to check on her during the entire time.

At 12:30pm the baby was brought to her to be breastfed. She fed the baby girl but the baby vomited and was having trouble breathing. Soni told the family to take the baby to the doctors. The doctors admitted the baby at about 1:00 PM. At that time the baby was bleeding from the nose.

The baby was admitted in the hospital for 11 days after which she died. During the baby's stay at the hospital, the family was asked to arrange medicines for the baby. As they did not have money, they used their smart card (RSBY) from which about eight thousand (Rs. 8000) was deducted.

Complaint lodged by the family and community health workers and protests thereafter

With the support of the mitanin, the husband Kadiram Baghel went to the Kotwali police station and lodged a complaint on 20.3.2016 itself, the day the baby was born. However, contrary to what has been reported in the media, the police have not yet registered an FIR. As a result criminal proceedings against the doctors and staff on duty have not been initiated. The police has recorded the statements of the doctors. Meanwhile it was reported in the media that the doctors and nurses involved had been suspended, however, this could not be validated by the fact finding team.

According to the family the baby's post mortem was conducted at Maharani Hospital itself, however the police claims that the report has not been handed over to them. The Collector directed the SDM to conduct an enquiry in the matter however, the family members are not aware of the outcome of the enquiry. The SDM seems to have recorded statements of doctors, but not of the family members. It is also not clear as to what action has been taken till date against the accused doctors and other staff members.

The family, along with villagers from Bilori, and mitanin from the district held a day long protest outside the Collector's office on 26.4.2016. On 28.4.2016, the Mitanins gave a collective general complaint against the Maharani Hospital, against ill treatment of women.

Rampant Corruption and Inhumane Treatment of Women at the Gynaecological Department, Maharani Hospital

It emerged that the staff of the Maharani Hopital have been indulging in corruption and malpractice openly for quite some time now. Several complaints have been made to the Collector by patients and Mitanins, but the ordeal continues for the people coming to the hospital for treatment. Some of the main complaints are that women who come for delivery being routinely slapped and abused. Moreover, Five hundred rupees is often charged per delivery illegally by the staff. The community has a tradition of taking the umbilical cord and disposing it themselves by burying it at a place of their choice. The hospital staffs use this to their advantage and refuse to give the umbilical cord unless a payment of rupees five hundred

or more is made. Sometimes the women are not shifted from the delivery room to the ward until the payment is made.

KEY FINDINGS

- This is an obvious case of utter negligence by the staff of the Maharani hospital. The behaviour of the staff and other health officials even after the incident has been appalling, without any sense of remorse or decency. The family is convinced that they have been treated this way because they are poor. They say that had if this incident had happened to a rich family, then the doctor would've been in jail for negligence, and moreover, such an incident might not have taken place in the first instance.
- The district and state officials are answerable for the seeming lawlessness at the hospital; they have failed to take action on several previous complaints.
- The police by not registering an FIR have violated the law. As of now no criminal proceedings have been initiated. The police do not have the power to conduct a preliminary enquiry of any sort and is bound to register an FIR under Section 154 of the Criminal Procedure Code.
- The SDM who is supposed to have conducted the mandatory disciplinary proceeding/enquiry has not made the family party to the proceedings in violation of the principles of natural justice.
- The family was supported by the mitanin all throughout, however; the mitanin has been subject to a lot of harassment, accusations and mental torture by the hospital staff regarding which she has also complained to the CMHO, Bastar. The family members are unsure about following up the case to ensure fixing of legal liability. At the minimum they expect an apology, an acknowledgment of the negligence and an assurance that such incidents will not happen in the future.
- The Maharani hospital is literally the lifeline of the region and it was felt by the fact finding team that there is fear of backlash from the hospital if the family or anyone else pursues the matter in court.

RECOMMENDATIONS

- Proper enquiry needs to be conducted verbal infant death autopsy on this incident, with independent members needs to be undertaken. Any previous enquiry reports need to be made public and accessible to the family.
- The Police must register an FIR U/s 304 of the Indian Penal Code, of culpable homicide not amounting to murder.

- Proper and adequate action should be taken against the staff indicted in this incident, including legal action, suspension, withholding of increment etc, and the family should be informed of the action being taken.

- A written apology should be made to the family by the CMHO or the Collector of the district for this gross negligence and to the mitanin for the harassment.

- Even though nothing will bring back the child, as this was a case of gross medical negligence, monetary compensation amounting to a minimum of Rs. 10 lakh should be paid to the bereaved family.

- Additionally, the amount of around Rs. 8000 that was deducted from their RSBY smart card for treatment of the baby and mother should be returned back to them.

- The amount that needs to be provided through JSY and IGMSY (a sum 1400 and a sum of 6,000 respectively) should be paid to the family this needs to be looked into to see whether they have been paid the question of eligibility might be raised as this is her third pregnancy however nowhere in the guidelines does it say that you will only be eligible to be paid for giving birth to two children

- The Government needs to urgently improve the quality of services being provided and behaviour being meted out to the patients at all the government facilities. The Maharani Hospital, regarding which numerous complaints have been made, needs to be monitored strictly so that such incidents do not occur in the future. All hospital staff need to be sensitized and oriented towards the rights of patients and the need to treat them like humans and not like animals!

- Instances of corruption by the hospital staff should not be tolerated and immediate action should be taken on all the complaints made.

Enclosed: Media reports

CONCLUSION

The fact-finding team was profoundly disturbed by the details surrounding the death of infant. There is a system in place that is designed to provide adequate and respectful and dignified maternity care for pregnant women and her infant child, and yet it was not properly administered. This is a direct violation of multiple international agreements that India is a party to, establishing a right to survive pregnancy and childbirth. The government of India has created multiple schemes to help provide services that guarantee pregnant women that right. In this particular instance,

The events of this case also constitute violations of multiple rights provided by the Constitution, including the fundamental right to health, and guaranteed access to medical services regardless of status. Every person in India is guaranteed the right to heath, regardless of his or her sex or status. .

There is fear that other women similarly situated may face the same fate if the state does not address these egregious violations. The need for corrective action is blatantly obvious, and needs to be taken immediately

GUARANTEES AND GUIDELINES

A. INTERNATIONAL CONVENTIONS

The right to survive pregnancy and childbirth is a basic human right. Under international law, India has a duty to ensure that women and infants do not experience death or morbidity from wholly preventable causes.[1]This duty arises from multiple international conventions to which India is a party, and which establish the right to health, the right to reproductive autonomy, and the right to be free from degrading treatment. Relevant conventions include the International Covenant on Civil and Political Rights (ICCPR),the International Covenant on Economic Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC).[2]

B. CONSTITUTIONAL GUARANTEES

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The Hon'ble Supreme Court has interpreted Article 21 to include numerous fundamental rights already protected under international law, including a fundamental right to health (both physical and mental)[3]; the right to live with dignity[4]; and the right to be free from torture and cruel, inhuman, or degrading treatment.[5]

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1 *See generally* Center for Reproductive Rights, *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change*, 2008, pp. 9, 27–38, *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/MM_report_FINAL.pdf; International Initiative on Maternal Mortality and Human Rights, *No More Needless Deaths: A call to action on human rights and maternal mortality* (2009), *available at* http://righttomaternalhealth.org/resource/no-more-needless-deaths.

2 *See especially* ICCPR Art. 6 (right to life); ICESCR Art. 12 & CEDAW Art. 12 (right to the highest attainable standard of health, including the right to health services that are accessible and of good quality); ICESCR Art. 15 (right to enjoy the benefits of scientific progress, including in obstetrics and paediatrics).

3 In *Consumer Education and Research Centre v. Union of India,* [1995 SCC (3) 43].

4 *Francis Coralie Mullin v. Union Territory of Delhi &Ors.,* [1981 SCR (2) 6].

5 *Id.*

Articles 14, 15, and 38 of the Constitution of India provide additional guarantees. Article 14 guarantees equality before the law, and the Hon'ble Supreme Court has described gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution of India." [6] Article 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. While the burdens of pregnancy and childbirth are inequitably borne by women, the ability to reproduce should not increase women's chances of death, disability, or illness. Finally, Article 38 guarantees access to medical services regardless of status.

C. KEY CASES

In *Francis Coralie Mullin v. Union Territory of Delhi &Ors.*, [1981 SCR (2) 6], the Supreme Court held that the right to live with dignity and protection against torture and cruel, inhuman or degrading treatment are implicit in Article 21 of the Indian Constitution.

In *Pt. Parmanand Katara v. Union of India &Ors.*,[1989 SCR (3) 997], the Supreme Court held that Article 21 of the Constitution casts the obligation on the state to preserve life.

In *Consumer Education and Research Centre v. Union of India,* [1995 SCC (3) 43], the Supreme Court held that Article 21 of the Constitution of India includes a fundamental right to health, and that this right is a "most imperative constitutional goal."

In *Paschim Banga KhetMazdoor Samity v. State of West Bengal*, [1996 SCC (4) 37], the Supreme Court affirmed that providing "adequate medical facilities for the people is an essential part" of the government's obligation to "safeguard the right to life of every person."

In *PUCL v. Union of India*,[1996 SCC], the Supreme Court held that all pregnant women should be paid Rs. 500 under NMBS at 8–12 weeks prior to delivery for their first two births, irrespective of the place of delivery and age.

In *Laxmi Mandal v. Deen Dayal Harinagar Hospital &Ors.*, [W.P. (C) 8853/2008], the Delhi High Court held that an inalienable component of the right to life is "the right to health, which would include the right to access government health facilities and receive a minimum standard of care. In particular this would include the enforcement of the reproductive rights of the mother."

In *Sandesh Bansal vs. Union of India &Ors.*,[W.P. (C) 9061/2008], the Indore High Court concluded that timely health care is of the essence for pregnant women to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India.

D. NATIONAL HEALTH MISSION (FORMERLY, NRHM)

In 2013, the Centre Government launched the National Health Mission (NHM) as an umbrella program with two main prongs: the National Rural Health Mission (NRHM), first launched in 2005, and the National

[6] *Apparel Export Promotion Council v. Chopra*, [AIR 1999 SC 625].

Urban Health Mission (NUHM).[7] The purpose of these schemes is to improve health infrastructure and health outcomes in India's rural and urban areas.

A major focus of the NRHM is improving maternal and infant health, which is revealed in the NRHM Service Guarantees. In addition to the Service Guarantees, the NRHM houses numerous individual benefit schemes with a more targeted focus. Individual schemes that focus on improving maternal and infant health are discussed below. They include the National Maternity Benefits Scheme (NMBS), Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK).

1. JANANI SURAKSHA YOJANA (JSY)

Since its implementation in 2005, the JSY scheme has aimed to reduce maternal and neonatal mortality by providing women with conditional cash assistance for registering their pregnancies and choosing institutional delivery. All women are eligible for JSY benefits, regardless of their age or number of children.

As a LPS, Chhattisgarh must provide JSY benefits of Rs. 1400 for institutional deliveries in rural areas, Rs. 1000 in urban areas, Rs. 1500 for Caesarean section patients, and Rs. 500 (from NMBS funds) for home deliveries conducted by skilled birth attendants. Although women who choose to deliver in private health facilities must bear the costs themselves, they are still eligible to receive JSY benefits for having had an institutional delivery.

To receive JSY benefits, women in Chhattisgarh must present a JSY Card and a referral slip from either an Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM), or Medical Officer (MO).

JSY BENEFIT FOR INSTITUTIONAL DELIVERIES
(in Rupees)

	Rural			*Urban*		
Category of States	Assistance to mother	Assistance to ASHA	Total	Assistance Mother	Assistance to ASHA	Total
LPS*	1400	600	2000	1000	400	1400
HPS**	700	600	1300	600	400	1000

* Low Performing States (LPS) include Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and Uttaranchal.
** High Performing States (HPS) include all states that are not LPS.

[7] C. Maya, Draft guidelines focus on quality health care, *The Hindu* (19 Dec. 2013), *available at* http://www.thehindu.com/todays-paper/tp-national/tp-kerala/draft-guidelines-focus-on-quality-health-care/article5476728.ece.

Source: Indian Ministry of Health & Family Welfare, Directive No. Z.14018/1/2012-JSY, 13 May 2013.

According to the 2012–2013 Annual Health Survey, 39.0% of new mothers in Chhattisgarh receive financial assistance for delivery under the JSY scheme, with a significant divide between rural women (32.9%) and urban women (39.0%). These numbers increase for women who undergo institutional deliveries (60%) and institutional deliveries in government health facilities only (75.4%), with similar gaps between women in rural and urban areas.[8]

2. JANANI SHISHU SURAKSHA KARYAKRAM (JSSK)

Through the NRHM, the government also coordinates the JSSK scheme, which it launched in June 2011 as a means of eliminating out-of-pocket expenses incurred by pregnant women and sick newborns, which are "without doubt, a major barrier" for pregnant women and children, many of whom "die on account of poor access to health facilities."Therefore, the JSSK scheme provides that pregnant women seeking institutional delivery and sick newborns until 30 days after birth are entitled to absolutely free care in all government health facilities.[9]

JSSK services are available to all women who deliver in government health facilities, regardless of age, number of children, or economic status. These free JSSK services include delivery (including Caesarean section), medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery and 7 days for Caesarean section), free transportation to and from the facility (and between facilities in cases of referral), and exemption form all user charges.[10]The JSSK scheme provides essentially the same free services to sick newborns that are available to pregnant women.[11]

INDIRA GANDHI MATRITVA SAHYOG YOJANA (IGMSY)

IGMSY is an initiative implemented by the Women and Child Department to improve the nutrition status for all with specific focus on children, adolescent girls, pregnant women and lactating mothers. It is a centrally sponsored scheme providing cash assistance directly to pregnant and lactating women from the 2nd trimester of pregnancy up to 6 months after delivery, Rs. 6,000 to be provided to fulfill specific conditions related health and nutrition of the mother and child. The scheme would address short term income support objectives with a long term objective of behaviour and attitudinal change. The scheme attempts to partly compensate for wage loss to pregnant and lactating women both prior to and after delivery of the child.

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8 Government of India, Office of the Registrar General & Census Commissioner, Vital Statistics Division, *Annual Health Survey 2012–13 Fact Sheet: Odisha* [hereinafter Government of India, *Annual Health Survey 2011–12 Fact Sheet: Chhattisgarh*, p. 75.

9 Government of India, Minstry of Health & Family Welfare, Maternal Health Division, *Guidelines for Janani-Shishu Suraksha Karyakram* (2011), Preface, p. 2.

10 *Id.*, p. 4.

11 *Id.*, p. 5.