INFANT MORTALITY AND INDIAN PUBLIC HEALTH STANDARDS
CUTTACK, ODISHA

Fact-finding Mission in Banki | February 4, 2015

Human Rights Law Network
Reproductive Rights Initiative
576, Masjid Road, Jangpura
New Delhi - 110014

Table of Contents

1. **Introduction**
   - *1.1.* Fact-finding Methodology
   - *1.2.* Maternal Death Narrative
   - *1.3.* Interviews
   - *1.4.* Summary of Findings

2. **Background**
   - *2.1.* Background - Odisha (population/census information)
   - *2.2.* Village Specific Information
   - *2.3.* Maternal Mortality in Odisha (Common Causes)

3. **Explanation of Government Medical Schemes**

4. **Constitutional Violations**
   - *4.1.* Article 14
   - *4.2.* Article 15
   - *4.3.* Article 21
   - *4.4.* Article 38
   - *4.5.* Article 47

5. **Violations of International Conventions**
   - *5.1.* The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
   - *5.2.* International Convention on Economic, Social and Cultural Rights (ICESCR)
   - *5.3.* International Convention on Civil and Political Rights (ICCPR)
   - *5.4.* United Nations Convention on the Rights of the Child (UNCRC)
   - *5.5.* Universal Declaration for Human Rights
   - *5.6.* International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)

6. **Recommendations: Schemes for Redress**

List of Acronyms

1. ADMO Assistant District Medical Officer
2. ANC Antenatal Checkup
3. ANM Auxiliary Nurse Midwife
4. ASHA Accredited Social Health Activist
5. AWC Anganwadi Centre
6. AWW Anganwadi Worker
7. BPL Below Poverty Line
8. CDMO Chief District Medical Officer
9. CHC Community Health Centre
10. HRLN Human Rights Law Network
11. IPHS Indian Public Health Standards
12. JSSK JananiShishuSurakshaKaryakram
13. JSY JananiSurakshaYojana
14. LPS Low Performing State
15. MCH Maternal and Child Health
16. MMR Maternal Mortality Rate
17. MOIC Medical Officer in Charge
18. MoHFW Ministry of Health & Family Welfare
19. NHM National Health Mission
20. NRHM National Rural Health Mission
21. OBGYN Obstetrician/Gynaecologist
22. OT Operational Theatre
23. PHC Primary Health Centre
24. PPH Postpartum Haemorrhaging
25. RKS RogiKalyanSamiti
26. SBA Skilled Birth Attendance
27. SDMO Sub Divisional Medical Officer
28. VHND Village Health and Nutrition Day (“MamataDiwas”)
29. WHO World Health Organization

State and District Maps[1]

ODISHA

Landmass:	:	1, 55,707 sq. km
Districts	:	30
Subdivisions	:	58
Tehsils	:	317
Community Development Blocks	:	314
Urban Local Bodies	:	107
Gram Panchayats	:	6,227
Villages (Inhabited)	:	47,529
Villages (Uninhabited)	:	3,820
Villages (Total)	:	51,349

[1]Map 1 and the corresponding information can be found at:http://www.odisha.gov.in/pc/Download/Economic_Survey_2014-15.pdf; Map 2 can be found at: http://www.mapsofindia.com/maps/orissa/tehsil/cuttack.html

CUTTACK
TEHSIL MAP
Angul
Dhenkanal
Jajapur
Kendrapara
Jagatsinghapur
Nayagarh
Khordha
Puri
Narasinghpur
Badamba
Tigiria
Athagad
Tangi-Choudwar
Mahanga
Salepur
Cuttack
Baranag
Nischintakoili
Cuttack Sadar
Barang
Banki-Dampara
Banki
Kantapada
Niali
Legend
District Boundary
Tehsil Boundary
Coastline
Miles
Copyright © 2015 www.mapsofindia.com
(Last Updated on 10th Sep 2015)

Introduction

1.1. Fact-finding Methodology

On Thursday, February 4, 2016, a fact-finding team from the Human Rights Law Network (HRLN) traveled to the Cuttack District to research an infant death and the Indian Public Health and Safety Standards in the Banki region. The fact-finding methodology employed during this visit included meetings and interviews with the ASHA who attended the pregnant mother, interviews the Anganwadi workers at the local AWC, a meeting with medical staff at the DamparaCHC, a meeting with the CMO and other doctors/medical staff at the SDH, a meeting with the Banki Police Inspector and a meeting with the Cuttack CDMO. All interviews were conducted in Oriya and translated by HRLN staff to English.

The fact-finding team consisted of: (1) Sarita Barpanda - Director, Reproductive Rights Initiative, New Delhi; (2) Sujatarani Dash - Activist, Cuttack; (3) Sevati Soren - Advocate, Cuttack (4) Morgan Wilson - Intern, New Delhi; (5) Budha Nayak- local activist (6) and ArabindaHarichandan - Sambad News. All pictures were taken with permission and are the property of the HRLN.

1.1. Infant Death Narrative

Date of Delivery	12/12/2015 (5am)
Date of Death	12/12/2015
Mother's Name	Kabita Barika Village/GP: Kusapangi SDH: Banki PS: Banki Dist: Cuttack
Father's Name	Siba Prasad Barika Village/GP: Kusapangi SDH: Banki PS: Banki Dist: Cuttack
Local Activist / Sarpanch's Husband	Budha Nayak
Medical Officer; CHC, Dampara	Dr. Padmolochana Panda
Doctor in Deputation (from city hospital)	Dr. GangadharaTarunguru

SDMO In Charge; SDH, Banki	Dr. Monoj Kumar Sethy
CDMO, Cuttack	Dr. Prafulla Kumar Behera, MS (Surgery)
Media Contact	Mr. ArabindaHarichandan Correspondent, Sambad newspaper Mob: 9437193383

This was the first (and to date, only) pregnancy for Kabita and Siba; they have no children and were looking forward to the opportunity to become parents and raise a child. Kabita registered her pregnancy with the ASHA under the JSY and Mamata schemes so that she would have access to necessary care and assistance. Although Kabita's family said the pregnancy was normal, the ASHA did not maintain Kabita's pregnancy book to confirm the same. Additionally, a review of Kabita's passbook (no. 33208721343) revealed that she did not receive the Rs. 1500 installment payment as prescribed under the local Mamata scheme. She was supposed to receive that payment at the end of her second trimester, but no payout has been made as of the date of this report.

On Friday evening, December, 11, 2015 Kabita was admitted to the Banki SDH for delivery. After Dr. Patra administered the injection, she sent Kabita to a recuperation ward to await delivery. Throughout the night Kabita was in considerable pain, but neither the duty nurse nor the doctor checked on her. She was left alone to suffer in silence.

Early Saturday, December 12, 2015 Kabita went into labor. The labor was difficult and Dr. Patra used forceps to assist in the delivery of Kabita's male child. The baby was born around 5am that morning and the family immediately noticed part if the baby's skull was crushed where Dr. Patra used forceps. Although the baby was born alive, it died few hours after delivery.

Given that villagers live communally, news of the death spread quickly and community members, in conjunction with Kabita and her family, protested for better health services in front the SDH.

1.2. Interviews

Upon arriving in the Kusupangi village in Banki, Cuttack, the fact finding team met with Kabita's father-in-law, close relatives and BudhaNayak, a local activist, to discuss the murder of Kabita's newborn child. They relayed the above account, supported with information from the ASHA and hospital records.

During the family interview, the fact finding team requested to speak with the ASHA. The ASHA brought with her Kabita's pregnancy booklet. The booklet was incomplete. In fact, there

was little information in the book about Kabita's pregnancy, nutrition or whether or not Katiba was receiving routine checkups. The ASHA did note that she was unable to travel with Kabita to the SDH because there was not enough room in the ambulance, as a number of Kabita's family attended the birth.

After meeting with Kabita's family, the fact finding team visited the AWC to speak with AWWs. The AWWs said they have 25 children in their care, 18 of which were present during the visit. The children attend school for ½ day and are fed a combination or rice, egg, daal and a soy by-product.[2] The AWWs also noted that they do not have enough books and chalk slates for each child, and do the best they can with meagre provisions.

HRLN Advocate talks with children at the Kusapangi AWC

As for the building, it does not have a door or a completed front wall, which is distracting to both the AWWs and the children. As a result, children are exposed to weather/elements while in school (heat/rain/bugs/etc). The AWWs said the community allows them to use the building

[2] Specifically, the AWWs said the weekly food plan is as follows: Monday/Thursday - rice and daal; Tuesday - rice and soy; and Wednesday and Friday - rice and eggs.

because there are no funds to erect a proper school. Because the building was not constructed for use as a school, there are no bathrooms or kitchen facilities (no stove, sink to wash dishes, or food storage units).

The AWC is housed in a dilapidated building that has no front wall/door

Without proper food storage, nutrition packets sent by the government for distribution to pregnant and lactating mothers, as well as, food purchased to feed the children while they attend school are vulnerable bugs and rodent infestations. When asked whether or not pregnant mothers eat the government issued nutrition packets that have become infested with bugs or compromised by rodents (like mice), the AWWs made clear that more often than not, the mothers give those packets to their cattle.

Adding insult to injury, the AWWs further advised that without a proper kitchen they are forced to cook "nutritious" meals on a small makeshift stove on the floor of the AWC. Smoke from the stove fills the AWC with a thick fog, blackening the walls and causing the children to cough. Smoke inhalation is not healthy for the AWWs or the children, whose lungs are still developing.

AWC "Kitchen" and "stove"

Smoke from the makeshift stove has blackened the ceiling and walls inside the AWC

After a brief visit to the AWC, the team traveled to the Dampara CHC. Unfortunately, one doctor was away on leave and the CMO was away at a meeting. However, the fact finding team was able to meet with the AYUSH Doctor, a Pharmacist and the staff nurse The medical staff

explained that the Dampara CHC was upgraded from a PHC to a Class 2 CHC. They further advised that portions of the CHC operate without running water (specifically the immunization room), that the ceiling in the immunization room leaks compromising their vaccine storage units and the medicine itself, there are no female doctors at the facility or on deputation from another location, and the CHC operates without the required number of medical staff. A tour of the facility - specifically the Labor room, Maternity word, Surgical Room, OPD ward, Eye surgery ward- confirmed the same, while also illuminating other distressing offenses (for example, ***there are NO bathrooms at the facility for patient use***).

Maternity / Surgical Building, Dampara CHC

After an hour-long tour of the Dampara CHC, the team visited the Pathapur sub centre. The team spoke at length with community members who indicated that the centre stood vacant for several months before a squatter and his family moved into the building. Community members claim that the CHC and the SDH are aware that the sub centre is closed but have done nothing to remedy the situation. Finally, the villagers also explained that the ANM had been absent for awhile.

The Pathapur sub centre is closed and in a state of disrepair.

Front door with lock - Pathapur Sub centre

The signage is worn away because no one maintains the building.

The team drove from the Pathapur sub centre to the Banki SDH and met with Dr. ManojSethy, the SDMO-in-Charge that day. Dr. Sethy explained that he was at the SDH the day Kavita delivered her child. He told the fact finding team that Kavita's family complained to him directly about Dr. Patra's behavior, explaining that Dr. Patra was verbally abusing Kavita and neglecting the newborn, resulting in the infant's death. Dr. Sethy said that according to Dr. Gita, the duty doctor for Kabita's delivery, the infant was stillborn.

In an effort to develop a more well-rounded picture of the medical staff involved in the death of Kabita's newborn, Dr. Sethy called Dr. GoberdhanaParamguru, MS and Dr. Gita, OBGYN so that the fact finding team could get their version of events. Upon arrival, Dr. Paramguru explained that Dr. Gita and the SDH SDMO are unavailable and that the team could make an appointment to come back and speak with them at a later date.

He also advised that Kabita's family complained to the SDMO about Dr. Gita's abusive language and said that her use of forceps caused severe damage to the newborn's skull.

Shortly thereafter, Dr. Padmalochan Panda - the Dampara CHC MO - arrived and explained to the team that he was unable to meet them at the CHC because he had a meeting in Banki. Dr. Panda further explained that due to sterilization work, as required by the Health department, he is very busy and therefore cannot entertain spur of the moment meetings.

After meeting with the SDH doctors, the fact finding team toured the facility to gauge whether or not IPHS were being implemented.

At 5pm, the team left the SDH to meet with Mr. Prafulla Kumar Behera, CDMO - Cuttack. The fact finding team asked Dr. Behera about district wide procedures for infant death reviews, to which Mr. Behera replied that, at present, health facilities do not conduct infant death reviews. When asked about Kabita's case specifically, Mr. Behera indicted that he had no knowledge of the incident but promised to conduct an investigation at the CDMO level. Mr. Behera further advised that if the investigation revealed that the OBGYN was at fault, she would be subject to "disciplinary action" (although he did not specify what constitutes disciplinary action).

The last stop of the day was at the Police Station in Banki to meet with the Inspector in Charge - NiranjanPadhi. The fact finding team asked the Inspector, what, if any, system is in place whereby a patient can file a complaint with the authorities against a doctor or the hospital. The Inspector replied that as per the Odisha State Medical Council, before a formal complaint can be lodged with the police against a doctor or the hospital, there must be a departmental inquiry. The team requested a copy of this information, but the Inspector was unable to produce the document and said he would mail it to the HRLN offices in Cuttack. As of the date of this report, HRLN has not received any correspondence from the Inspector.

Meeting with the Banki Police Inspector

1.3. Summary of Findings / Observations

→ *Anganwadi Centre*

The AWC is in disrepair and is not in line with the *Operational Guidelines for Food, Safety and Hygiene*,[3] which mandates operational and functional requirements for AWCs.

The guidelines make clear, "cleanliness is essential for effective control of all pests (mainly rodents, birds, and insects)...The building must be kept in good condition and repair to prevent

[3] *Operational Guidelines for Food Safety and Hygiene for Supplementary Nutrition under ICDS,* Ministry of Women and Child Development, Government of India [hereinafter FSH Guidelines]; *available at*http://wcd.nic.in/fnb/fnb/guidelines/merged_document_3.pdf.

access and to eliminate potential breeding sites. Holes, drains and other places where pests are likely to gain access must be kept sealed. Wire mesh screens, for examples on open windows, doors and ventilators, will reduce the problem of pest entry. The kitchen & AWCs surrounding areas must be regularly examined for evidence of infestation."[4] The Kusapangi AWC building is dilapidated and has no provision to pest control as evidenced by photos of the kitchen and information gleaned from conversation with the AWWs about the infestation of government issued nutrition packets.

Additionally, storage facilities (storehouses) for raw materials, processed foods and packaged foods are mandatory under the guidelines.[5] With regard to the construction of the storage facility, the guidelines state that it "***needs to be located in the place that is free from contaminations*** due to industrial pollution, flooding, drainage etc. It should not be a passage or entrance. ***It should be spacious enough to accommodate stock at least for few months***. ***It should have proper ventilation to prevent buildup of heat, steam, condensation or dust and to remove contaminated air and be well lit.***"[6] The Kusapangi AWC has not such place and certainly the kitchen does not suffice.

The kitchen fails all standards provided in the guidelines which stipulates that "adequate space should be provided for [the] kitchen, it should be separate from activity/ class rooms, ***preferable*** [sic] ***located at a safe, but accessible distance.[Kitchens] should be well ventilated*** and ...adequate natural or artificial lighting should be provided throughout the kitchen area. Lights and fixtures should be cleaned regularly to keep it free from dust, dirt and carbon. ***Smokeless chulhas should be used to the extent possible. Fuel (kerosene/fuel wood/charcoal/LPG) should be stored safely, so that there is no fire hazard. To the extent possible firewood should not be used in the interest of environmental protection.*** If kerosene/gas is used for cooking, the cook /AWH should be specifically trained in safe handling of stoves, gas cylinders etc."[7] Because of the layout of the AWC, the makeshift stove filled the centre with black smoke, and there are not enough provisions for storing fuel. The kitchen is small, not well lit or ventilated and posing a serious risk to both the children and the AWWs.

→ *Pathapur Sub Centre:*

Because the subcentre was closed, the factfinding team was unable to assess how the IPHS are implemented at this level in Banki. However, according to the Subcentre Guidelines Manual, "the building should have a ***prominent board*** displaying the name of the Centre in the local language at the gate ***and on the building Prominent display boards in local language***

[4]FSH Guidelines, pg. 9.
[5]Id. at 10.
[6]Id. at 26-27.
[7]Id. at 7.

providing information regarding the services available and the timings of the Sub-centre should be displayed at a prominent place.”[8]Because the building isn't properly maintained, the signage almost invisible and would need to be repaired if the sub centre reopens.

→ *Dampara CHC:*

A tour of the facility revealed a number of IPHS violations. To begin, there are no patient restrooms at the facility, even though all CHCs are required to have separate bathroom facilities for men and women.[9] In fact, the CHC Guidelines are clear that entry, ambulatory, diagnostic and intermediate zones should each of their own set of bathroom facilities.[10]

There is no proper waste management system at the CHC. The medical staff use a small pit near the OT and Labor Room area to burn trash and medical waste. CHCs are required to follow the *Guidelines for Health Care Workers for Waste Management and Infection Control in Community Health Centres*.[11] The guidelines for waste management make clear that microbiology & biotechnology waste (i.e. waste from laboratory cultures) must first be treated through an autoclaving or microwaving process before incineration.[12] The guidelines further advise that discarded medicines and cytotoxic drugs (i.e. outdated, contaminated and discarded medicines), solid waste (i.e. items contaminated with blood, and body fluids including cotton dressings, soiled plaster casts, lines, beddings, other material) must be incinerated whereas waste generated from disposable items such as tubings and catheters must be shredded.[13]

---

[8]Directorate General of Health Services, *Indian Public Health Standards (IPHS): Guidelines for Sub-Centres,* Ministry of Health and Family Welfare, Government of India (2012, revised); pg. 16 [hereinafter Subcentre Guidelines] *available at*http://health.bih.nic.in/Docs/Guidelines/Guidelines-Sub-Centers-(Revised)-2012.pdf.

[9]Directorate General of Health Services, *Indian Public Health Standards Guidelines (IPHS) for Public Health Centres,* Ministry of Health and Family Welfare, Government of India (2012 revised); pg. 13 [hereinafter CHC Guidelines]; *available at*http://health.bih.nic.in/docs/guidelines/guidelines-community-health-centres.pdf.

[10]Id. at 14-15.

[11]Id. at 17.

[12]*Infection Management and Environment Plan,* Ministry of Health and Family Welfare, Government of India; pg. 65 [hereinafter Waste Management Guidelines]; *available at*http://nrhm.gov.in/images/pdf/guidelines/nrhm-guidelines/imep/imep-guidelines-in-chc.pdf.

[13]Id. at 66.

The Labor Room was in a state of disrepair. The delivery table was dusty and looked as if it had not been used in quite some time, the scale used to weigh newborns was filthy and the medical equipment was scattered and unorganized.

Delivery table in the Labor Room

Scale used to weigh newborns. Also note that the scale is on the floor, which is equally dirty.

Medical Equipment in used during delivery in the labor room

Around the corner from the Labor Room is the Operation Theatre (OT), which is also in a state of disrepair. The step stool and tables are rusted, there are surgical tools laying haphazardly in window sills or out on tables, bloody cotton swabs are left on the floor while surgical waste is left out in the open although there are proper bio-waste bins.

Operation Theatre

Medical instruments left on windows and biowaste in a garbage bins next to the proper disposal bins.

Waste from surgery earlier in the morning that has not been properly disposed.

The guidelines specify that both the operation theatre (OT) and the labor room should have storage area for sterile supplies, a scrub area and an instrument sterilization area.[14] From the pictures above, neither location has a proper sterilization unit and the medical staff make little to no effort to sterilize or shelve instruments after use. In both wards instruments were left laying out haphazardly where they pose a danger to non-medical staff. Additionally, patients are at serious risk of contracting infections from improperly or non-sterilized surgical equipment.

Even if there was a proper sterilization area, there are no storage facilities for the safekeeping of sterile supplies. In fact, the CHC keeps their supplies on open shelves where they are exposed to environmental elements like weather, rodents, and dust. Moreover, the supplies are disorganized and pose a threat to patients undergoing surgery or labor. Doctors and medical staff must be able to locate instruments in a timely manner to ensure the best surgical outcome for their patients.

Although both rooms had scrub areas (sinks with running water), there was no soap or other disinfectant for use by the surgical team prior to and after labor or surgery.

Next, the fact finding team asked to see the female ward. The medical staff informed us that the ward has been closed for some time because a wall collapsed and had yet to be fixed. As a result

[14]CHC Guidelines, pg. 13.

women are placed in the male recuperation ward as there is no place to house pregnant and lactating mothers in need of care. The male ward has no privacy screens so any female patients placed in this ward - particularly pregnant and lactating mothers - cannot recuperate or breastfeed in privacy. It is mandatory to have separate male and female wards, with separate spaces/rooms for patients needing isolation.[15]

The CHC Guidelines also indicate that there should a nursing station with enough room to "accommodate a medicine chest/a work counter (for preparing dressings, medicines), hand washing facilities, sinks, dressing tables ***with screen in between*** and colour coded bins (as per IMEP guidelines for community health centres). It should have provision for Hub cutters and needle destroyers."[16] No such place exists at the Dampara CHC.

Locked door to the female ward

The male ward is a dimly lit small room with 6 beds, since it is the only patient recuperation/post surgery area, it should have 30 patient beds, as per the guidelines.[17]

[15]CHC Guidelines, pg. 13.
[16]Id.
[17]Id. at 11.

A bed in the male ward. The fact finding team had to use the camera flash in order to take the picture because the ward was so poorly lit.

According to the District disaster management plan, Cuttack is a flood and cyclone prone[18]area which means that the CHC should undertake disaster prevention measures to ensure building and internal structural integrity. Specifically, the external and internal structure "should be made disaster proof especially earthquake proof, flood proof and equipped with fire protection measures."[19] With leaking roofs and cracked walls the Dampara CHC is not equipped to withstand floods or cyclones.

[18]Works Department, *Disaster Management Plan,* Ministry of Health and Family Welfare, Government of Odisha (2013-2014); pg. 3 [hereinafter DM Plan]; *available at*http://wcdodisha.gov.in/node/242.
[19]CHC Guidelines, pg. 11.

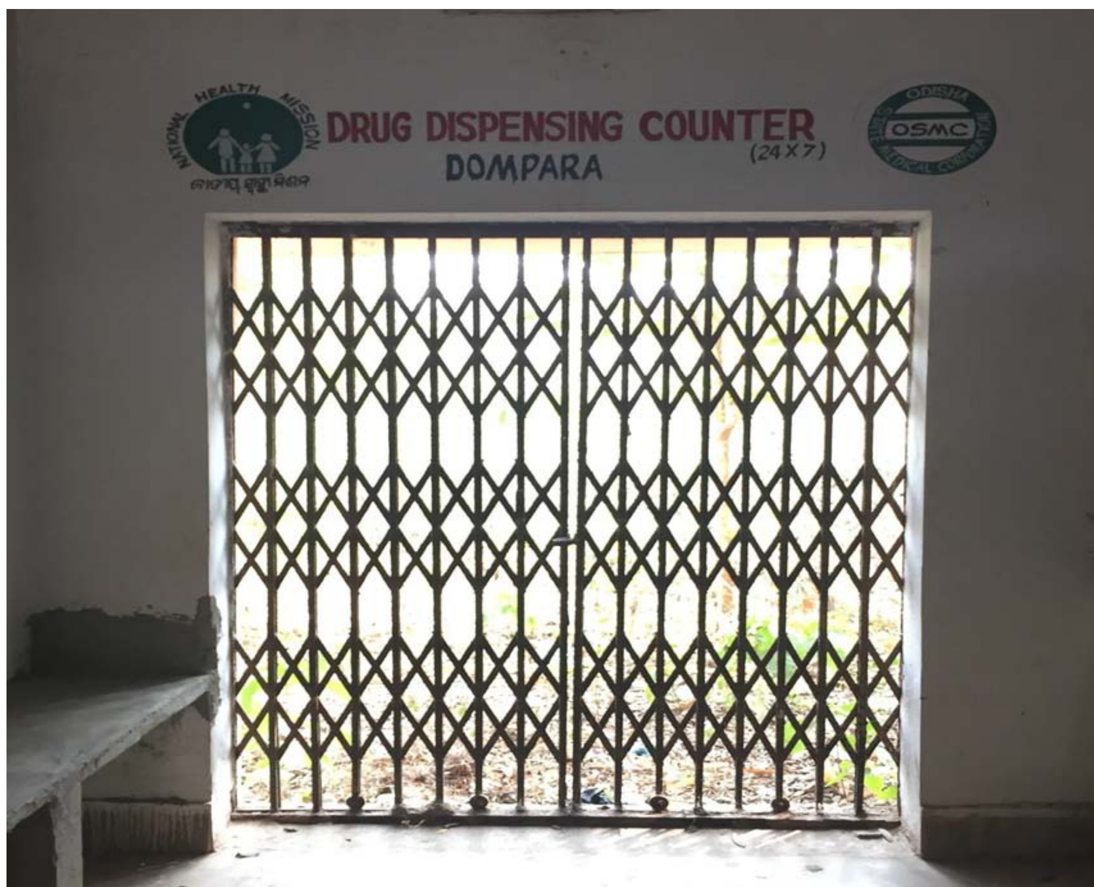
Ceiling in the Immunization Room with gaps where rainwater, fecal matter from birds and monkeys, and other debris enter the room, exposing medical staff, patients and the medicine to harmful environmental elements.

Vaccine and medical storage in the Immunization Room

Vaccination storage unit surrounded by papers and other assorted items.

Finally, Dampara does not have a functional drug dispensation counter/pharmacy. According to the guidelines, "the dispensary and compounding room should have two dispensing windows, compounding counters and shelves,"[20] and should be open 24 hours.[21]

[20] Id. at 13.
[21] Id. at. 71.



Pharmacy door leads outside.

→ *Banki SDH:*

During a tour of the facility the fact finding team observed that the Stabilization Unit had only three beds, instead of the required four.[22] Additionally there was no staff nurse or pediatrician in the stabilization unit, although the guidelines indicate that at least one staff nurse or pediatrician should be present to provide 24 hour care.[23] Newborns in the warming units were being monitored by their mothers, who are not doctors/nurses and have not been trained on the appropriate procedures for use of the warming beds.

Another area of concern is that the registration center was closed and remains so throughout a majority of the day. As such there is no one to assist patients and their families upon arrival at the SDH. The SDH guidelines indicate that a "registration, assistance and enquiry counter facility be made available in all the clinics along with proper sitting arrangement, drinking water,

---

[22]Directorate General of Health Services, *Indian Public Health Standards Guidelines (IPHS) for Public Health Centres,* Ministry of Health and Family Welfare, Government of India (2012 revised); Annexure VB, 73 [hereinafter SDH Guidelines]; *available at*http://health.bih.nic.in/Docs/Guidelines/Guidelines-SD-&-SDH-(Revised)-2012.pdf.
[23]Id. at 72.

ceiling fans and toilet facility separate for male and female."[24] Furthermore, these counters should be "functioning around the clock."[25] Patients and their families may lose critical time if they have to search the hospital (consisting of multiple buildings) for help when they should be able to go directly to the registration center.

Finally the post female ward is immediately across from the male recuperation ward and there are no privacy screens in the room to shield lactating mothers from prying eyes when the door opens or from families visiting their loved ones in the ward.

In the female ward, specifically, the beds are falling apart and there are no sheets, pillows or pillow cases. Leaking ceilings have left water marks and mold on the walls. Moreover, there are no privacy screens. Lactating mothers who wish to breastfeed their children must do so in full view of anyone else in the room, to include male families members of other lactating mothers. Thus, in order to have any comforts, convalescing women must bring sheets, food, etc. from their homes.

A bed in the maternity ward without sheets or pillows. The walls are unclean.

[24]Id. at 20.
[25]Id. at 55.

Bed with stuffing falling out and tiles missing from the wall.

Bed with ripped and stained mattress in the maternity ward.

Hospitals should be clean with up-to-date facilities. Particularly, with regard to linens, the manual lists the following essential items:[26]

Equipment	31-50 Bedded Sub-district Hospital	51-100 Bedded Sub-district Hospital
Bed sheets	200 (Desirable + 100)	400 + 200 (Desirable)

[26]SDH Guidelines, pg. 40.

Bedspreads	300	600
Blanket; Red/Blue	20 (Desirable + 80)	30
Towels	100	150
Pillows	60	150
Pillow covers	150	300

Family in the maternity ward talking with an HRLN fact finding team member. The family indicated that they brought sheets and food from home for the lactating mother.

1. Background

1.1. Odisha (population/census information)

The State of Odisha is located on the eastern coast of India, facing the Bay of Bengal. It is comprised of 30 districts, with a population of 44,338,419 (44.3 million)[27], of which “more than

[27] http://www.indiaonlinepages.com/population/orissa-population.html

83 percent...[live] in rural areas."[28] According to a 2015 study titled *Inequality in the Utilization of Maternal Healthcare Services in Odisha, India*,

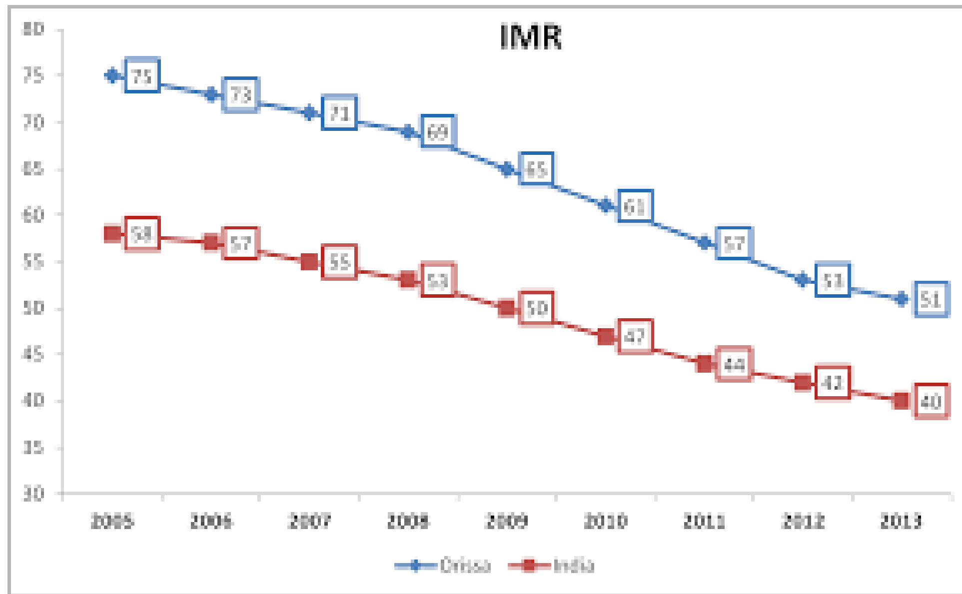
> In terms of the Human Development Index, the state ranks at the bottom 22nd position (out of 23), and, according to the Planning Commission's Tendulkar Committee Report 2009, the poverty headcount ratio of Odisha at 57.2 percent is the worst among all Indian states and way above the national average of 37.2 percent. Moreover, the extent of poverty is not evenly distributed in all the regions and among all social groups. The scheduled castes (SCs) and scheduled tribes (STs) of the state that comprise about 40 percent of the total population have high proportion of poverty as compared to the SCs and STs in the country as a whole.[29]

Poverty, disease and lack of reliable access to medical care contribute to the high crude death rate in the state. The 2014-2015 *Odisha Economic Survey* released by the Government of Odisha highlighted this trend, saying, "[t]he crude birth rate in the State is 19.6 against the national average of 21.4 in 2013, but the crude death rate stood at 8.4 compared to 7.0 for the country."[30] The survey further stated, "[l]ife expectancy at birth in the State for male and female are projected at 64.3 years and 67.3 years respectively which are lower than the national average of 67.3 years and 69.6 years respectively. Infant mortality rate has come down to 51 during 2013. The IMR at all India level during 2013 stood at 40.."[31] As is evident from the high overall mortality rate, infrastructure - both economic and medical - are lacking.

---

[28] Ranjan Kumar Prusty, Jitendra Gouda, and ManasRanjanPradhan, *Inequality in the Utilization of Maternal Healthcare Services in Odisha, India*, International Journal of Population Research Volume 2015, pg. 2; *available at*http://dx.doi.org/10.1155/2015/531485.
[29] Id.
[30] *Odisha Economic Survey,* Planning and Coordination Department, Government of India (2014-2015); pg. 46 [hereinafter Odisha Economic Survey] *available at*http://www.odisha.gov.in/pc/Download/Economic_Survey_2014-15.pdf.
[31] Id.

1.4. Infant Mortality in Odisha (Common Causes)



Odisha has the third highest IMR in India, and roughly "70 per cent of infant deaths take place in the first month of the child's life largely from preventable causes. Low skill levels of medical and paramedical staff are a continuing challenge for quality service delivery. Investment in health infrastructure such as colleges to train all categories of service providers is lagging behind.[32] According to the Odisha Economic Survey, there are three main factors that explain the astronomical IMR: "(i) poor availability of professional attendants at birth, (ii) high percentage of low birth weight babies, and (iii) ***lack of professional pre - and post-natal care.*** Sixty-four percent infant deaths are attributed to neonatal mortality….***Verbal autopsy has been made mandatory for each infant and child death.***[33]

A 2012 study conducted by the World Health Organization, Child Health Epidemiology Reference Group (WHO-CHERG) estimated that "among children who die before their fifth birthday, almost one third of them die of infectious causes, nearly all of which are preventable."[34]

---

[32]http://unicef.in/StateInfo/Odisha/Challenges

[33]*Odisha Economic Survey,* Planning and Coordination Department, Government of India (2014-2015); pg. 430 [hereinafter Odisha Economic Survey] *available at*http://www.odisha.gov.in/pc/Download/Economic_Survey_2014-15.pdf.The survey further explains, "Premature deliveries result in 38.5 percent infant deaths. Pneumonia, respiratory infections in newborn babies, tetanus, and diarrhoea result in 34.1 percent infant deaths. Anaemia, which is caused due to malnutrition suffered by both pregnant mothers and infants, explains 8.1 percent infant deaths. Other causes account for another 19.3 percent infant deaths. There also appears to be a high correlation between IMR and Maternal Mortality Rate (MMR). Odisha has launched an IMR Mission with a view to expediting faster reduction in IMR and MMR." Id.

[34]Id. at 20. Specifically, the study indicated that "the major causes of neonatal deaths are prematurity (18%), that is, birth of a child before 37 weeks of gestation, infections (16%) such as pneumonia and

INDICATORS	RATE
Crude Birth Rate (CBR), 2012 (2013- SRS)	19.6 per 1000 population.
Crude Death Rate, 2012 (2013-SRS)	8.4 per 1000 population
Infant Mortality Rate, 2012(2013-SRS)	51 per 1000 live birth.
Infant Mortality Rate, Urban 2012 (2013-SRS)	38 per 1000 live birth
Infant Mortality Rate –Rural, 2012 (2013SRS)	53 per 1000 live birth
Natural Growth Rate, 2012 (2013-SRS)	11.3%.
Total Fertility Rate, (2011)	2.1 %
Couple Protection Rate (NHFS-3)	47 %
Life Expectancy at Birth (2021-25 Projection)	Male 67.8 years, Female 71.6 years
Maternal Mortality Ratio (MMR) (2012SRS)	235 per 1000 live births

Demographic Indicators in Odisha[35]

2. Explanation of Government Medical Schemes

The National Health Mission (NHM) is an umbrella strategy for implementing uniform health care standards, known as Indian Public Health Standards (IPHS), across the country. To do so, the Government utilizes a healthcare hierarchy: Sub Centres, Primary Health Centres, Community Health Centres, and Hospitals (subdistrict and district). As of 2012, there were 14,8366 Sub Centres in India, of which 6688 were in Odisha; there were 24049 PHCs in India, of which 1226 were in Odisha; and there were 4833 CHCs in India, of which 377 were in Odisha.[36] Within this framework, the government recognized two types of services: (1) Essential Services, i.e. services that should be available at each facility, and (2) Desired Services, i.e. services that may be available at a facility contingent upon manpower and resources. The goal of the NRM is to provide "promotive, preventive, curative, referral services and all the national health programmes" using action plans specific to the rural and urban populations.[37]

---

septicaemia and asphyxia (10%), that is, inability to establish breathing immediately after birth and congenital causes (5%)."

[35]Odisha Economic Survey, pg. 428.

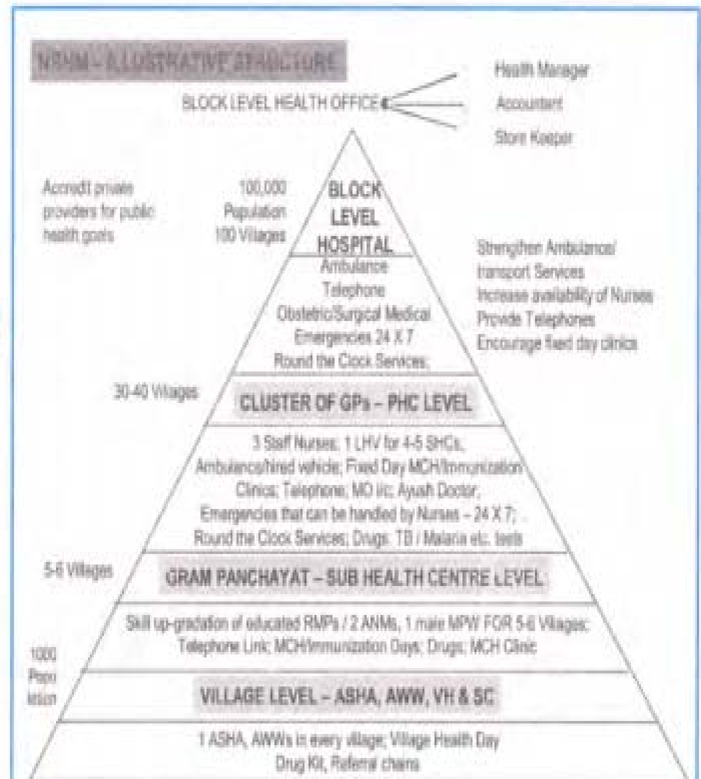
[36] Statistics Division, *Rural Health Statistics in India,* Ministry of Health and Family Welfare, Government of India (2012); pg. 23 [hereinafter Rural Health Statistics Manual] *available at*http://mohfw.nic.in/WriteReadData/l892s/492794502RHS%202012.pdf.

[37]Press Information Bureau, *Indian Public Health Standards*, Ministry of Health and Family Welfare, Government of India (15-July-2014 13:17 IST), http://pib.nic.in/newsite/PrintRelease.aspx?relid=106599

Specifically, the NHM is comprised of two schemes: (1) the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM).[38] The focus of this report will be on the NRHM and its implementation in rural Odisha.

2.1. National Rural Health Mission (NRHM)

In 2005, the Government of India launched the NRHM with the goal of "improv[ing] the availability of access to quality health care by people, especially for those residing in rural areas, the poor, women and children through equitable, affordable, accountable and effective primary health care."[39] The NRHM further seeks to reduce the infant and maternal mortality ratios (IMR/MMR respectively) by providing "universal access to public services for food and nutrition, sanitation and hygiene...with emphasis on services addressing women's and children's health and universal immunization."[40]



HM Scheme[41]

At each level, the NRHM Service Guarantees and IPHS Guidelines establish minimum requirements with regard to healthcare services, staffing, equipment, medicines, hygiene, and quality of care. As a general rule, all of the services that are deemed essential for smaller facilities are also essential for larger facilities.

Within the NRHM, there are a number of initiatives aimed at pregnant women and children. The focus of this report will be on the JananiSurakshaYojana (JSY) and JananiShishuSurakshaKaryakram (JSSK) schemes.

---

[38] http://nrhm.gov.in/nhm.html
[39] http://nrhm.gov.in/nhm/nrhm.html
[40] Id. at 15.
[41] *National Rural Health Mission: Meeting people's health needs in rural areas - Framework for Implementation,* Ministry of Health and Family Welfare, Government of India (2012); pg. 6 [hereinafter NRHM Implementation Manual] *available at* http://nrhm.gov.in/images/pdf/about-nrhm/nrhm-framework-implementation/nrhm-framework-latest.pdf

- Launched in 2005, JananiSurakshaYojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among the poor pregnant women.[42] JSY modified the National Maternity Benefit Scheme (NMBS) and falls under the purview of the Department of Health & Family Welfare.[43] The scheme is being implemented in all states and Union Territories (UTs), with a special focus on Low Performing States (LPS). LPS are defined as states having institutional delivery of 25% or less. States that qualify as LPS are: Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chattisgarh, Bihar, Jharkhand, Rajasthan, **Odisha**, Assam and Jammu & Kashmir. Those states which have institutional delivery rate more than 25% are classified as HPS.[44]

  In theory, "JSY integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health worker."[45]Benefits under the scheme are linked to use of the ante-, post- and neo-natal check ups (at minimum three checkups) and institutional delivery. In the *JSY Guidelines for Implementation*, a publication of the MoHFW, it clearly states, "[o]ne of the accepted strategies for reducing maternal mortality is to promote deliveries at health institutions by ***skilled personnel like doctors and nurses***."[46]

---

[42]Directorate General of Health Services, *Indian Public Health Standards (IPHS): Guidelines for Sub-Centres,* Ministry of Health and Family Welfare, Government of India (2012, revised); pg. 9 [hereinafter Subcentre Guidelines] *available at*http://health.bih.nic.in/Docs/Guidelines/Guidelines-Sub-Centers-(Revised)-2012.pdf

[43]Id.

[44]http://nrhm.gov.in/nrhm-components/rmnch-a/maternal-health/janani-suraksha-yojana/background.html

[45]*JananiSurakshaYojana Guidelines for Implementation,* Ministry of Health and Family Welfare, Government of India; pg. 1 [hereinafter JSY Guidelines]; *available at*http://www.ilo.org/dyn/travail/docs/683/JananiSurakshaYojanaGuidelines/MinistryofHealthandFamilyWelfare.pdf

[46]Id. at 3.

Category of States	Rural Area			Urban Area			Eligibility Criteria
	Mother	ASHA*	Total	Mother	ASHA**	Total	
	Financial Assistance for Institutional Delivery						
Low Performing States (LPS)	Rs.1400	Rs.600	Rs.2000	Rs.1000	Rs.400	Rs.1400	Available to all women regardless of age and number of children for delivery in government /private accredited health facilities
High Performing States (HPS)	Rs. 700	Rs.600	Rs.1300	Rs.600	Rs.400	Rs.1000	**Available only to BPL/SC/ST women regardless of age and number of children for delivery in government /private accredited health facilities**

Cash Assistance Strategy[47]

- In 2011, six years after the JSY initiative, the JSSK initiative was introduced to curtail "high out of pocket expenses" incurred during institutional delivery.[48] As a result, JSSK "assure[s] free services to all pregnant women and sick neonates accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries and caesarian section operations and also treatment of sick newborn[s] (up to 30 days after birth) in all Government health institutions across State/UT."[49]

The below excerpt, from the JSSK Guideline Manual,[50] makes clear that services under this initiative are supposed to be free:

[47] Id.
[48] http://nrhm.gov.in/nrhmcomponnets/reproductive-child-health/jssk.html
[49] Indian Ministry of Health & Family Welfare, *Directive No. Z.14018/1/2012-JSY*, 13 May 2013, http://tripuranrhm.gov.in/Guidlines/2705201302.pdf.
[50] Maternal Health Division, *National Rural Health Mission Guidelines for JananiShishuSurakshaKaryakram (JSSK),* Ministry of Health and Family Welfare, Government of India;

It stipulates out that all expenses related to delivery in a public institution would be borne entirely by the government and no user charges would be levied. Under this initiative, a pregnant woman would be entitled to free transport from home to the government health facility, between facilities, in case she is referred on account of complications, and also drop-back home after 48 hours of delivery.

Entitlements would include free drugs and consumables, free diagnostics, free blood wherever required, and free diet for the duration of a woman's stay in the facility, expected to be three days in case of a normal delivery and seven in case of a caesarean section.

Included in these free services is ***assured ambulance transport*** from the patient's home to the requisite health facility, as well as, ***inter-facility transfer in case of referral*** and drop back. JSSK envisioned a free transportation scheme to curtail healthcare delays resulting from unavailability of transportation services or private vehicles.[51] Vehicles should have a "provision for advanced life support, trained staff and equipment...to manage emergencies during transit."[52]

---

pg. 3 [hereinafter JSSK Guidelines]; *available at*http://nrhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf.

[51]RMNCH+A Manual, pg. 21.

[52] Id.

Entitlements for Pregnant Women:
Free delivery
Free caesarean section
Free drugs and consumables
Free diagnostics (Blood, Urine tests and Ultrasonography etc.)
Free diet during stay (upto 3days for normal delivery and 7days for caesarean section)
Free provision of blood
Free transport from home to health institution, between health institutions in case of referrals and drop back home
Exemption from all kinds of user charges

Entitlements for Sick Newborn till 30 days after birth:
Free and zero expense treatment
Free drugs & consumables
Free diagnostics
Free provision of blood
Free transport from home to health institution, between health institutions in case of referrals and drop back home
Exemption from all kinds of user charges

Inclusions for Pregnant Women and Children under JSSK[53]

2.2. AWW

Anganwadi workers are tasked with providing services outlined in the national Integrated Child Development Service Scheme (ICDS). These services include: "supplementary nutrition, immunization, health checkups, referral services, nutrition and health education for mothers/pregnant women, nursing mothers and to adolescent girls."[54] Specifically, AWWs monitor the growth of children, organize supplementary feeding, help organize immunization sessions, distribute vitamins and supplements, treat minor ailments and refer cases to medical facilities.[55] For this reason, AWWs play a crucial role in promoting child growth and development because they have close and continuous contact with the beneficiaries.[56]

[53]Id. at 15.
[54]Sandhyarani, M.C. and Dr. C. UshaRao, *Roles and Responsibility of Anganwadi Workers,* International Journal of Science, Environment and Technology, Vol. 2, No 6, 2013, 1277 – 1296; pg. 1277 [hereinafter AWW Roles and Responsibilities]; *available at* http://www.ijset.net/journal/205.pdf.
[55]Id. at 1278. For a more complete list of the roles and responsibilities of AWWs, see page 1279-80 of this report.
[56]Id.

AWWs are responsible for all data capture pertaining to services and beneficiaries.[57] This information must be forwarded to a Child Development Project Officer (CDPO) in Monthly Progress Reports.[58] When the AWWs go into the field they must capture data on a variety of child and maternal factors. Specifically they must record population details, births and deaths of children, maternal deaths, number of pregnant and lactating mothers, and number of "at risk" mothers.[59]AWWs must also provide a monthly summary of the supplementary services rendered to pregnant and lactating mothers, while also assisting ASHAs and ANMs in the delivery of healthcare services and maintenance of records under the ICDS Scheme.[60] Finally, when an AWW learns of a pregnancy, she is required to visit that household to collect information on the mother.

Under the OdishaMamata Scheme, AWWs monitor pregnant and lactating women ages 19 and older, who do not have paid maternity benefits through their or their husband's employer, for their first two live births.[61] To participate in the MAMATA scheme, a pregnant woman must register with the AWC to which she belongs within six months of conception. Upon registration, AWW issues the pregnant woman a Mother and Child Protection (MCP) Card, which will serve as a means of recording the beneficiary's fulfillment with the conditions of payment. Administratively, AWWs are charged with submitting to their supervisors the names of beneficiaries entitled to Mamata payments.

2.3. ASHA

Accredited Social Health Activists (ASHAs) are the first line of defense for pregnant women and children in need of health care. They work at the village level and keep track of all expectant mothers and newbornthrough the JananiSurakshaYojana (JSY) scheme.[62]

As articulated under the JSY, an ASHA's role is to:

- Identify pregnant women from poor families as beneficiaries of the scheme
- Bring women to the sub-centre or PHC for registration
- Provide or help women receive at least three antenatal checkups

---

[57]Specifically, AWWs "bring to the notice of the Supervisors/ CDPO any development in the village [that] requires their attention and intervention, particularly in regard to the work of the coordinating arrangements with different departments." *AWW Roles and Responsibilities*, pg. 1280.
[58]Monitoring in ICDS, Ministry of Women and Child Development, pg. 2.
[59]*Integrated Child Development Services (ICDS) Scheme*, Ministry of Women and Child Development, http://wcd.nic.in/icds.htm, last visited 20 Mar. 2015; *Monitoring in ICDS,* Ministry of Women and Child Development, pg. 6, wcd.nic.in/icdsformat/ICDSMONITORINGMANUAL.doc.
[60]*Monitoring in ICDS*, Ministry of Women and Child Development, pg. 9; *AWW Roles and Responsibilities*, pg. 1280.
[61]http://wcdodisha.gov.in/node/46.
[62]Subcentre Guidelines, pg. 9.

- In consultation with the ANM and the PHC, provide information about institutional delivery and decide on a location for delivery
- When pregnant women are in labor, escort them to the pre-determined health centre and remain with the women until delivery is complete and they are discharged
- Arrange to immunize the newborn until 10 weeks of age
- Register birth or death of the child or mother
- Conduct postnatal visits within 7 days of pregnancy and track mother's health
- Provide new mother with information about how to breastfeed[63]

S No.	Activity	To be undertaken by	Proposed Time Line
(a)	**Identification of beneficiary** and filling up of the JSY **Card.** (See ANNEXURE - V)	ASHA or an equivalent worker (Those registered with SC/PHC)	Atleast 16-20 weeks before the expected date of delivery.
(b)	**Registering the expectant mother for ANC in the sub-centre/health centre.** Filling of Maternal and Child card (which will be part of the JSY Card).	**Same as above** Registered accredited worker should be present during registration	To start immediately on identification
(c)	**Preparing the birth plan including dates of ANCs and recording it on the JSY card and inform the mother**	ANM in the presence of ASHA possibly in consultation with husband or other family members.	At least 8-10 weeks before the expected date of delivery.
(e)	**Completion of formalities for receiving JSY benefit** **Including collecting necessary BPL certificates wherever necessary** from Panchayat / local bodies / Municipalities	Registered ASHA or an equivalent worker	Within 2-3 weeks from identification
(f)	**Motivating for institutional delivery** by explaining enhanced JSY benefits	ASHA or an equivalent worker in consultation with MO, PHC	Within 2-3 weeks of identification
(e)	**Identify the health centre** for all referral as well as the place of delivery and inform the pregnant women / her husband / family member and the Registered ASHA.		

ASHA duties[64]

[63] JSY Guidelines, pgs. 9-10.

2.4. Subcentre

At the village level, Sub Health Centres ("Sub Centres") are next in the healthcare lineup. They are "expected to provide promotive, preventive and few curative primary health care services."[65] Taking into account population density, there shall be one sub centre established for every 5000 people in plain areas and one for every 3000 population in hilly/tribal/desert areas. With that said, the Government advises that the number of Sub-centres should depend on the caseload of the facility and distance of the village/habitations which comprise the Sub-centres.[66]

There are two types of sub centres outlined in the NRHM: Type A and Type B. With the exception of conducting deliveries, Type A sub centres provide family planning and contraceptive services; Ante- and Postnatal care; child care including immunizations; adolescent health care; facilities under JSY; and treatment of minor ailments/first aid.[67] However, in regions with difficult (i.e. hilly, desert or tribal) terrain where transport to a facility may be difficult, the ANM is required to be Skilled Birth Attendance (SBA) trained and to conduct home deliveries.[68]

Similarly, Type B sub centres are inclusive of all the aforementioned services and have the infrastructure // resources to conduct deliveries and give Neonatal care at the sub centre itself. In this way, the Type B sub centre acts as a Maternal and Child Health (MCH) centre with basic facilities for conducting deliveries and newborn care.[69]

Type of subcentre	Sub-centre A		Sub-centre B (MCH Sub-centre)	
Staff	Essential	Desirable	Essential	Desirable
ANM/Health Worker (Female)	1	+1	2	
Health Worker (Male)	1		1	
Staff Nurse (or ANM, if Staff Nurse is not available)				1**
Safai-Karamchari*	1 (Part-time)		1 (Full-time)	

*To be outsourced.

** if number of deliveries at the Sub-centre is 20 or more in a month

Essential/Desirable Manpower - Sub Centre[70]

---

[64] Id. at 8. This is not an exhaustive list.
[65] Subcentre Guidelines, pg. 6.
[66] Id. at 3.
[67] Id. at 54.
[68] Id. at 4.
[69] Id. at 6.
[70] Id. at15.

2.5. PHC

A Primary Health Centre is the first location where rural villagers have access to a doctor, either by referral from a sub centre or by walk-in. As per government norms, "[a] typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 6 indoor/observation beds. It acts as a referral unit for 6 Sub-Centres and [may] refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level."[71] The IPHS guidelines are clear that where a Community Health Centre is over an hour away, a PHC "may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing number of Medical Officers."[72]

In addition to all the services provided by a sub centre, a PCH should also provide: intranatal care; medical termination of pregnancies, Reproductive Tract Infection and Sexually Transmitted Infection (RTI/STI) management, School health and nutrition services, promote safe drinking water, national disease prevention programs, laboratory and diagnostic services, as well as, organize, in conjunction with the ASHAs and AWWs, a Village Health and Nutrition Day (VHND).[73]

---

[71] Directorate General of Health Services, *Indian Public Health Standards Guidelines (IPHS) for Public Health Centres,* Ministry of Health and Family Welfare, Government of India (2012 revised); pg. 1 [hereinafter PHC Guidelines]; *available at*http://health.bih.nic.in/Docs/Guidelines/Guidelines-PHC-2012.pdf.

[72] Id.

[73] Id. at 4-11.

Manpower: PHC

Staff	Type A		Type B	
	Essential	Desirable	Essential	Desirable
Medical Officer- MBBS	1		1	1#
Medical Officer –AYUSH		1^		1^
Accountant cum Data Entry Operator	1		1	
Pharmacist	1		1	
Pharmacist AYUSH		1		1
Nurse-midwife (Staff-Nurse)	3	+1	4	+1
Health worker (Female)	1*		1*	
Health Assistant. (Male)	1		1	
Health Assistant. (Female)/Lady Health Visitor	1		1	
Health Educator		1		1
Laboratory Technician	1		1	
Cold Chain & Vaccine Logistic Assistant		1		1
Multi-skilled Group D worker	2		2	
Sanitary worker cum watchman	1		1	+1
Total	**13**	**18**	**14**	**21**

* For Sub-Centre area of PHC.
# If the delivery case load is 30 or more per month. One of the two medical officers (MBBS) should be female.
^ To provide choices to the people wherever an AYUSH public facility is not available in the near vicinity.

Essential/Desirable Manpower - PCH[74]

2.6. CHC

After PHCs, CHCs are the next rung of the healthcare ladder. In addition to the services available at a PHC, a CHC should also have "routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology, Paediatrics, Dental and AYUSH in addition to all the National Health Programmes."[75] ***Specifically, a CHC should be equipped to handle 24-hour delivery services including normal and assisted deliveries***; treatment of all referred cases of pregnancy, labour and postnatal complications. CHCs are required to allow for a minimum 48 hour stay after delivery, and 3-7 day stay post delivery for complicated deliveries. Furthermore, medical staff should proficient in identifying and managing complications arising from post-partum hemorrhaging, eclampsia, and sepsis. Essential and emergency obstetric care, including surgical interventions like cesarean sections and other medical interventions, provisions for JSY and JSSK should also be available at the facility.[76]

Each CHC is supposed to have a monitoring mechanism in place as per the IPHS and the CHC Guidelines. For example the CHC Guidelines state, "[t]o maintain quality of services, external monitoring through Panchayati Raj Institutions and internal monitoring at appropriate intervals is advocated. It is mandatory for every CHC to have functional RogiKalyanSamiti (RKS) to ensure

[74] Id. at 16.
[75] CHC Guidelines, pg. 1.
[76] Id. at 13.

accountability. A grievance redressal mechanism under the overall supervision of RKS would also be set up.[77]

2.7. Subdistrict / Subdivision Hospital

In instances where the CHC is unable to assist a needy patient, subdistrict hospitals (SDH) should be equipped with the manpower and resources to handle the referral. A subdivision hospital caters to about 5-6 lakhs people and ranges between 31-100 available patient beds.[78]

Above and beyond the services provided by a CHC, SDHs focus on: ***newborn care (i.e. they should have newborn care corners and a newborn stabilization unit)***; family planning; psychiatric services; physical medicine and rehabilitation services; geriatric services, accident and trauma services; and have an Integrated Counseling and Testing Centre."[79] Given the objective of a SDH is to provide "emergency obstetrics care and neonatal care and help in bringing down the Maternal Mortality and Infant Mortality,…[i]t is desirable that every Sub-district Hospital should have a Postpartum Unit with dedicated staff to provide Post natal services, all Family Planning Services, Safe Abortion services and immunization in an integrated manner."[80]

2.8. Odisha Specific Health Care Schemes

2.8.1. Odisha Emergency Medical Ambulance Service

With the support of the Central Government, Odisha State Government launched a free ambulance service (108) to provide a "high-end ambulance transportation system from the doorstep of the patient to the appropriate care in a hospital."[81] Under this scheme, ambulances are split into two types: 'Basic Life Support' (BLS) and 'Advance Life Support' (ALS).[82] Cuttack was allotted 21 BLS and 05 ALS ambulances, for a total of 26 ambulances[83] to service at minimum 18 CHCs.[84]Per the guidelines, the ambulances are supposed to be positioned such that each ambulance has a 30 km. service area and serves a population of 1 lakh. Furthermore,

---

[77]Id. at 11.
[78]Directorate General of Health Services, *Indian Public Health Standards Guidelines (IPHS) for Public Health Centres,* Ministry of Health and Family Welfare, Government of India (2012 revised); pg. 16 [hereinafter SDH Guidelines]; *available at*http://health.bih.nic.in/Docs/Guidelines/Guidelines-SD-&-SDH-(Revised)-2012.pdf.
[79]Id. at 13.
[80] Id.
[81]http://www.nrhmorissa.gov.in/frm108services.aspx
[82] Id.
[83]pg. 1; http://www.nrhmorissa.gov.in/writereaddata/Upload/Documents/108-NAS%20Writeup.pdf
[84]*CHC Directorate*, http://dhsodisha.nic.in/?q=node/89.

the average response time should be 20 minutes for urban locations, 25 minutes for semi-urban and 35 minutes for rural locations.[85]

2.8.2. *MAMATA*

In September 2011 the State Government launched a conditional cash transfer scheme for pregnant and lactating women thereby enabling them to "seek improved nutrition" while also promoting "health seeking behavior."[86] Under the scheme, pregnant and lactating women may receive a total of 5,000 Rs. in four instalments, conditioned upon completion of certain prerequisites.[87]

First Installment	1500 Rs., given at the end of 2nd trimester	• Pregnancy registered at the AWC. • Received at least one antenatal check-up. • Received IFA tablets. • Received at least one TT vaccination. • Received at least one counseling session at the AWC/VHND
Second Installment	1500 Rs., given 3 months after delivery	• Child birth is registered. • Child has received BCG vaccination. • Child has received Polio 1 and DPT-1 vaccination. • Child has received Polio 2 and DPT-2 vaccination. • Child has been weighed at least two times after birth. • After delivery, mother has attended at least two IYCF counseling sessions at the AWC / VHND / Home Visit.

[85] http://www.nrhmorissa.gov.in/frm108services.aspx
[86] *Mamata Guidelines,* Women and Child Development Department, Government of Orissa (2011); pg. 1 [hereinafter Mamata Guidelines]; *available at*http://wcdodisha.gov.in/sites/default/files/circular/MamataGuideline_English.pdf.
[87] Id. at 4.

Third Installment	1000 Rs., given when the infant is 6 months of age	● Child has been exclusively breastfed for first six months. ● Child has been introduced to complementary foods on completion of six months. ● Child has received Polio 3 and DPT-3 vaccination. ● Child has been weighed at least two times between age 3 and 6 months. ● Mother has attended at least two IYCF counseling sessions between 3 and 6 months of lactation, at the AWC/VHND/Home Visit.
Fourth Installment	1000 Rs., given when the infant is 9 months of age	● Measles vaccine has been given before the child is one year old. ● Vitamin A first dose has been given before the child is one year old. ● Age specific appropriate complementary feeding has started and is continuing. ● Child is weighed at least two times between six months to nine months of age.[88]

2. **Constitutional Violations**

2.1. *Article 14*: "The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India."

The concept of equality and equal protection of laws guaranteed by Art. 14 in its proper spectrum encompasses social and economic justice in a political democracy. *See Dalmia Cement (Bharat) Ltd. v. Union of India,* (2001) 10 SCC 104 (para 15).

[88] Id. at 5-7.

2.2. *Article 15*: Article 15(1): "The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth of any of them."

Article 15 (3): "Nothing in this article shall prevent the State from making any special provision for women and children."

2.3. *Article 21*: "No person shall be deprived of his life or personal liberty except according to procedure established by law."

In *Munshi Singh Gautam v. State of M.P.*, (2005) 9 SCC 631 : AIR 2005 SC 402, the Supreme Court held that Article 21 "[l]ife or personal liberty includes a right to live with human dignity. There is an inbuilt guarantee against torture or assault by the State and its functionaries."[89]*See also Francis Coralie Mullin v. Union Territory Delhi, Administrator*, AIR 1981 SC 746 (para 3): 1981 1 SCC 608 (holding 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); *Olga Tellis v. Bombay Corpn.*, AIR 1986 SC 180 (paras 33-34): (1985) 3 SCC 545; *D.T.C. v. Mazdoor Congress Union D.T.C.*, AIR 1991 SC 101 (paras 223, 234, 259): 1991 Supp. (1) SCC 600; *Consumer Education & Research Centre v. Union of India*, (1995) 3 SCC 42 (para 22).

In *State of Maharashtra v. Chandrabhan*, AIR 1983 SC 803 (paras 1, 20): (1983) 3 SCC 387, the Supreme Court found that the right to life means something more than "nominal subsistence." *See alsoNoise Pollution (V)*, *In re* (2005) 5 SCC 733, 745-46 (para 10): AIR 2005 SC 3136; *Noise Pollution (VI), In re,* (2005) 8 SCC 794: (2005) 8 Scale 101.

In *SandeshBansal 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.

In *LaxmiMandal v. DeenDayalHarinagar 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 *PaschimBangaKhetMazdoorSamity 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 Pt. *ParmanandKatara 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.

[89]*Munshi Singh Gautam v. State of M.P.*, (2005) 9 SCC 631, 637 (para 4): AIR 2005 SC 402

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."

2.4. *Article 38(1)*: "The state shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institution of the national life."

Article 38(2): "The State shall, in particular, strive to minimise the inequalities income, and endeavor to eliminate inequalities in status, *facilities and opportunities*, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations." See*Dalmia Cement (Bharat) Ltd. v. RathodLabhuBechar*, (2001) 3 SCC 574, 591 (para 32): AIR 2001 SC 706

In *Captain Sube Singh v. Lt. Governor of Delhi*, (2004) 6 SCC 440, 452 (paras 31 and 32) : AIR 2004 SC 3821, the Court held that the State cannot pass on the burden of its social obligation on the private parties.

2.5. *Article 39(f)* reads in part*:* The State shall, in particular, direct its policy towards securing that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity…"

2.6. *Article 47*: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among *its primary duties*…"

In *Ratlam Municipal Council v. Vardhichand*, AIR 1980 SC 1622 (para 24) : (1980) 4 SCC 162, the Court held that public health is a primary duty of the State and the Court should enforce this duty against a defaulting local authority.

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 *M.C. Mehta v. Union of India*, (2002) 4 SCC 356, 362 (para 1) : AIR 2002 SC 1696, the court held "Articles 39(*e*), 47 and 48-A by themselves and collectively cast a duty on the State to secure the health of the people, improve public health and protect and improve the environment."

3. Violations of International Conventions

In addition to the litany of Constitutional violations, the State of Odisha has also violated a number of International Conventions signed by the government of India. Under these binding Conventions, India has a duty to protect women from sexual, caste and gender discrimination and violence. The relevant Conventions are produced below in part.

1.1. The *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*

CEDAW makes clear "the social significance of maternity and the role of both parents in the family and in the upbringing of children." The convention recognizes "that the role of women in procreation should not be a basis for discrimination."[90]

Article 12(1), (2) states, "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure...access to health care services, including those related to family planning. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[91]

Article 16 states, "States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating...family relations and in particular shall ensure…[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[92]

1.2. International Convention on Economic, Social and Cultural Rights (ICESCR)

Article 10(1-3) states, "States Parties to the present Covenant recognize that [t]he widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society. Special protection should be accorded to mothers during a reasonable period before and after childbirth. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions.[93]

Article 12 states, "States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken

---

[90]*Convention on the Elimination of All Forms of Discrimination against Women*, (entry into force 3 September 1981), pg.2, http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf
[91]Id. at 5.
[92]Id. at 6.
[93]*International Covenant on Economic, Social and Cultural Rights*, (entry into force 3 January 1976), pgs.3-4; http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf.

by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[94]

Article 15 states, "States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications.[95]

1.3. International Convention on Civil and Political Rights (ICCPR)

Article 6 states, "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.[96]

Article 23(1), (2) states, "[t]he family is the natural and fundamental group unit of society and is entitled to protection by society and the State. The right of men and women of marriageable age to marry and to found a family shall be recognized."[97]

1.4. United Nations Convention on the Rights of the Child (UNCRC)

Article 24 (1-3) states, "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into

---

[94]Id. at 4.

[95]Id. at 5.

[96]*International Covenant on Civil and Political Rights,* (March 23, 1976), pg. 174; https://treaties.un.org/doc/Publication/UNTS/Volume%20999/volume-999-I-14668-English.pdf.

[97]Id. at 179.

consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and postnatal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services.

States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."[98]

1.5. Universal Declaration for Human Rights

Article 16 (1), (3) state, "Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State."[99]

1.6. International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)

Article 5 states, "States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment…[t]he right to public health, medical care, social security and social services."[100]

4. Recommendations: Schemes for Redress

The below list of recommendations should be implemented effective immediately to ensure compliance with monitoring guidelines and create a more robust redress process.

4.1. ASHAs

[98] *Convention on the Rights of the Child*, (entry into force 2 September 1990), pg.7; http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf.
[99] *The Universal Declaration of Human Rights*, http://www.un.org/en/universal-declaration-human-rights/.
[100] *International Convention on the Elimination of All Forms of Racial Discrimination,* (entry into force 4 January 1969); http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx.

The ASHA is one of the first lines of contact a pregnant woman has with the medical world. As such, ASHAs should be diligent in their duties and meticulous in reporting their interactions with pregnant women and mothers. In Kabita's case the ASHA kept poor pregnancy records and did little to help motivate Kabita to follow through with routine checkups.

ASHAs who show little motivation to interact with and care for the pregnant women and mothers should be monitored by the ANM. If the quality of care does not improve with a reasonable time frame, the ASHA should be monitored by both the ANM and a designee from the nearest health facility (PHC/CHC). ASHAs who have a pattern and practice of being ineffective should be removed from their posts after a suitable replacement is found.

4.2. Subcentre

The Sub Centre needs to be reopened effective immediately. In so doing, the government will need to update the signage on the building to ensure it accurately reflects hours of operation and any other relevant information as per the guidelines.

Since the sub centre has been closed for sometime and the ANM is often away, the State Government should designate someone to monitor the sub centre/ANM and meet regularly with community members to ensure the center adheres to IPHS guidelines and meets the needs of the community.

4.3. CHC

The Dampara CHC does not properly handle management of waste and bio-hazard material. Either the State Government of Odisha or the Government of India should send an envoy to train the CHC staff on proper disposal methods in accordance with the guidelines. Moreover, the envoy should assess whether or not the CHC has the appropriate disposal equipment (biohazard waste bins, shedders for hard plastic objects, etc.) and knows how to use it. If the CHC does not have the appropriate equipment, the envoy should list of missing but necessary waste management equipment and send it to the CDMO, and the state and local government with a request to furnish the missing items.

Once trained, there should be routine quality assurance checkups to ensure the hospital staff adhere to the IPHS directives as to appropriate handling and disposal procedures.

The labor room and operation theatre need to be modernized. The sinks, step stools and tray tables are rusted and peeling; the ceilings and walls are cracked and stained; and there is no place for proper storage of medical equipment or first aid items.

The female ward must be rebuilt. Funds should be directed to ensure a safe and private space for women recuperating after delivery or surgery. Privacy screens should be put in both the male and female wards with sheets and pillows for convalescing patients.

Patient bathrooms must be built in accordance with the IPHS requirements as enumerated in the guidelines.

Finally, the ceiling and walls need to be rebuilt or fortified in order to bring the facility in compliance with IPHS guidelines on disaster management and the Odisha Guidelines of disaster prone areas.

4.4. SDH

A quick survey of the Banki SDH did not provide any instruction or guidance as to where/how a patient could file a complaint with the SDH to make the facility aware of issues arising from interactions with doctors, medical staff and/or facility administrators. In fact the registration office was closed. The result being families complain to the SDMO or other doctors in an effort to elicit some assistance.

To address this issue, registration counters should remain operational during normal business hours and designated support staff should be present to help guide/direct patients and their families. Furthermore, all health facilities should have signage directing patients as to how/where to file a complaint. A human resources officer should be assigned to interact with patients wishing to file a complaint in order to walk them through the procedure, and ensure that the patient has a point of contact at the facility with whom they can follow up. Patient complaints should be assigned a grievance number so that they can track whether or not their complaint is being addressed. Copies of all complaints should be filed with the MOIC and the CDMO/ADMO. A copy of the complaint should also be forwarded to the local police for follow up in cases of death or serious bodily injury.

Certainly, doctors have a heightened duty of care to their patients. Therefore, doctors who are negligent, wilfully or otherwise, in the administration of their duties should be punished to the fullest extent of the law ***to include jail, monetary compensation to the victim/victim's family, and loss of medical license***. Patients should be made aware of their legal rights, particularly in instances of medical malpractice/negligence, should they desire to bring a case for remuneration.

The Stabilization Unit needs another warming bed and a staff nurse should be assigned to that unit at all time in order for the SDH be in compliance with the guidelines. Mothers should not have to play doctor/nurse to their newborns in a facility whose sole purpose is the care of patients.

4.5. Infant Death Review

At present there is no requirement for healthcare facilities to conduct infact death reviews. As evident from the high IMR, a “verbal autopsy” is insufficient to address causal factors. In a state with such a high IMR, infant death reviews - particularly in cases where the patient/family makes a negligence claim - should be mandatory. State and local guidelines should require these reviews, the same way they require maternal death reviews.

4.6. Review Process for Individual Doctors and Health Centers/Hospitals

Although the guidelines make clear that external and internal groups should be monitoring hospitals/doctors, it is unclear exactly how the review/monitoring is implemented and whether or not it actually occurs. Monitoring groups should be required to submit quarterly reports of their findings to the CDMO/ADMO. These reports should include copies of all complaints lodged against the hospital and medical staff. Additionally, to increase chances of fair outcomes, determinations of guilt/fault should be exclusively assigned to independent review boards or the courts.

Additional Pictures of the Dampara CHC:

Inside of a sink the labor room. This is the doctor's "scrub area."

Improper disposal of old medicine bottles in a corner of the CHC immediately next to the labor room and operation theatre.

Doctor's office where patients are screened.

Close up of the checkup table and "privacy" screen.