REPORT ON MATERNAL MORTALITY AND INDIAN PUBLIC HEALTH STANDARDS
BALASORE, ODISHA

Fact-finding Mission in Basta | February 5, 2016

Human Rights Law Network
Reproductive Rights Initiative
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List of Acronyms

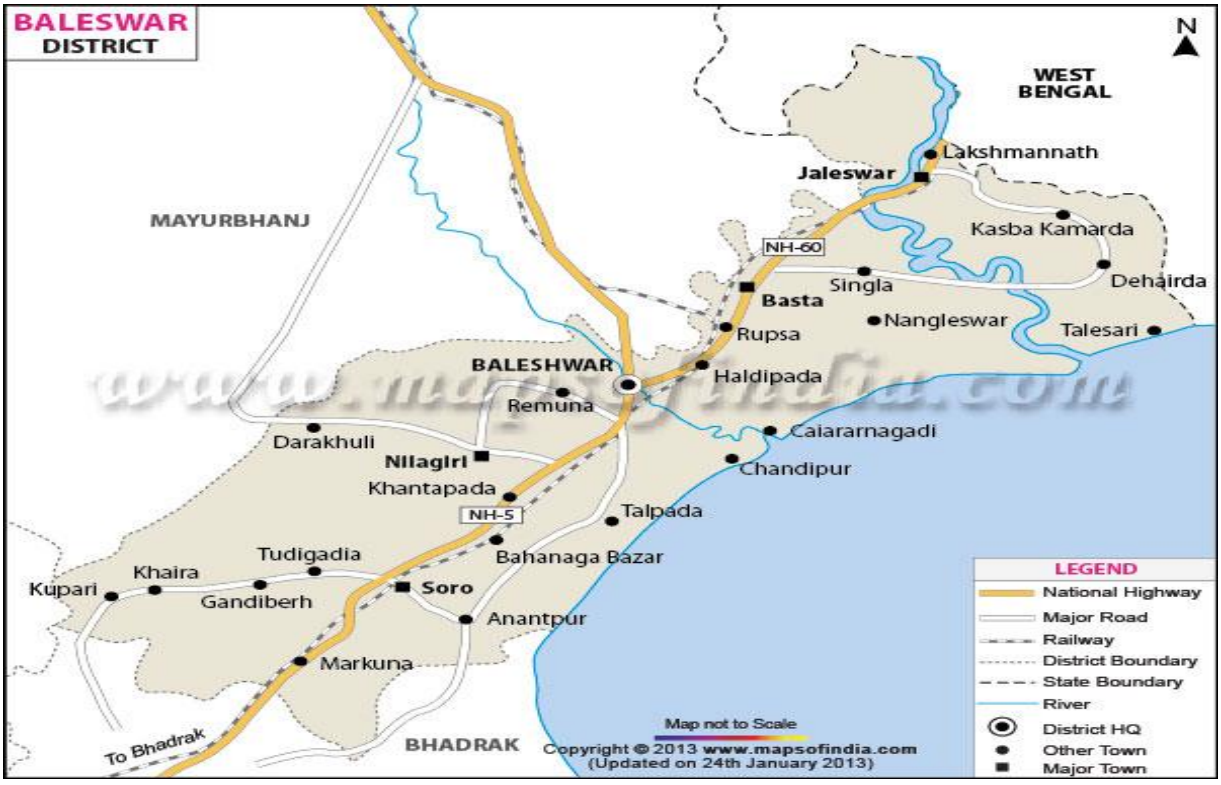
1.	ADMO	Assistant District Medical Officer
2.	ANC	Antenatal Checkup
3.	ANM	Auxiliary Nurse Midwife
4.	ASHA	Accredited Social Health Activist
5.	AWC	Anganwadi Centre
6.	AWW	Anganwadi Worker
7.	BPL	Below Poverty Line
8.	CDMO	Chief District Medical Officer
9.	CHC	Community Health Centre
10.	HRLN	Human Rights Law Network
11.	IPHS	Indian Public Health Standards
12.	JSSK	Janani Shishu Suraksha Karyakram
13.	JSY	Janani Suraksha Yojana
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.	VHND	Village Health and Nutrition Day (“Mamata Diwas”)
28.	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/districts/baleshwar.htm


BALESWAR
DISTRICT
N
WEST
BENGAL
Lakshmannath
Jaleswar
MAYURBHANJ
Kasba Kamarda
NH-60
Dehairda
Singla
Basta
Nangleswar
Talesari
Rupsa
BALESHWAR
Haldipada
Remuna
Darakhuli
Caiararnagadi
Nilagiri
Chandipur
Khantapada
NH-5
Talpada
Tudigadia
Bahanaga Bazar
Khaira
Kupari
Gandiberh
Soro
Anantpur
Markuna
To Bhadrak
BHADRAK
Map not to Scale
Copyright © 2013 www.mapsofindia.com
(Updated on 24th January 2013)
LEGEND
National Highway
Major Road
Railway
District Boundary
State Boundary
River
District HQ
Other Town
Major Town

1. Introduction

1.1. Fact-finding Methodology

On February 5, 2016, a fact-finding team from the Human Rights Law Network (HRLN) traveled to the Balasore District to research a maternal death in the Basta area. The fact-finding methodology employed during this visit included meetings and interviews with the decedent's family, a meeting with Sarpanch, an interview with the MO at the Basta CHC, and a meeting with the local Police Investigator. All interviews were conducted Oriya and translated by HRLN staff to English.

The fact-finding team consisted of: (1) SaritaBarpanda - Director, Reproductive Rights Initiative, New Delhi; (2) Sujatarani Dash - Activist, Cuttack; (3) Morgan Wilson - Intern, New Delhi, and (4) two reporters from the local news that have extensively covered maternal deaths in the Basta region. All pictures were taken with permission and are the property of the HRLN.

1.2. Maternal Death Narrative

Name of Decedent	GauriSasmal (30 yrs. old)
Date of Delivery	29/11/2015; 5:25pm
Death of Date	29/11/2015; 7:15pm
Husband of the Decedent	AlinSasmal (35 yrs. old; married for at least 14 years)
Mother of the Decedent	DuhkiPolai
Mother-in-law of the Decedent	ShantilataSasmal
Father-in-law of the Decedent	PriyaNathSasmal
Relatives responsible for raising the child	SakuntalaKhatuwala (Uchadiha Village) W/O RanjanKhatuala (Uchadiha Village)
ASHA, Kainagar Village	JharanaBehera
AWW, Kainagar Village	MinatiBehera
Health Worker (M), Kainagar Sub centre	BanabihariSampat
Sarpanch, SahadaGramaPanchayat	Anjan Kumar Dandapata

Medical Officer, Basta CHC	Dr. Ratnkar Das
Inspector-in-Charge, Basta Police Station	Mr. Krushna Chandra Polai
CDMO, Balasore	Mr. S. Panigrahi
District Collector	Mr. Promod Kumar Das
District Correspondent	Mr. TariniPadhy, Dharitri& Orissa Post Newspaper (Mob.: 9437193383) Mr. Rabi Narayan Satpathy, Dharitri Newspaper; Reporter (Mob.: 9437561772)

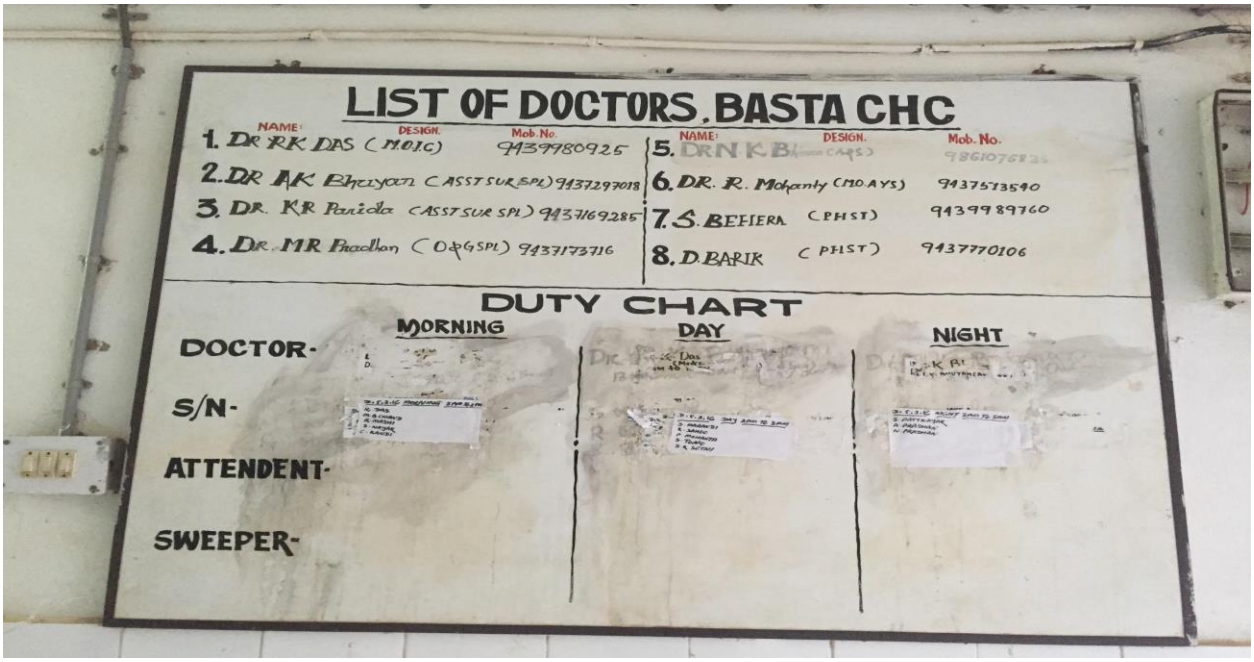
Gauri Sasamal was a 30 year old daughter, wife and mother of two sons (aged 14 and 11). In hopes of having a daughter, she and her husband – Alin Sasmal - got pregnant a third time. According to her MCTS card, Gauri's LMP : 19.02.2015 and EDD 26.11.2015, MCTS (mother and child tracking system) enrolled number: 210814101611500035. Once pregnant, Gauri registered with the ASHA under the JSY scheme to ensure a safe institutional delivery and access to antenatal care, along with other medical services. As a "Below Poverty Line" (BPL) person living in rural India, Gauri was entitled to register under the NRHM for pregnancy services related to the health and well-being of both the child and the mother. Having been through two successful pregnancies, Gauri met with the local ASHA regularly and received routine check-ups, all of which were normal. A review of her pregnancy record, maintained by the ASHA, confirms the same.

At 2pm on Sunday, November 29, 2015, accompanied by her mother, mother-in-law and the ASHA, Gauri was admitted to the Basta CHC for delivery. Because the OBGYN was not present, the attending Medical Officer was Dr. AK Bhuyan, Asst. Surgeon Specialist. As evident by his title, Dr. Bhuyan is not an OBGYN and does not specialize in the delivery and care of pregnant women, particularly those with complications. Upon assessing Gauri, Dr. Bhuyan informed Gauri and her family that the baby was in an awkward position, which made for a complicated delivery. Additionally, Gauri's body was severely weak from anemia, making what promised to be a difficult delivery worse.

At 5:25pm that same day, nearly three and a half hours after being admitted to the Basta CHC, Gauri delivered a healthy baby boy. Sadly, her mother and mother-in-law explained Gauri did so ***under significant abuse from Dr. Bhuyan***, who kept asking Gauri why she was having another child. After delivery, Gauri's condition worsened as she began bleeding profusely. Although Gauri's family begged Dr. Bhuyan for help, he did nothing. Because there is no blood bank at the Basta CHC, and Dr. Bhuyan did not administer blood clotting medication or attempt

to stop the bleeding, Gauri's family desperately called both the 102 and 108 ambulances in hopes of getting Gauri to the district hospital in Balasore for treatment. ***The ambulances never came.***

At 7:15pm, after a tragic two hour wait for an ambulance, Gauri BLED TO DEATH on the labor table at the Basta CHC in front her family. Adding insult to injury, Gauri's family had to pay out of pocket to take her body back to Kainagar village because the ambulance never arrived.



List of Doctors at the Basta CHC; take by HRLN staff on 5/2/2016

1.3. Interviews

The fact-finding team visited Gauri's family in the Kainagar village, Balasore district, Odisha. Upon arriving at the village, we met with Gauri's mother-in-law, ShantilataSasamal, and mother, DukhiPolai, who gave a teary-eyed account of the harrowing details of Gauri's delivery and subsequent death. It is clear from their accounts, that Gauri died as a result of systemic failures in the healthcare system and a negligent doctor who refused to uphold his duty of care to patients.

As a result of Gauri's death due to medical malpractice and negligence, there was no one in Gauri's immediate family who had the resources to care for the newborn. As such, the

family made the difficult decision to give the newborn to a close relative, Shakuntala Khatuala of Uchadiha Village,Tihidi Gramapanchayata who recently gave birth to a girl. In order to care for Gauri's newborn, Shakuntala (who already had four daughters of her own) had to give away her youngest daughter to another woman in her village. In this way, three families have been disrupted by Dr. Bhuyan's negligence and the failure of the healthcare system in Balasore.

As of the date of the report, no maternal death review has been conducted by the hospital. Furthermore, the family did not receive entitlements due to them under the JSY and JSSK scheme.

Gauri's relatives caring for her newborn.

Gauri's mother (in blue and purple) and mother-in-law (in green) speaking with the fact-finding team and local reporters at their home in Kainagar.

The fact-finding team next met with Alin, Gauri's husband of at least 14 years, who confirmed the above account. He made clear that in addition to several attempts to call the 102 and 108 ambulances which never arrived, the family also made a concerted effort to find a private vehicle to transport Gauri to the subdivision hospital. Unfortunately, no private vehicles were available that day. It was clear from Alin's demeanor that he was distraught by Gauri's death and concerned about raising two young boys without their mother.

While speaking with Alin, the fact-finding team requested to meet with the ASHA worker, who was in charge of Gauri's prenatal care. Upon arrival, the ASHA - JharanaBehera - stated that she met regularly with Gauri and that everything was normal up until delivery. She also told the fact-finding team that Gauri received her nutrition allotment in addition to routine checkups. Jharana further explained that the Village Health and Nutrition Day (VHND) was held monthly (at the cyclone shelter on the top floor where the village had allotted them a space). It should be noted that Jharana was very thorough in her interactions with Gauri and certainly in her meticulous efforts to document her meetings with pregnant villagers.

HRLN fact finding team with Alin (in black), his 11 yr. old son, and the ASHA

After speaking with Jharana, the fact-finding team traveled to meet with Mr. Anjana Kumar Dandapata, Sarpanch of Sahada GP. Mr. Dandapata meets regularly with the ASHA and AWWs (either monthly or bi-monthly) to discuss their plan of activities and remains very involved in the health and wellbeing of the local community.

Mr. Dandapata told the team that he was only allotted a budget of 32,000 Rs., under the HarishchandraSahayataYojana[2] scheme run by the state of Odisha, from which he must payout 84 beneficiaries. 32,000 Rs. is not sufficient to give each family enough money to fully cover burial costs. As such, Alin only received 1000 Rs. to cover Gauri's funeral costs.

Mr. Dandapata further advised that there have been a significant number of deaths in this district[3], such that the community staged a protest in front of the hospital. He described an

[2] HSY is a state initiative that provides financial assistance to poor and destitute families to conduct last rites of their family member. Under the scheme, "the Sarpanch/Chairperson/Mayor will decide the destitute persons and deserving poor for assistance. [The] sarpanch can sanction assistance between Rs.1000/ to 2000/- in rural areas and Chairperson/Mayor can sanction between Rs.1000/- to Rs.3000/- in urban areas."*Odisha Govt to implement HarishchandraYojana across state from Aug 15*, Odisha Diary Bureau, Bhubansewar (Saturday, August 03, 2013), http://www.orissadiary.com/CurrentNews.asp?id=42926.

[3]Mr. Dandapata cited 12 deaths in the last year, of which 8 were maternal deaths.

unfortunate death of an elderly man with heart problems who died at the hospital because he was not provided with oxygen. (Unfortunately, the protest did little to address the very real concerns of the community. In fact, many villagers did not continue agitating for fear of reprisals from the local police in conjunction with the hospitals/doctors.) More terrifying than the extremely high death rate in this particular area, is the fact that at least 8 or 9 of the deaths at the Basta CHC in 2015 have been attributed to Dr. Bhuyan, who has been working at the CHC for the past 10 years. ***It's clear from his record, that Dr. Bhuyan should more accurately be called Dr. Death.***

There is no reprieve from such injustice for the villagers, who cannot choose which doctor they see. Mr. Dandapata noted that villagers file complaints against the CHC and hospital to no avail. The local police take kickbacks, in the form of services or money, from the doctors in exchange for their refusal to accept complaints by villagers. For those bold villagers who tried to file a complaint with the police, a counter-complaint was filed against them by the authorities.

Taken together, it was no surprise when Mr. Dandapata stated that most families go to privateinstitutions rather than government run institutions. In this way, BPL families are forced to pay significant out-of-pocket expenses for adequate and safe healthcare.

Meeting with Mr. Dandapata

The team traveled next to the Basta CHC to meet with Dr. Bhuyan, who was not onsite. Instead, the team met with Dr. Ratnkar Das, MO/IC at the CHC. Upon arrival to the CHC, we visited a meeting room turned sterilization recuperation ward. Aside from the glaring NRHM/CHC Guideline violations, the recently sterilized women were left on the floor without any supervision by either doctors or nurses.

Young mothers sterilized at the Basta CHC the morning on 5/2/2016[4]

Meeting Room turned sterilization recuperation ward.

The fact-finding team asked Dr. Ratnkar about Gauri's death at the hands of Dr. Bhuyan. He replied that there is shortage of doctors at the CHC and made clear there that, at present, there were only four doctors available to assist patients. As such, Dr. Bhuyan always conducted deliveries. Dr. Ratnkar further explained that it was his understanding that Gauri died due to postpartum hemorrhaging (PPH). When asked why in spite of several complaints against Dr.

[4] Each of the women pictured are between the ages of 20-25, have at least two children. There were three ASHAs in the room who explained that they have sterilization quotas to meet and for this reason they conduct vigorous campaigns to encourage poor women to get sterilized. Each woman receives 1400 Rs. to be sterilized, which is a significant amount of money to BPL families.

Bhuyan for negligence was he still allowed to interact with patients, Dr. Ratnkar claimed that he was unfamiliar with the procedures and processes by which a doctor could be removed from active duty and/or disciplinary action could be taken against the negligent doctor. When asked whether a doctor who has a heightened duty of care kills patients in violation of the Constitution, International Human Rights Conventions, and the Hippocratic Oath should be criminally charged, Dr. Ratnkar remained silent.

After an hour long meeting with Dr. Ratnkar, the fact-finding team moved across the street to meet with Basta Police Inspector, Mr. Krushna Chandra Polai. Mr. Polai made clear that his office was aware of the litany of complaints against the hospital/doctors. He further indicated that if a complaint was lodged by the victim's family the police would investigate the claim. With that said, Mr. Polai explained that the state medical council issues a circular which states that without departmental inquiry there can be no investigation of a doctor by the police. The fact-finding team requested a copy of that notice, but Mr. Polai was unable to produce the document. He said he would send it by mail. As of the date of the report, HRLN has yet to receive it.

1.4. Summary of Findings/Observation

Taking into account both information gleaned from interviews and observations made along the way, the fact-finding team came to the conclusion that Gauri's unnecessary death resulted from systemic failures of the healthcare system, lack of infrastructure and resources, as well as a general (and disturbing) disregard for the lives of villagers.

- ➢ Village Health and Nutrition Day

After speaking at length with the ASHA, the fact-finding team visited the cyclone shelter where the VHND takes place monthly. This location also doubles as the AWC. As evidenced from the below photo, the room is NOT equipped to conduct medical examinations. To begin no medical equipment, surgical waste bins, or a proper table to conduct examinations/checkups of pregnant women and their children are in the room. When asked about the dearth of supplies, Mr. Banabihari Sampat, a male health worker, stated that in spite of multiple complaints, the CHC has been unwilling to supply an appropriate table to conduct checkups.

The ASHA further explained that when medical staff from the Basta CHC visit the center they bring with them the requisite medical supplies. This approach, of course, is problematic. What happens when medical staff forgets to bring, for example, enough syringes to administer vaccinations? There is nothing in the room to supplement their supplies/resources and the villagers are left without proper medical care. What is more, the table pictured below is plastic and not very sturdy - a hazard for both pregnant mothers and children, there are no privacy

screens for use during checkups nor any place to store medications/vaccinations (especially those needing refrigeration).

Per the VHND Guidelines, the ANC should be clean, there should be a place of privacy for the ANC, and any vaccines being administered should be delivered prior to the VHND.[5] None of this occurs at the Kainagar VHND.

This rooms doubles as the location of the VHND and the AWC

➢ Basic Infrastructure

At the CHC level, the problems were even more disconcerting. The wards were filthy. A close examination of the picture on page 11 shows recently sterilized women layingon a blood stained cloth, on an unclean floor. Patients who undergo (major) surgery are more susceptible to infection. A hospital that lacks any standard for cleanliness creates healthcare problems and puts patients at risk.

[5]*Monthly Village Health and Nutrition Day: Guidelines for AWWs/ASHAs/ANMs/PRIs*, Ministry of Health and Family Welfare, Government of India; pg. 11 [hereinafter VHND Guidelines] *available at* http://nrhm.gov.in/images/pdf/communitisation/vhnd/vhnd_guidelines.pdf.

Additionally, there is no blood bank at the CHC, which prevents doctors from administering lifesaving treatment to patients in need. If the Basta CHC had an operational blood bank, presumably Dr. Bhuyan could have given Gauri blood to balance out the blood she was losing. As per the guidelines, a CHC should have a blood storage unit equipped with blood bank refrigerators with a storage capacity of 50 units of blood.[6]
CHCs should be in charge of ambulance services in their region, which makes the lack of ambulatory services in Gauri's case all the more baffling. Given that Dr. Bhuyan referred Gauri to the subdistrict hospital, the ambulance should have been made available to transport her. Instead, Gauri and her family were made to wait for nearly two hours for an ambulance that never came. Had the 102 or 108 ambulance made a good faith effort to transport Gaurito the subdistrict hospital, she might be alive today and her family might have more faith in the healthcare system.

Finally, the CHC is operating at diminished capacity with only four doctors available or on call. There should be at minimum: 1 General Surgeon, 1 Dental Surgeon, 1 Physician, 1 OBGYN, 1 Pediatrician, and 1 Anesthesiologist.[7] Without a full staff versed in a wide range of medical and surgical procedures, the CHC cannot function properly to the detriment to its patients.

➢ Discrimination

Caste and tribal discrimination play a significant role in the administration of care to patients in rural areas. Some instances of discrimination, like Dr. Bhuyan yelling abuses at Gauri during delivery, are overt; however, the more pervasive and destructive forms of discrimination manifest themselves more subtly. In her study *Reflections on Discrimination and Health in India*, R. Srivatsan argues that,

> In all but the worst instances, discrimination *masks* itself, sometimes as a logical and ethical expression of liberal thinking and, at other times, even as modern science. Thus, [d]iscrimination against the 'lower' castes in hospitals is explained away as the inverse of respect towards fee paying patients and is also criticised as secular callousness toward the poor. One, most often the poor belong to the 'lower' castes. Two, these 'free' patients are unquestioning subjects on whom young doctors improve their practical medical skills in government hospitals –again a form of discrimination. Doctors not wanting to touch 'poor' (actually 'lower' caste)

[6] Directorate General of Health Services, *Indian Public Health Standards Guidelines (IPHS) for Community Health Centres*, Ministry of Health and Family Welfare, Government of India (2012 revised); pg. 65 [hereinafter CHC Guidelines]; *available at*http://health.bih.nic.in/docs/guidelines/guidelines-community-health-centres.pdf.
[7]CHC Guidelines, pg. 9.

> patients may explain their behaviour as not discriminatory by arguing that touch is rendered obsolete by modern medical imaging techniques.[8]

Covert forms of discrimination prevent doctors, specifically, and healthcare facilities, generally, from giving poor/lower caste patients equal treatment and care. Arguably, allowing a patient suffering from PPH to bleed out on the table in front her family amounts to more than negligence...***it amounts to murder*** resulting from discriminatory beliefs.

2. Background

2.1. 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)[9], of which "more than 83 percent...[live] in rural areas."[10] 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.[11]

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."[12]The survey further stated, "[l]ife expectancy at birth in the State for male and female

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[8] R. Srivatsan, *Reflections on Discrimination and Health in India*, Indian Journal of Medical Ethics, Vol 12, No 1 (2015), pgs. 15-16; http://ijme.in/index.php/ijme/article/view/2174/4656 (emphasis in original).

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

[10]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.

[11] Id.

[12]*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.

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."[13] As is evident from the high overall mortality rate, infrastructure - both economic and medical - are lacking.

2.2. Maternal Mortality in India

The Maternal Mortality Ratio (MMR) "is defined as the number of maternal deaths per 100,000 live births due to causes related to pregnancy or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy."[14] According to a 2013 report on reproductive, maternal, newborn, child and adolescent health, conducted by the Ministry of Health & Family Welfare (MoHFW) in 2013, "there are still 56,000 maternal deaths each year. About two-thirds of maternal deaths occur in just a few states – Assam, Uttar Pradesh (including Uttarakhand), Rajasthan, Madhya Pradesh (including Chhattisgarh), Bihar (including Jharkhand) and Odisha."[15] The Ministry attributes these deaths to "three delays: (1) the delay in deciding to seek care, (2) the delay in reaching the appropriate health facility, and (3) the delay in receiving quality care once inside an institution. The delay in deciding to seek care can occur ***due to inadequate resources***, ***poor access to high-quality health care***. The unavailability of basic reproductive health services, including contraceptives, pre- and postnatal care and emergency obstetric and neonatal care, as well as delays in seeking institutional care and ***the poor quality of care provided in the health facility*** can potentially contribute to maternal...deaths."[16]

Specifically, the most common direct medical causes of maternal death as per SRS (2001–03) are postpartum hemorrhaging (37%), sepsis (11%), and obstructed labour (5%).[17] "***These conditions are largely preventable and once detected, they are treatable***."[18]

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[13] Id.

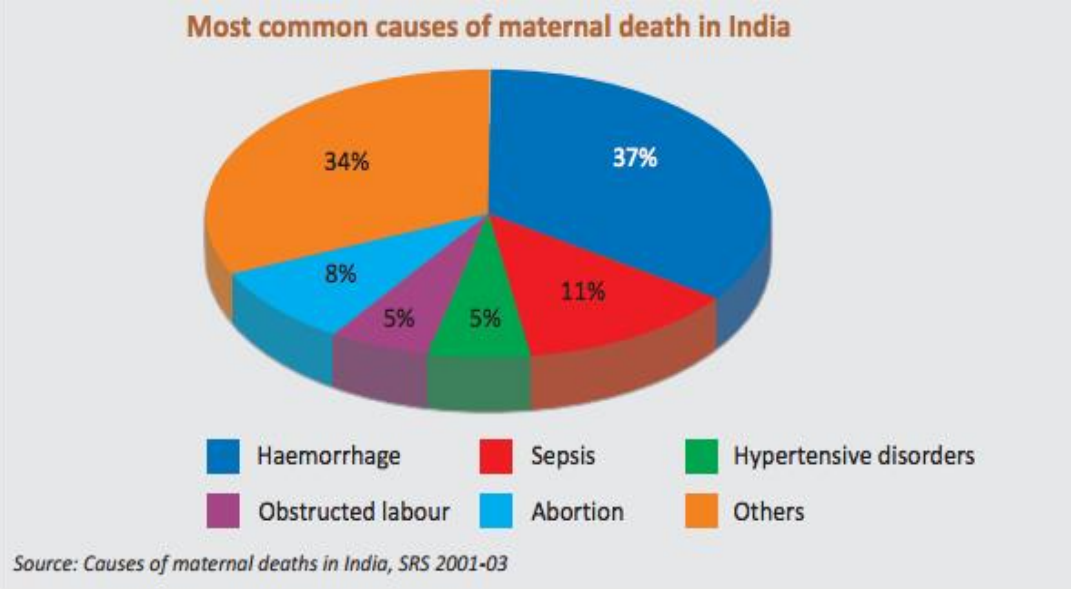
[14] https://data.gov.in/catalog/maternal-mortality-ratio-india

[15] *A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India: For Healthy Mother and Child*, Ministry of Health and Family Welfare, Government of India (2013); pg. 18 [hereinafter RMNCH+A Manual] *available at* http://nrhm.gov.in/images/pdf/programmes/rmncha-strategy.pdf.

[16] Id. at 21.

[17] RMNCH+A Manual, pg. 6. The corresponding chart can be found on pg. 7.

[18] Id. at 6.



2.3. Maternal Mortality in Odisha (Common Causes)

In 2012-2013, the MMR in Odisha was 235 as compared to a MMR of 178 across India.[19] Although the government of Odisha argues, "[t]here has been an improvement in women's health in recent times" because "[i]ncreasingly, more pregnant women have been receiving antenatal and postnatal care" and "[i]nstitutional deliveries have increased from about 37 percent in 2005-06 to 80.8 percent in 2012-13"[20] the MMR is still significantly higher than the national average. This is in spite of the fact that "[t]he pregnancy burden of women in [Odisha] is lower than that of their counterparts in the country."[21] Arguably, the MMR can, in part, be attributed to medical malpractice by negligent doctors and ill-equipped health centres to address patient needs. To this end, the MoHFW noted that "[m]ost obstetric complications and maternal deaths occur during delivery and in the first 48 hours after childbirth. ***This makes the intrapartumperiod (defined as labour, delivery and the following 24 hours) a particularly critical time for recognising and responding to obstetric complications*** and seeking emergency care to prevent maternal deaths."[22]

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[19]Id. at 46.*See also*, Central Statistics Office, *India in Figures*, Ministry of Statistics and Programme Implementation, Government of India (2015); pg. 2 [hereinafter India in Figures] *available at*http://mospi.nic.in/Mospi_New/upload/India_in_figures-2015.pdf; Central Statistics Office, *India in Figures*, Ministry of Ministry of Home Affairs, Government of India, (last visited Feb. 17, 2016; 6:52pm) [hereinafter Census 2011] *available at*http://www.censusindia.gov.in/2011-common/census_2011.html.

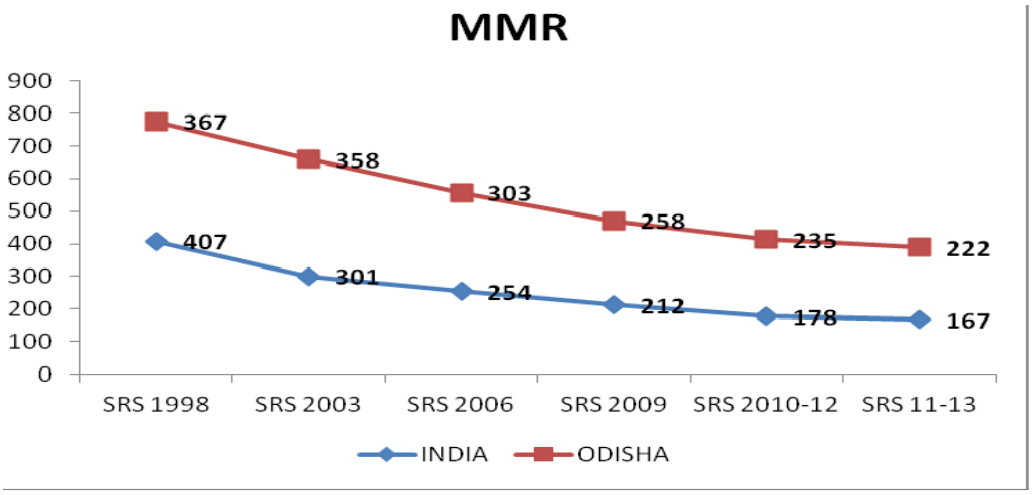
[20]Odisha Economic Survey,pg. 47.

[21] Id.

[22]RMNCH+A Manual, pg. 32.

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[23]



3. 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: Subcentres, Primary Health Centres, Community Health Centres, and Hospitals (subdistrict and district). As of 2012, there were 14,8366 subcentres in India, of which 6688 were in Odisha; there were 24049 PHCs in India, of which

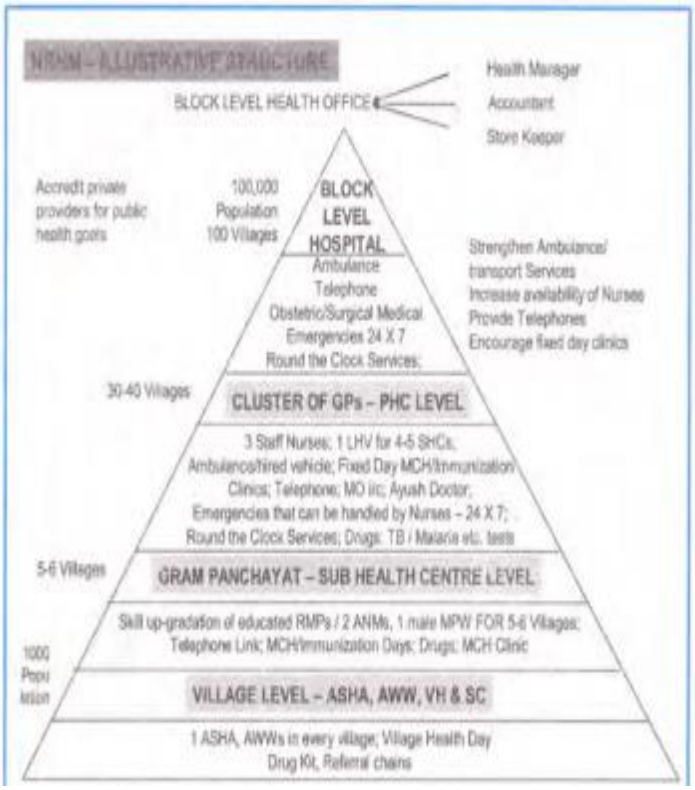
[23]Odisha Economic Survey, pg. 428.

1226 were in Odisha; and there were 4833 CHCs in India, of which 377 were in Odisha.[24] 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.[25]

Specifically, the NHM is comprised of two schemes: (1) the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM).[26] The focus of this report will be on the NRHM and its implementation in rural Odisha.

3.1. 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."[27]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."[28]



[24] 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.
[25]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
[26]http://nrhm.gov.in/nhm.html
[27]http://nrhm.gov.in/nhm/nrhm.html
[28]Id. at 15.

NRHM Scheme[29]

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.

- 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.[30] JSY modified the National Maternity Benefit Scheme (NMBS) and falls under the purview of the Department of Health & Family Welfare.[31] 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.[32]

  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."[33]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

[29]*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

[30]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

[31]Id.

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

[33]*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

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***."[34]

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[35]

➢ In 2011, six years after the JSY initiative, the JSSK initiative was introduced to curtail "high out of pocket expenses" incurred during institutional delivery.[36] 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."[37]

[34]Id. at 3.
[35]Id.
[36]http://nrhm.gov.in/nrhmcomponnets/reproductive-child-health/jssk.html
[37] Indian Ministry of Health & Family Welfare, *Directive No. Z.14018/1/2012-JSY*, 13 May 2013, http://tripuranrhm.gov.in/Guidlines/2705201302.pdf.

The below excerpt, from the JSSK Guideline Manual,[38] makes clear that services under this initiative are supposed to be free:

> 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.[39] Vehicles should have a "provision for advanced life support, trained staff and equipment...to manage emergencies during transit."[40]

[38]Maternal Health Division, *National Rural Health Mission Guidelines for JananiShishuSurakshaKaryakram (JSSK)*, Ministry of Health and Family Welfare, Government of India; pg. 3 [hereinafter JSSK Guidelines]; *available at*http://nrhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf.
[39]RMNCH+A Manual, pg. 21.
[40] Id.

Inclusions for Pregnant Women and Children under JSSK[41]

3.2. 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."[42] 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.[43] For this reason, AWWs play a crucial role in promoting child growth and development because they have close and continuous contact with the beneficiaries.[44]

[41]Id. at 15.
[42]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.
[43]Id. at 1278. For a more complete list of the roles and responsibilities of AWWs, see page 1279-80 of this report.
[44]Id.

AWWs are responsible for all data capture pertaining to services and beneficiaries.[45] This information must be forwarded to a Child Development Project Officer (CDPO) in Monthly Progress Reports.[46] 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.[47]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.[48] 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.[49] 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.

3.3. 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 newborn through the JananiSurakshaYojana (JSY) scheme.[50]

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

[45]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.
[46]*Monitoring in ICDS*, Ministry of Women and Child Development, pg. 2.
[47]*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.
[48]*Monitoring in ICDS*, Ministry of Women and Child Development, pg. 9; *AWW Roles and Responsibilities*, pg. 1280.
[49]http://wcdodisha.gov.in/node/46.
[50]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[51]

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.		

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

ASHA duties[52]

3.4. Subcentre

At the village level, Sub Health Centres ("Subcentres") are next in the healthcare lineup. They are "expected to provide promotive, preventive and few curative primary health care services."[53] Taking into account population density, there shall be one subcentre 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.[54]

There are two types of subcentres outlined in the NRHM: Type A and Type B. With the exception of conducting deliveries, Type A subcentres 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.[55] 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***.[56]

Similarly, Type B subcentres are inclusive of all the aforementioned services and have the infrastructure // resources to conduct deliveries and give Neonatal care at the subcentre itself. In this way, the Type B subcentre acts as a Maternal and Child Health (MCH) centre with basic facilities for conducting deliveries and newborn care.[57]

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[58]

[52] Id. at 8. This is not an exhaustive list.
[53] Subcentre Guidelines, pg. 6.
[54] Id. at 3.
[55] Id. at 54.
[56] Id. at 4.
[57] Id. at 6.
[58] Id. at15.

3.5. PHC

A Primary Health Centre is the first location where rural villagers have access to a doctor, either by referral from a subcentre 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."[59]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."[60]

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).[61]

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[62]

[59]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.
[60]Id.
[61]Id. at 4-11.
[62]Id. at 16.

3.6. 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."[63] 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.[64]

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 accountability. A grievance redressal mechanism under the overall supervision of RKS would also be set up.[65]

3.7. 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.[66]

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."[67] 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

[63]CHC Guidelines, pg. 1.
[64]Id. at 13.
[65]Id. at 11.
[66]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.
[67]Id. at 13.

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."[68]

3.8. Odisha Specific Health Care Schemes

3.8.1. 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."[69] Under this scheme, ambulances are split into two types: 'Basic Life Support' (BLS) and 'Advance Life Support' (ALS).[70]Balasore was allotted 19 BLS and 4 ALS ambulances, for a total of 23 ambulances[71] to service at minimum 17 CHCs.[72] 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, the average response time should be 20 minutes for urban locations, 25 minutes for semi-urban and 35 minutes for rural locations.[73]

3.8.2. 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."[74] Under the scheme, pregnant and lactating women may receive a total of 5,000 Rs. in four instalments, conditioned upon completion of certain prerequisites.[75]

First Installment	1500 Rs., given at the end of 2nd trimester	• Pregnancy registered at the AWC. • Received at least one antenatal check-up.

[68] Id.
[69]http://www.nrhmorissa.gov.in/frm108services.aspx
[70] Id.
[71]pg. 1; http://www.nrhmorissa.gov.in/writereaddata/Upload/Documents/108-NAS%20Writeup.pdf
[72]*CHC Directorate*, http://dhsodisha.nic.in/?q=node/89.
[73]http://www.nrhmorissa.gov.in/frm108services.aspx
[74]*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.
[75]Id. at 4.

		● 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.
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.[76]

4. Constitutional Violations

4.1. *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).

4.2. *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."

4.3. *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."[77]*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).

[76]Id. at 5-7.
[77]*Munshi Singh Gautam v. State of M.P.*, (2005) 9 SCC 631, 637 (para 4): AIR 2005 SC 402

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.

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."

4.4. *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.

4.5. *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 paidRs. 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."

5. 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.

5.1. 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."[78]

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."[79]

[78]*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
[79]Id. at 5.

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."[80]

5.2. 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.[81]

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 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.[82]

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.[83]

5.3. 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.[84]

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[80]Id. at 6.
[81]*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.
[82]Id. at 4.
[83]Id. at 5.
[84]*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

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."[85]

5.4. 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 pursue full implementation of this right and, in particular, shall take appropriate measures [t]o ensure appropriate pre-natal and postnatal health care for mothers."[86]

5.5. 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."[87]

5.6. 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."[88]

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[85]Id. at 179.
[86]*Convention on the Rights of the Child*, (entry into force 2 September 1990), pg.7; http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf.
[87]*The Universal Declaration of Human Rights*, http://www.un.org/en/universal-declaration-human-rights/.
[88]*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 mother, newborn son, and the mother-in-law of the decedent.

6. Recommendations: Schemes for Redress

CHCs should have internal and external monitoring mechanisms, as well as, a grievance redressal mechanism in place to ensure accountability of both doctors and the hospitals where they work. Unfortunately the interviews illuminate the inadequacy of these "monitoring" procedures. The below list of recommendations should be implemented effective immediately to ensure compliance with monitoring guidelines and create a more robust redress process.

6.1. Patient Grievance Scheme

A quick survey of the Basta CHC did not provide any instruction or guidance as to where/how a patient could file a complaint with the CHC to make the facility aware of issues arising from interactions with doctors, medical staff and/or facility administrators.

To address this issue, 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. (According to Dr. Das, at best negligent doctors are transferred to another district...to continue harming or killing their patients.) 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.

6.2. 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.

Annexure 1: Additional Pictures of the Cyclone Shelter:

Ceiling above the AWC/VHND room

Debris and animal/bird fecal matter in the stairwell leading to the AWC