IN THE HIGH COURT OF DELHI AT NEW DELHI

EXTRA ORDINARY CIVIL JURISDICTION

WRIT PETITION (CIVIL) NO.5913 OF 2010

IN THE MATTER OF:

COURT SUO MOTO …Petitioner

Versus

UNION OF INDIA …Respondent

INDEX

	Singh dated 18.9.2010	
10.	**ANNEXURE 4**: True copy of the map showing the place of incident the police post and the medical hospitals, mobile medical units etc. dated nil	
11.	**ANNEXURE 5**: True copy of extract of image from the film of the dead body and of the post incident of the death dated nil	
12.	**ANNEXURE 6**: True copy of DVD of the recordings of the incident on	
13.	**ANNEXURE 7**: True copy of final judgment passed by this Hon'ble Court in Laxmi Mandal versus Deen Dayal Harinagar Hospital W.P.(C) 88537of 2008 dated 4.6.2010	
14.	**ANNEXURE 8**: Copy of the draft Policy Framework and Plan for Caring and Protecting the rights of homeless citizens of Delhi	
15.	**ANNEXURE 9**: True copy of the Recommendations towards Protecting Human Rights of Delhi's Homeless by Shahri Adhikar Manch: Begharon Ke Liye	
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REPORT OF THE FACT FINDING MISSION ON THE DEATH OF LAXMI OCCURRED IN DELHI ON THE AUGUST 1, 2010

WRITTEN BY SANJAI SHARMA , FRANCESCA FERUGLIO AND Adv.JAYSHREE SATPUTE

INTRODUCTION

I. The present petition was initiated by the Court suo moto on the basis of a newspaper report dated 29th August 2010 published in Hindustan Times. The report was regarding a destitute woman, on a busy street, died four days after giving birth to a baby girl, namely Karishma, who is now struggling for her life at Kalawati Saran Children Hospital.

II. It also highlights the failure of the Public Health System to eradicate maternal mortality. 1,17,000 women die each year in India during pregnancy and child birth, which is highest in world. Most of these of deaths are preventable and because of the systemic failure. Despite the fact that standard of living are poorer in rural areas, many maternal deaths still take place in urban areas, even though medical facilities are easier to reach and skilled personnel are available in plenty.

III. Sr. Advocate Mr. Colin Gonsalves, Amicus Curiae of the Court in this petition, appointed Mr. Sanjai Sharma and Ms. Francesca Feruglio and Adv.Jayshree Satpute to carry out a fact finding on the circumstances of the death of Laxmi, a destitute woman living below the poverty line.

IV. Mr. Sanjai Sharma is a peoples health rights activist having experience of serving communities in rural and urban areas located across several states of the Union Of India. He has been working on a wide range of public health problems including reproductive health.

V. Ms. Francesca Feruglio is a human rights law activist. Her work focuses

on deprivation of right to health and food as well as non-discrimination and gender equality issues.

VI. Advocate Jayshree Satpute is a reproductive rights lawyer practicing in Delhi.

VII. The fact-finding was carried out over the month of September 2010. The following report was written according to the information received and the analysis of the authors.

FACTS OF THE CASE

1. Laxmi was a homeless woman between 30 and 35 years of age, who spent the four last months of her life scavenging for food and alms, as referred by local vendors and shopkeepers.

2. According to Mr. Indarjeet Singh, who runs Annapurna food Corner across the road, the late Laxmi used to live on the doorsteps of the Mohan Singh Building, popularly known as Coca-Cola building, a dilapidated and abandoned structure adjacent to Shankar Market opposite Vidyut Bhawan in Connaught Place. Photograph of the Mohan Singh Building is annexed hereto and marked as **ANNEXURE –1.**

3. Mr. Singh referred that Laxmi was married with a man from Bihar and moved to his village after wedding. She was subjected to sever domestic violence in the hands of her husband and in laws. They once set her on fire with intension to kill her but she managed to escape. Later Laxmi sustained sever burn wounds on her body according to her acquaintances.

4. Mr. Singh referred that once returned to Shankar Market, she was

abused by an auto-rickshaw driver who lives nearby in an area notorious for goonda's and drug peddlers. Although no further information have been disclosed on the auto-rickshaw driver, it emerged that his name is Babbar. The police has not carried out an investigation.

5. Laxmi was a women living below the poverty line. During her pregnancy she sustained herself on the discarded food and garbage. While she was pregnant was not even taken once to the clinic/ hospital for check up nor was given entitled benefits under any of the assisting schemes of the Government of India.

6. Mukesh, another homeless person who lives across the street in front of Arora Store, said that on the night of July 25, 2010 i.e. around 2.10 a.m. Laxmi started to have labour pains and her waters broke. As no one was around her she had to crawl about 50 meters to call for help. Mukesh heard her cry and immediately called his wife to help Laxmi.

7. Mukesh and his wife realized that laxmi was about to deliver. It is very important to note that neither Mukesh nor his wife are remotely skilled for assisting women during childbirth. Mukesh and his wife could only give her emotional support and comfort her on that pavement.

8. Laxmi delivered a baby girl under the dim streetlights on the footpath near the authorized auto stand located between Coca-Cola building and Shankar Market at around 2.30 a.m. Probably the umbilical cord broke and the placenta remained inside the womb. Photograph of the place where Laxmi gave birth to a baby girl is annexed hereto and marked as **ANNEXURE-2**.

9. After helping in the delivery Mukesh and his wife left the baby girl besides Laxmi on the same spot and went off to sleep. It was rainy season and

to protect her baby from rain after some time of the delivery she crawled back under the shelter along with the infant.

10. No skilled assistance or medical guidance was given prior or post partum. No medical facility or personnel was informed of the pregnancy or the delivery.

11. Mukesh who is the eyewitness made a statement stating that Laxmi after the delivery was lying in pain and without food on the roadside along with her baby. With no medical assistance, unremoved placenta, infection from street, hunger and fatigue lead to septicemia Laxmi died on the fourth day of the delivery. The baby, who was in urgent in need of medical care, was lying besides Laxmi's dead body with flies hovering around and people passing by. True copy of statements of Mukesh the eyewitness of the incident and of Mr. Indrajeet Singh are annexed hereto and marked as **ANNEXURE –3 (Collectively).**

12. On 26th July morning the cries of the baby attracted people. Mr.Singh reached Laxmi with money and food. The baby attracted attention of other shopkeepers and people passing by. Mr. Singh approached Ms. Ritu Arthur Fredrick who owns a garment store in Shanker Market. As confirmed by Ms. Fredrick, they washed the baby and wrapped it in clothes. She also bought some baby food and fed the child. Ms. Fredrick and Mr. Singh would keep the baby in the safety of their shops during the daytime and hand her over to Laxmi at night.

13. Ms. Fredrick declared to have brought the child to a private doctor, namely Dr. Gandhi in Bengali Market, for a checkup between 26th and 29th of July 2010. She added that the doctor saw the child and simply suggested to breastfeed her. He did not ask about the mother, even though Ms. Fredrick did not seem to have been recently pregnant. It was

later found that the child had septicemia.

14. Mr. Singh informed Sanjai Sharma that Dr. Pandey, on getting information about the baby by Ms. Fredrick, came to the spot on 28th July 2010. Thereafter, she came back on the 29th July between 5.00 pm- 6.30 pm along with Udayan workers, in order to bring the child to the Udayan Care home, situated in Doctor's Lane in Gol Market. Ms. Fredrick and Mr. Singh, together with Laxmi, resisted this attempt, as they did not trust Udayan Care workers. Despite Laxmi's visible suffering, Udayan Care workers did not take any step to improve Laxmi's condition or to take her to medical hospital.

15. It is pertinent to note here that Laxmi's physical and mental health was deteriorating. Severe anaemia and post partum bleeding required urgent treatment.

16. It must be also noted that Shankar Market is a busy urban area constantly and systematically guarded by the police. There is a police beat located at Barakhambha Metro Station, just a few minutes away from the place where Laxmi delivered. True copy of the map showing the place of incident the police post and the medical hospitals, mobile medical units etc is annexed hereto and marked as **ANNEXURE-4**. However, no step was undertaken by any State servant, doctor or policeman, to save the life of a mother and of a newborn.

17. Laxmi was in post partum depression, thus she refused to call for medical attention or to go to the hospital. She only explicitly asked Ms. Fredrick to take care of the child in case of her death-as referred by Ms. Fredrick herself- further adding:

"how many children can I look after?"

18. On the morning of the 1st of August Laxmi was found dead by shopkeepers of the area, who called the police to bring her body to the hospital. A few hours later the body was taken away, after being dragged onto a CNG truck driven by a policeman. No doctor or skilled personnel, nor medical facilities, such as ambulance, were involved in this operation. The photographs of the dead body are annexed and the photographs of the post incident of the death are annexed hereto and marked as **ANNEXURE-5 (Collectively)**

19. The Kairali TV correspondent P. Rajan Sunil recorded the hours when the body was found and broadcasted the news on the 2nd of August. A copy of the video is submitted to this Court. DVD of the recordings of the incident in annexed hereto and marked as **ANNEXURE –6.**

20. Sub Inspector Prashant, who responded to the call and went on the site, said that he found the body lying on the footsteps. He then took the body to Lady Hardinge Medical College and Hospital where a post mortem was done.

21. Although he did not have a copy of the document with him, he remembered that the cause of death in the report was septicemia. Septicemia is a severe infection of the human body requiring emergency care. It results in death if left untreated. Sub Inspector Prashant confirmed that Laxmi had marks of healed burn wounds on her neck.

22. Medical analysis revealed that the child has septicemia as well, although in a milder form. The baby was sent to Udayan Care in Gol Market under instructions of the Child Welfare Committee.

23. In a telephone conversation with Shailaja Singh from Udayan Care home, Sanjai Sharma was informed that the child has meningitis also, which is a life-threatening condition, and has been hospitalized at Kalawati Saran Children's Hospital.

24. After Laxmi's death Ms. Ritu Arthur Fredrick wanted to adopt the baby girl and asked Sub Inspector Prashant to hand over the baby directly to her. However, the management of Udayan Care home refused to give custody without fulfilling proper legalities.

25. That the news of the death came out on 30th August in newspapers, almost one month after Laxmi's death.

26. Sub Inspector Prashant laments that the world is still interested in the baby and not in the mother who died in the heart of Delhi, the capital city of India. However, he did not give explanation on the reasons why no policeman intervened to help Laxmi nor why the body was treated with such a lack of dignity and respect

27. The Hindustan Times reporter Nivedita Khandekar has revealed that after asking a policeman why they did not intervene to save Laxmi's life, she was told:

"We cannot touch women."

28. Located at walking distance is the Municipal Allopathic Dispensary of the Municipal Corporation of Delhi in the premises of the Delhi Fire service Head Quarters. This dispensary has a fully qualified doctor sitting in it every day from 8 a.m. to 2 p.m. Which can be figured viewing **ANNEXURE –4.**

29. On the 7th October, when asked by Sanjai Sharma the doctor on duty who refused to tell his name as to whether he remembers the incident of Laxmi's death said "yes." However the doctor said that this being a commercial area no schemes like the Janani Suraksha Yojana are operational here. He also recounts that many similar deaths have taken place on the streets.

30. Located at 10 minutes walking distance from the place where Laxmi lived, gave birth and died there is the Medical Center of New Delhi Municipal Corporation (NDMC), situated in Babar Road. Which can be figured viewing **ANNEXURE –4.**

31. The Chief Medical Officer Dr Gyanendra Kumar said that he was not informed about Laxmi's pregnancy or health condition. He then referred Sanjai Sharma to the Mother and Child Welfare Center (MCWC), located on the first floor of the building.

32. The Chief of the MCWC Dr. Ms. S.Bagga said that she did not know about the incident and that it is not her job to look after people on the street. She said that the hospital does antenatal check up only of those who go there. She added that the hospital has no defined operational area or any idea of population to be covered. Finally, when asked to provide the name of the local ASHA, she answered that no ASHA is assigned to that hospital.

33. It is also pertinent to note that three of India's top medical college and hospital namely,Lady Hardinge Medical College and Hospital ,Kalavati Saran Childrens Hospital and Sucheta Kriplani Hospital are located in the viscinity at a walking distance of 15 minutes from the spot where Laxmi died.

LEGISLATIVE SCHEMES

1. Several social schemes, often overlapping one with each other, have been designed to cover all kind of health needs. These schemes, tailored specifically toward poor women and children.

SNAPSHOT OF THE SCHEMES:

2. Relevant extracts of the observation of this Hon'ble High Court made in Laxmi Mandal versus Deen Dayal Harinagar Hospital W.P.(C) 88537of 2008 are reproduced herein under:

I.THE JANANI SURAKSHA YOJANA

The JSY is a safe motherhood intervention scheme under the National Rural Health Mission (NRHM) implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. This was launched on 12th April 2005. It is a 100% centrally sponsored scheme and integrates cash schemes with delivery and post-delivery care. The JSY identifies the Accredited Social Health Activist (ASHA) as an effective link between the Government and the poor pregnant women. She usually works under an Auxilliary Nurse Midwife (ANM) and their work is expected to be supervised by a Medical Officer (`MO').

Under the JSY the role of the ASHA or any other link health worker associated with JSY would be to:

i. Identify pregnant woman as a beneficiary of the scheme and report or facilitate registration for ANC. This should be done at least 20-24 weeks before the expected date of delivery.

ii. Assist the pregnant woman to obtain necessary

certifications wherever necessary, within 2-4 weeks of registration.

iii. Provide and / or help the women in receiving at least three ANC checkups including TT injections, IFA tablets.

iv. Identify a functional Government health centre or an accredited private health institution for referral and delivery, immediately on registration.

v. Counsel for institutional delivery,

vi. Escort the beneficiary women to the pre-determined health center and stay with her till the woman is discharged.

vii. Arrange to immunize the newborn till the age of 14 weeks.

viii. Inform about the birth or death of the child or mother to the ANM/MO.

ix. Post natal visit within 7 days of delivery to track mother's health after delivery and facilitate in obtaining care, wherever necessary.

x. Counsel for initiation of breastfeeding to the newborn within one-hour of delivery and its continuance till 3-6 months and promote family planning.

xi. A micro-birth plan must mandatorily be prepared by the ASHA or equivalent health activist.

A child under the JSY is entitled to:

1. Emergency care of sick children including Integrated Management of Neonatal and Childhood Illness (IMNCI)
2. Care of routine childhood illness
3. Essential Newborn Care

4. Promotion of exclusive breastfeeding for 6 months.
5. Full immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI
6. Vitamin A prophylaxis to the children as per guidelines
7. Prevention and control of childhood diseases like malnutrition, infections, etc.

One feature of the JSY is that only a woman, more than 19 years of age who is BPL can be a beneficiary in High Performing States (`HPS'). In case a poor woman does not have a BPL card then the beneficiary can access the benefit upon certification by *Gram Panchayat* or *Pradhan* provided the delivery takes place in a government institution. Cash assistance in HPS is limited to two live births. The disbursement is made at the time of delivery. Cash assistance of Rs. 700 in case of rural and of Rs. 600 in case of urban is given for institutional delivery and of Rs. 500 is given for home delivery. In rural areas, cash assistance for referral transport to go to the nearest health centre for delivery is provided. The JSY identifies only 10 states as low performing states ('LPS') and the remaining as high performing states ('HPS'). What is to be borne in mind however is that the cash incentive is but one component of the JSY.

The NCT of Delhi has not been named as LPS. Nevertheless, the figures of utilisation of the funds allocated under the JSY for 2006-07, as well as the percentage of home deliveries as recorded by the Supreme Court in order dated 20th November 2007 have a different story to tell.

II.NATIONAL MATERNITY BENEFIT SCHEME

The National Maternity Benefit Scheme (`NMBS') basically talks of providing cash assistance of Rs.500 to pregnant women. In order to clear the confusion that the cash assistance under the NMBS is independent of the cash assistance under the JSY, the Supreme Court on 20th November 2007 passed an order in the *PUCL Case* directing that all the State governments and Union Territories (UTs) shall continue to implement the NMBS and ensure that "all BPL pregnant women get cash assistance 8-12 weeks prior to the delivery." It was specifically directed that "the amount shall be Rs. 500/- per birth irrespective of number of children and the age of the woman." It was reiterated that "It shall be the duty of all the concerned to ensure that the benefits of the scheme reach the intended beneficiaries. In case it is noticed that there is any diversion of the funds allocated for the scheme, such stringent action as is called for shall be taken against the erring officials responsible for diversion of the funds."

III.INTEGRATED CHILD DEVELOPMENT SERVICES

The objectives of the Integrated Child Development Services (ICDS) Scheme, which was launched in 1975, are:

i. To improve the nutritional and health status of children in the age-group 0-6 years;

ii. To lay the foundation for proper psychological, physical and social development of the child;

iii. To reduce the incidence of mortality, morbidity, malnutrition

and school dropout;

iv. To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and

v. To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The package of services provided under the ICDS include:

1. Supplementary nutrition,
2. Immunization,
3. Health check-up,
4. Referral services,
5. Pre-school non-formal education and
6. Nutrition & health education.

The working of the ICDS has been examined by the Supreme Court and several orders have been passed by it. In its order dated 29th April 2004, the Supreme Court noted that the implementation was "dismal" and that "…a lot more deserves to be done in the field to ensure that nutritious food reaches those who are undernourished or malnourished or others covered under the scheme." The Court observed that according to the Government of India norms, an *Anganwadi Centre* (AWC) will be opened for every 1000 population, and 700 in case of tribal areas. It noted that six lakh AWCs had been opened, and ordered that all of them should be made operational by 30th June, 2004. The sanctioned AWCs were to supply nutritious food to the

beneficiaries for 300 days in a year under the ICDS scheme. Reports were called from the Chief Secretaries to indicate how many children; adolescent girls, lactating women and pregnant women were provided with nutritious food in the number of days in the year. On 13th December 2006, the Supreme Court issued further directions. It was observed that the universalisation of ICDS "involves extending all ICDS services to every child under the age of 6, all pregnant women, lactating mothers and adolescent girls."

IV.ANTYODAYA ANNA YOJANA (AAY)

A central feature of the Antyodaya Anna Yojana (AAY) is the provision of rations up to 35 kgs which would include grains and nutritional supplements. In its order dated 28th November 2001, the Supreme Court directed the States and the UTs to complete the identification of beneficiaries, issuing of cards and distribution of grain latest by 1st January 2002. It noted that "some Antyodaya beneficiaries may be unable to lift grain because of penury." In such cases the Centre, the State and the UTs were requested "to consider giving the quota free after satisfying itself in this behalf."

On 2nd May 2003, the Supreme Court directed the Government of India to place on AAY category the following groups of persons: (1) Aged, infirm, disabled, destitute men and women, pregnant and lactating women, destitute women; (2) widows and other single women with no regular support; (3) old persons (aged 60 or above) with no regular support and no assured means of subsistence; (4) households with a disabled adult and assured means of subsistence; (5) households where due to old age, lack of physical or mental fitness, social customs, need to care for a disabled, or other reasons, no adult member is available to engage in gainful

employment outside the house; (6) primitive tribes"

In its order dated 17th November 2004, the Supreme Court noted that the AAY was "meant for the poorest of the poor." It went on to observe that: "A person entitled to the benefit under this scheme is issued a red card. The holder of red card entitles him/her to obtain grain and rice from the dealer of Public Distributor System (PDS) at a highly subsidised rate which at present is rupees two per kilogram for wheat and rupees three per kilogram for rice. Those falling under this category should be immediately identified. The special attention is required to be given to Primitive Tribal Groups, which we are told, are in large in Maharashtra, West Bengal, Jharkhand and Madhya Pradesh, which are still be to identified in large numbers, card issued and grains supplied. We direct all the State Governments to complete the process of identification of persons falling under this scheme and issue them the red card by the end of the year 2010 so that immediately thereafter supply of food grains to them may commence."

V.NATIONAL RURAL HEALTH MISSION

The National Rural Health Mission (NRHM) was launched on 12th April 2005, throughout the country, with an objective to reduce the Maternal Mortality Rate, the Infant Mortality Rate and the Total Fertility Rate. The Service Guarantees provided under this scheme, which are to be made available by 2010 (according to the timeline prescribed by the Government) are:

- Early registration of pregnancy before 12th week of pregnancy

- Minimum of 4 antenatal check ups first – when pregnancy is suspected, second – around 26 weeks of pregnancy, third – around 32 weeks, fourth – around 36

weeks

- Associated services like general examination such as weight, BP, anemia, abdominal examination, height and breast examination,

- Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs)

- Minimum laboratory investigations like haemoglobin, urine albumen and sugar

-Identification of high-risk pregnancies and appropriate and prompt referral

- Folic acid supplementation in the first trimester

- Iron and Folic Acid supplementation from twelve weeks,

- Skilled attendance at home deliveries as and when called for

- A minimum of 2 postpartum home visits. First within 48 hours of delivery, second within 7-10 days

- Initiation of early breast-feeding within half hour of birth

- Counseling on diet and rest, hygiene, contraception, essential newborn care, infant and young child feeding. (As per Guidelines of GOI on Essential newborn care) and STI/RTI and HIV/AIDS

-Education, Motivation and counseling to adopt appropriate Family planning methods,

-Provision of contraceptives such as condoms, oral pills,

emergency contraceptives, IUD insertions (Wherever the ANM is trained on IUD insertion)

- Counseling and appropriate referral for safe abortion services (MTP) for those in need.

- Appropriate and prompt referral of cases needing specialist care

- Essential Newborn Care

- Promotion of exclusive breast-feeding for 6 months

- Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI

- Vitamin A prophylaxis to the children as per guidelines

- Prevention and control of childhood diseases like malnutrition, infections, etc.

The copy of final judgment passed by this Hon'ble Court in Laxmi Mandal versus Deen Dayal Harinagar Hospital W.P.(C) 88537of 2008 is annexed hereto and marked as **ANNEXURE-7**

VI.NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

The National Vector Borne Disease control Programme is an umbrella programme for prevention and control of vector borne diseases viz., malaria, filariasis, kala-azar, Japanese encephalitis, dengue and chikungunya. The Directorate of NVBDCP, under the Directorate General of Health Service (Dte. GHS), Ministry of Health and Family Welfare (MOHFW), Government of India, is the national level unit dedicated to the programme. The Directorate of NVBDCP is the nodal agency for planning for programme implementation, oversight and coordination with the states. It is responsible for formulating

policies and guidelines, monitoring, and carrying out evaluations. It is also responsible for administering GOI's financial assistance to the states in the context of the program.

VII.REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

The goal of the Revised National Tuberculosis Control Programme is to decrease mortality and morbidity due to TB and cut transmission of infection until TB ceases to be a major public health problem in India. The objective of TB control Programme is to achieve and maintain cure rate of at least 85% in new sputum positive pulmonary TB patients, and to achieve and maintain detection of at least 70% of such cases.

According to the Strategic Vision for TB control for the country up to 2012, the strategies are:

- Administrative and Political commitment, community awareness and participation
- Provision of services: human resource development, diagnostic facilities, and treatment, directly observed treatment
- Supervision, monitoring and evaluation
- Attention to special groups: migrants, tribal groups, gender
- Newer services: treatment of multi-drug resistant TB cases, treatment of TB/HIV coordination.

VIII. As this Court underscored in *Laxmi Mandal* Case, "the essential thrust of NRHM is of 'convergence' of different schemes. The idea is to put in place a system that facilitates easy accessibility of the public health system while at the same time making it accountable."

IX. In addition to Public Health System Schemes implementation orders, the Supreme Court also directed the government to protect the right to food and life of homeless people.

X. The Supreme Court on the 20th January 2010 ordered:

> "While some of these people were symbolically given ration cards by the Chief Minister in a public function on August 15, 2009, none of them have yet been able to lift any ration using these cards. Further, most of those identified by the survey are yet to even receive ration cards. In this the Commissioners have sought further directions, which are as follows:
>
> 1. Direct the Government of Delhi, the Municipal Corporation of Delhi, the New Delhi Municipal Corporation and Cantonment Board to set up at least 100 temporary shelters for people living on the streets within the next one week.
>
> 2. Direct the Government of Delhi, the Municipal Corporation of Delhi, the New Delhi Municipal Corporation and Cantonment Board to set up at least 140 permanent shelters for people living on the streets by December 2010.
>
> 3. Direct the Government of Delhi to set up at least 500 community kitchens across the city, providing nutritious and cheap cooked food.
>
> 4. Issue AAY ration cards for all homeless people in Delhi, with a validity of at least two years, renewable if they remain homeless in Delhi, latest by March 31, 2010.

5. Direct the Government of Delhi, the Municipal Corporation of Delhi and the New Delhi Municipal Corporation and Cantonment Board to file an affidavit in the Supreme Court on the steps undertaken to protect the food and shelter rights of homeless people in the city, by 15th February 2010."

XI. Pursuant to this and following orders, the Government formulated a draft Policy Framework and Plan for Caring and Protecting the Rights of Homeless Citizens of Delhi. The Framework, according to the Government's affidavit filed in April 2010, should be "examined and acted upon" by October 2010. A copy of the draft Policy Framework and Plan for Caring and Protecting the Rights of Homeless Citizens of Delhi is annexed hereto and marked as **ANNEXURE-8.**

XII. The draft framework significantly states that "homelessness is an inevitable consequence of urbanization" caused by migration from rural areas. However, as stressed by the Report drafted by the NGO Shahri Adhikar Manch, the main causes of homelessness are slum demolitions, evictions, such as those due to Commonwealth Games, and discrimination. A copy of the Recommendations towards Protecting Human Rights of Delhi's Homeless by Shahri Adhikar Manch: Begharon Ke Liye is annexed hereto and marked as **ANNEXURE -9**

XIII. In addition, it has to be noted that most of the constructions projects workers, such as those working on Commonwealth Games sites, are trafficked and lured by private contractors from rural areas to Delhi.

XIV. Furthermore, the Framework recognizes the essential contribution of homeless people, which are Delhi's "moving forces." For this reason, and in pursuance to the Supreme Court orders, the Government expresses the will to improve homeless' living conditions. However, it proposed to allocate only 1% of the annual budget. Moreover, most of the services provided for under the Framework would actually be carried out by NGOs or charities.

XV. In regard with the issuance of AAY cards, as to April 2010, only 437 homeless cards were distributed, as oppose to the 15000 beneficiaries identified by the NGO 'Chintan,' which carried out a survey to estimate the number of homeless people living in Delhi.

XVI. Furthermore, the Government refused to issue AAY cards with validity of two years, arguing that no such provision is contained in the Delhi Specified Articles (Regulation of Distribution) Orders, 1981. According to the Government, the "homeless" is a shifting population and the issuance of a two-years AAY card "will lead to permanent settlement of the migratory population." It has been proved that the "homeless" is not a shifting population at all. Dr. Saxena, Commissioner of the Supreme Court, pointed out that "a study ('Living Rough' by the Centre for Equity Studies) conducted for the Planning Commission confirmed that a sizeable number of homeless people, almost 60%, have lived in the city for more than ten years." The Government policy falls short to provide for a long-term solution enhancing homeless' living standard and enjoyment of human rights. It seems to be aimed to force homeless people to move somewhere else, in order to avoid "a permanent settlement" of poor population which would entail specific obligations on the State.

NATIONAL AND INTERNATIONAL RELEVANT LAW

RIGHT TO LIFE AND HEALTH

1. It is settled law that the right to health is an integral to the right to life under Art. 21 of the Constitution of India (CoI). In *Chameli Singh v State of UP* (1996) 2SCC 549 the Court has ruled that:

> "The right to life in any civilized society implies the right to food, water, shelter, education, medical care and decent environment. These are basic human rights known to any civilized society. The civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights and Conventions or under the CoI cannot be exercised without these basic human rights."

2. The Preamble of the International Covenant on Economic, Social and Cultural Rights, which India has ratified, stresses that:

> "these rights derive from the inherent dignity of the human person"

3. General Comment No 14 (2000) of the Committee on Economic, Social and Cultural Rights, which is the best interpretation of the right to health to date, states:

> "8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and

entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."

4. A copy of the General Comment N.14 (2000) on the right to the highest attainable standard of health is annexed hereto and marked as **ANNEXURE -10**

REPRODUCTIVE RIGHTS

5. The International Cairo Programme of Action, 1994, which India is a signatory of, defines reproductive rights as follow:

"Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly

the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence."

6. The Committee on the Elimination of All forms of Discrimination Against Women (CEDAW), to which India is a signatory of, in General Recommendation 24 on women and health spells out:

"11. Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

17. The duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those that emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States

parties of Possible breaches of their duties to ensure women's access to health care.

27. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.

29. States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services."

VIOLATIONS

Reproductive rights

1. The UN Special Rapporteur for the Highest Attainable Standard of Health, Paul Hunt, in his country mission in April 2010, pointed out that "for a middle country income of its stature and level of development, the rate of maternal deaths in India is shocking." Furthermore, "there is a yawning gulf between India's commendable maternal mortality policies and their urgent, focused, sustained implementation. For the most part, maternal mortality reduction is still not a priority in India." In fact, Laxmi's case demonstrates the failure to implement the four cornerstone strategies to reduce maternal mortality: family planning, skilled birth attendance, effective referral networks and EmOC.

2. The most striking aspect of this particular case is the lack of any sort of documentation ante mortem regarding Laxmi. As far as the surveyed people recall, Laxmi spent the last four months of her life in the streets surrounding Connaught place. In these months she had burn wounds, septicemia and she was pregnant. Her skin was yellow due to anaemia and she was visibly ill. However, there are no records of medical visits, check ups, nor any evidence that Laxmi met, spoke with or was seen by local ASHA or ANM. Moreover, she had not been identified as beneficiary under the AAY, the ICDS, the JSY and the NMBS. She had no BPL card nor she applied for one.

3. The law provides for one ASHA and one Anganwadi Centre every 1000 inhabitants. While the AWC is in charge of assisting patients who go there, ANMs and ASHAs have a much more active role. They have to ensure that all pregnant women are registered and brought to the hospital. They are not exempted to fulfill their obligations because a

woman has no fixed residence. This true fact should rather lead to the opposite approach: homeless women live in an unhealthy environment, are less safe and poorer. For example, the risk of malaria and infections such as septicemia is remarkably higher. Therefore they should be given special care and attention.

4. Although according to the neighbors she refused medical assistance, the local authority or health service has not undertaken any effort to approach Laxmi. Her refusal to call for medical attention could be due to the clearly depressed condition in which she was conducting her life, as well as the fear to have to pay for hospitalization, or more simply the fact that her precarious health did not allow her to reach the hospital.

5. The building, which is a Maternity and Child Welfare Centre as well as Counseling Service Point, is located only 10 minutes away from the spot where Laxmi was living. The statement made by Dr. Ms. S. Bagga-that she had no idea about the incident and is not her job to look after people in the street- is remarkably significant.

6. The fact that in this case the hospital did not know about Laxmi's situation cannot be presented as an argument in favour of the respondent. In fact, it makes the scenario even grimmer. The first step in the implementation of existing schemes is to identify beneficiaries, i.e. the poor, especially women.

7. The NRHM Framework for Implementation 2005-12 spells out the main actions to carry out by 2009, among which features that "district health plan reflects convergence with wider determinants of health, like water, sanitation, women's empowerment etc." Health programs should be

designed to suit local needs. Consequently, Government Order D.O. No.Q. 11011/1/2007-NHRM-II provides for "the setting up of community monitoring committees at various levels" as part of the implementation. Therefore, it is Government duty to design and enact specific plans responding to Delhi's reality, viz thousands of homeless people in need of health care.

8. Laxmi's death was predictable and preventable, as most maternal deaths are. She died slowly and painfully. She had been sick for a long time before giving birth, and four days passed between her delivery and her death. It could be pointed out that nobody took her to the hospital before she died. However, it is not legal obligation of other citizens to do so. Conversely, it is duty of the State to ensure citizen's enjoyment of rights to health, food and reproductive rights. States have obligations to **ensure** equal access to health care system, shelter, food and health and sexual education. In short, it is duty of the State to protect the right to life of its citizens.

9. More specifically, Laxmi was also entitled to:

    - Being registered under ICDS and JSY
    - Being identified by the local ASHA and assisted to obtain appropriate certification
    - Receiving at least three ANC checkups including TT injections, IFA tablets
    - Being informed on a functional Government health centre or an accredited private health institution for referral and delivery
    - Receiving counsel for institutional delivery
    - Being escorted by the ASHA to the pre-determined health center and not left alone until the delivery

- A minimum of 2 postpartum visits. First within 48 hours of delivery, second within 7-10 days Associated services like general examination such as weight, BP, anemia, abdominal examination, height and breast examination,
- Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs)
- Folic acid supplementation in the first trimester
- Iron and Folic Acid supplementation from twelve weeks,
- Skilled attendance of delivery
- Counseling on diet and rest, hygiene, contraception, essential newborn care, infant and young child feeding.
- Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions
- Food as provided for in AAY and ICTS

Non-discrimination

10. In addition to that, Laxmi's death is also due to negligence by the police. The lack of action on behalf the police amounts to failure to fulfill all State obligations under international law. General Comment n.14 states that:

> "34.In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and

abstaining from imposing discriminatory practices relating to women's health status and needs.

37. The obligation to *fulfill (facilitate)* requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfill (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfill (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population."

11. Failure to help Laxmi amounts to discrimination against women. Leaving a dying woman to herself and refusing to help her because of the social stigma that a man cannot touch a woman is an action of discrimination against women. It is of utmost gravity that it is carried out by a public servant. A pregnant, destitute woman is in an extremely disadvantage position. For this reason she is entitled to particular attention from the State. In this sense, General Comment N.14 significantly spells out:

"21. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights."

12. Maternal mortality is the result of a breach of the rights to life and gender equality enshrined in Art.21 and 14 of the Indian Constitution. In Apparel Export Promotion Council v. Chopra (1999) the Supreme Court

recognized these rights as "the two most precious fundamental rights guaranteed by the Constitution of India."

CONCLUSION

Serious violations of Laxmi's reproductive rights, as well as right to food, health, shelter and life resulted in her death. Moreover, as a direct consequence of her lack of access to health care and of the violations of her reproductive rights, the life of her child is under severe threat. For this reason, her daughter Karishma should be granted adequate compensation. As stipulated by the Supreme Court in the *Nilabati Behara v. State of Orissa* 1993 (2) SCC 746:

> "Award of compensation in a proceeding under Art. 32 by this Court or be the High Court under Art 226 of the Constitution is a remedy available in public law, based on strict liability for contravention of fundamental rights to which the principle of sovereign immunity does not apply (…) Enforcement of the constitutional right and grant of redress embraces award of compensation as part of the legal consequences for its contravention. A claim in public law for compensation for contravention of human rights and fundamental freedoms, the protection of which is granted in the Constitution, is an acknowledged remedy for enforcement and protection of such rights .
>
> It is this principle which justifies award of monetary compensation for the contravention of fundamental rights guaranteed by the Constitution, when that is the only practicable mode of redress available for the contravention made by the State or its servants."

In *Laxmi Mandal v. Deen Dayal Harinagar Hospital* the Court recognized that State's negligence resulted in Shanti Devi's death and ordered the Government to pay Rs 2.4 lakhs. Likewise, Laxmi's death was clearly avoidable. However, in this case Laxmi was the only parent to look after the child. While Shanti Devi's daughter can count on the support of her father and her family, Karishma is orphan. For this reason she should be entitled to a compensation of Rs 30 lakhs. This sum of money should be made available only once she reaches the age of 18.

Karishma should also be given a sum of Rs10,000 since under the NFBS Laxmi is recognized as 'primary bread winner.'

Karishma is also entitled to the benefits provided under the Balika Samridhi Yojana Scheme, launched by the Government of India, specifically a post delivery grant of Rs.500 and Annual Scholarship for attending school.

Karishma should receive the benefits denied to her mother, namely Rs.600 and Rs.500 provided for under JSY and NMBS, as well as the AAY card and the benefits under ICDS.

A through investigation on the person known as Babbar should be carried out as soon as possible.

An inquiry on the conduct of the local ASHA and ANM should also be carried out. If no ASHA or ANM has been appointed, the Medical Officer will respond for this failure of implementation.

A transparent and effective accountability mechanism for ASHAs, ANMs and MOs should be established. In *Laxmi Mandal* this Court ruled "every

ASHA/ANM will report to the MO if any beneficiary is declining the assistance provided or refusing to take medicines or is reluctant to go in for institutional delivery. The MO will then either undertake a personal visit to the woman or issue necessary instructions." None of these steps was here undertaken. Therefore ASHA, ANM and MO responsible should be identified and held accountable.

Furthermore, the conduct of policeman in charge of guarding Shankar Market between the 24th July and the 1st August should be investigated through an external inquiry and punished according to the law. It is of utmost importance that police are held accountable for acts of negligence and omission. Police forces' task is to enforce the law. Therefore they should be trained and operate accordingly to the principles of the CoI.

More general actions should be sought by the Government in order to improve the implementation of NRHM while at the same time protecting the rights of homeless people, such as, *inter alia*:

- Each hospital should be responsible for covering an urban area. People living in that area must be given minimum information on which hospital they can refer to, such as contact information of referral facility including staff member, name, address and phone number. BPL patients must be guaranteed free transport and treatment.

- Each hospital is provided with Mobile Health Units, which have already been introduced under the NRHM. According to the report on the status of the

implementation of NRHM in the State of Delhi "all 9 districts have functional Mobile Medical Unit (MMU)." However, MMUs are only available on call in emergency situations. They should instead monitor streets and public spaces, especially poor areas, on fixed beats in order to make public health system truly accessible and suitable to the needs of the most disadvantaged.

- Funds allocation is by far too little. Not only India has one of the lowest budgets for public health, but also funds allocated for public health system are often not or mis-used by Governments. For instance, the State of Delhi Report on the Implementation of NRHM 2005-2010 highlights that the expenditure on ASHAs was only 17% of the total funds allocated for this purpose. 2266 ASHA have been selected but none of them has been trained.

- ASHAs must be trained as soon as possible.

- Throughout identification of the beneficiaries of BPL, JSY as well as AAY, as already ordered by the Supreme Court in WRIT PETITION (C) NO.196 OF 2001, 20th January 2010.

- Lastly, the Court could direct the Government to formulate an effective plan to address the situation of homeless people in Delhi as soon as possible. Such plan should take on board the recommendations advanced by

NGOs, such as the Shahri Adhikar Manch, and not merely derogate State's duties to the civil society.

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