IN THE HON'BLE HIGH COURT OF CHHATTISGARH

AT BILASPUR

WRIT PETITION (PIL) No. OF 2014

PETITIONER: National Alliance for Maternal Health and Human Rights (NAMHHR), Through its Convener, Jashodhara Dasgupta Aged about 52 years P.S. Saket At G-66, Saket, New Delhi-110017

Versus

RESPONDENTS:

1. State of Chhattisgarh, through Secretary, Department of Health Mantralaya, Raipur (CG).
2. Mission Director, National Health Mission, (NHM/NRHM), State of Chhattisgarh, Mantralaya, Raipur (CG).

WRIT PETITION (PUBLIC INTEREST LITIGATION) UNDER ARTICLE 226 OF THE CONSTITUTION OF INDIA

1. PARTICULARS OF THE PETITIONER:
   As stated in the cause title above.

2. PARTICULARS OF THE RESPONDENTS:
   As stated in the cause title above.

3.

(A) PARTICULARS OF THE ORDER AGAINST WHICH THE PETITION IS BEING PRFERRED:

Not Applicable

(B) SUBJECT MATTER IN BRIEF:

The present Petition is being filed in public interest, under Article 226 of the Constitution of India, seeking the recognition and implementation of the provisions of the Medical Termination of Pregnancy Act, 1971 which aims to provide access to safe and legal abortion services in the public and the private sector. It is pertinent to state here that Unsafe Abortion is a leading cause of Maternal Deaths and accounts for an estimated 18% of Maternal Deaths in India. Lack of access due to non-implementation of the MTP Act is a leading cause for unsafe abortions.

(C) (I) The present Petition is being filed in public interest, under Article 226 of the Constitution of India, seeking the recognition and implementation of the provisions of the Medical Termination of Pregnancy Act, 1971 which aims to provide access to safe and legal abortion services in the public and the private sector. It is pertinent to state here that Unsafe Abortion is a leading cause of Maternal Deaths and accounts for an estimated 18% of Maternal Deaths in India. Lack of access due to non-implementation of the MTP Act is a leading cause for unsafe abortions.

(II) The Petitioner is a national alliance of individuals and organisations called National Alliance for Maternal Health and Human Rights (hereinafter referred to as 'NAMHHR') which was started on 20.01.2010 with the realization that strong rights-based strategies are needed to build greater accountability for the thousands of preventable deaths among women in

India. The Alliance currently has 36 members from 13 states of India, including the Respondent State of Chhattisgarh, as well as expert advisors working on research and Right to Food, public health, right to medicines and budget accountability. The group recognizes that there is an urgent need for women's organizations, health organizations, groups working on law and human rights, and mass-based organizations to come together on this issue. The NAMMHR works through research, capacity building, budget tracking and engages in policy, legal and media advocacy. The alliance is represented through its Convener Ms. Jashodhara Dasgupta.

(III) That the petitioner is filing the present petition on its own and not at the instance of someone else. The litigation cost, including the advocate's fee is being borne by the petitioner itself.

(IV) That the source of information of facts pleaded in this petition are based on three main sources as the basis for the clear and complete violation in the obligation to provide access to safe and legal abortion services by the Respondents. The first source is the compilation of responses to specific Right to Information (RTI) Applications filed by a member of the Petitioner Alliance. The second sources of information are the various public records, documents and reports which clearly point out the fact that these services are not available in the public sector. The third source of information is the information gathered by members of the Petitioner alliance over 3 different visits to some of the districts in the Respondent State in the years 2013 and 2014.

(V) That to the best of knowledge of the petitioner, no public interest petition raising the same issue has

been filed before the Hon'ble Court or any other Court.

4. WHETHER CAVEAT FILED IN THIS PETITION, IF YES, WHETHER COPY OF THE PETITION IS SUPPLIED TO THE PETITIONER

The petitioner submits that no caveat has been filed in this matter to the best of their knowledge and no notice of caveat filed has been served on them.

5. DETAILS OF REMEDIES EXHAUSTED

The petitioner has no other alternative remedy except to file this writ petition as inspite of the oral and written applications made to the Respondents there has been no progress in the implementation of the MTP Act.

6. MATTER NOT PREVIOUSLY FILED OR PENDING WITH ANY OTHER COURT ETC.

The petitioners respectfully submit that they have not filed any application or petition in any other Court of law.

7. DELAY IN FILING THE PETITION

There is no delay in filing the present petition.

8. FACTS OF THE CASE:

8.1. The present Petition is being filed in public interest, under Article 226 of the Constitution of India, seeking the recognition and implementation of the provisions of the Medical Termination of Pregnancy Act, 1971 which provide to access safe and legal abortion services in the public and the private sector. It is pertinent to state here that Unsafe Abortion is a leading cause of Maternal Deaths and accounts for an estimated 18% of Maternal Deaths in India. Lack of

access due to non-implementation of the MTP Act is a leading cause for unsafe abortions.

8.2. The Petitioner is a national alliance of individuals and organisations called National Alliance for Maternal Health and Human Rights (hereinafter referred to as 'NAMHHR') which was started on 20.01.2010 with the realization that strong rights-based strategies are needed to build greater accountability for the thousands of preventable deaths among women in India. The Alliance currently has 36 members from 13 states of India, including the Respondent State of Chhattisgarh, as well as expert advisors working with research, Right to Food, public health, right to medicines and budget accountability. The group recognizes that there is an urgent need for women's organizations, health organizations, groups working on law and human rights, and mass-based organizations to come together on this issue. The NAMMHR works through research, capacity building, budget tracking and engages in policy, legal and media advocacy. The alliance is represented through its Convener Ms. Jashodhara Dasgupta.

8.3. Respondent no 1 is the Department of Health and Family Welfare, Government of Chhattisgarh which is the nodal department responsible for the implementation of health and family welfare related laws, policies and schemes. Respondent No 2 is the Mission Director, National Rural Health Mission (NRHM) for the state of Chhattisgarh responsible for the

implementation of the National Rural Health Mission and for ensuring access to health services within the State of Chhattisgarh.

8.4. That the present petition has been filed in public interest by the Petitioner seeking specific directions to the Respondents to implement provisions of the Medical Termination of Pregnancy Act, 1971 and the Medical Termination of Pregnancy Rules 2003. The Respondents by violating the provisions of the above said law have failed to provide access to safe and legal abortion services, as mandated by law, to women seeking abortion services, in both the public sector and the private sector. It is pertinent to state here that Unsafe Abortion is a leading cause of Maternal Deaths and accounts for an estimated 18% of Maternal Deaths in India. Lack of access due to non-implementation of the MTP Act is a leading cause for unsafe abortions.

8.5. To set the background, the National Rural Health Mission (hereinafter referred to as 'NRHM') is the Government's flagship programme and was launched in 2005 with the goal of "improving the availability of, and access to, quality health care, especially for those residing in rural areas, the poor, women and children through equitable, affordable, accountable and effective primary healthcare." Initially the period for the NRHM was from 2005 to 2012 with the first indicators of implementation from 2007, now the NRHM has been extended and has brought within its parameters the

urban health concerns and is known as the National Health Mission. The Respondent State had been identified as one of the focus States and part of the Empowered Action Group (EAG) due to the poor level of implementation of health services in the State.

8.6. The NHM/NRHM committed to increase public health expenditures, community participation, and among other things, reduce regional imbalances and the MMR to 100 for 100,000 live births. To explain briefly, the programme created a tiered health care delivery system to guarantee, inter alia, maternal health services to all communities and imposed legal obligations on each entity to provide services specifically related to reproductive and child health such as those outlined below:

(1) Sub Health Centre (SHC)

(2) Primary Health Centre (PHC)

(3) Community Health Centers (CHC)

(4) District Hospital

Under the NHM, the specific delivery points which were not being implemented have been emphasized. The targets for different categories of facilities are:

A) All District Hospitals and other similar district level facilities to provide the following services:

   a. 24*7 service delivery for Caesarian Section and other Emergency Obstetric Care.

   b. 1st and 2nd trimester abortion services.

   c. Facility based Maternal Death Review.

d. Essential new-born care and facility based care for sick newborns. Special Newborn care Units (SNCU) for care of the sick newborn should be established in all District Hospitals. All resources meant for establishment of SNCUs should be aligned in terms of equipment, manpower, drugs etc. to make SNCUs fully operational.
e. Family planning and adolescent friendly health services
f. RTI/STI services.
g. Functional BSU/BB.

B) CHCs and other health facilities at sub district level (above block and below district level) functioning as FRUs to provide the same comprehensive services as the district hospitals.

C) 24*7 PHCs and Non FRUs to provide the following services:
a. 24*7 BEmOC services including conducting normal delivery and handling common obstetric complications.
b. 1st trimester safe abortion services. (MVA upto 8 weeks and MMA upto 7 weeks)
c. RTI/STI services.
d. Essential new-born care and facility based care for sick newborns. NBSUs being set up at FRUs should be utilised for stabilization of sick newborns referred from peripheral units. Dedicated staff posted at NBSU must be adequately trained and should have the skills to provide care to sick newborns.

e. Family planning

f. Adolescent health services

D) All identified SCs/ facilities will:

a. Conduct Delivery by SBAs.

b. Provide IUD Services

c. Provide Essential New born care services.

d. Provide ANC, PNC and Immunization services.

e. Provide Nutritional and Family planning counselling.

f. Conduct designated VHND and other outreach services.

8.9 To be able to implement the Mission objectives and purpose in entirety Accredited Social Health Activists (ASHAs) were assigned to every village to promote the use of health services of pregnant women. The ASHA serves as a link between the Government and the pregnant woman. It is pertinent to state here that in the State of Chattisgarh under the Mitanin Programme, health workers similar to ASHAs existed since 2002. The Mitanin programme has been found to have better reach and the Mitanins have now been given the responsibilities of the ASHAs in addition to their original terms of reference.

8.10 It is pertinent to state here that the expenditure for the implementation of NRHM/NHM has already been budgeted and the central government has been regularly releasing funds for the same. There are some aspects on which the State is expected to pool in funds, but the major chunk of the expenses are budgeted and provided by the Central Government. This also includes building the capacity of staff, creating physical infrastructure,

accountability mechanisms, financial capacity, provision of drugs amongst other heads. Having said that it is clarified that the role of the Central Government continues as the responsibility of monitoring implementation lies with the Centre.

8.11 That under the broad umbrella of providing health services to the rural and urban India, the NRHM/NHM had promised to provide access to quality maternal health services which includes access to safe and legal abortion services in the public sector.

8.12 In India, presently abortions are regulated under The Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as 'The Act') and The Medical Termination of Pregnancy Rules, 2003 (hereinafter referred to as 'The Rules') and The Medical Termination of Pregnancy Regulations 2003 (hereinafter referred to as 'The Regulations').

8.13 That the Act provides for when a medical termination of pregnancy can take place, where it can place, why it can take place and who can conduct a medical termination of pregnancy. Any other termination of pregnancy that occurs is an offence under The Indian Penal Code, Secs 312 to 318.

8.14 That the government facilities, by virtue of being government facilities, are covered under the Act and are not required to be registered under the Act as a separate exercise. Any private facility that seeks to provide MTP facilities is mandated to be registered under the Act as per Section 4 (b) of the Act. The said provision reads as follows:

> "4. Place where pregnancy may be terminated- No termination of pregnancy shall be made in accordance with this Act at any place other than-
>
> (a) A hospital established or maintained by Government, or
> (b) A place for the time being approved for the purpose of this Act by Government or a District Level Committee constituted by the Government with the Chief Medical Officer or District Health Officer as the Chairperson of the said Committee
>
> Provided that the District Level Committee shall consist of not less than three and not more than five members including the Chairperson, as the Government may specify from time to time."

8.15 That further, the Rules provide for the composition of the above said District Level Committee, the requirements needed to be met for a place to be registered and the process of registration amongst other provisions. Therefore, without a functional District Level Committee, it would be impossible for a private facility to be registered and provide the service of termination of pregnancy as per law. It is pertinent to state here that due to the inaccessibility of registered Medical Termination of Pregnancy Centres, the Act was amended in the year 2002 to include the establishment of District Level Committees to make the certification procedure for private health facilities accessible and in turn make registered MTP centers accessible for women locally.

8.16 That the present petition relies on three main sources as the basis for the clear and complete violation in the obligation to provide access to safe and legal abortion services by the Respondents. The first source is the compilation of responses to specific Right to Information (RTI) Applications filed by a member of the Petitioner Alliance. The second source of information are the various public records, documents and reports which clearly point out the fact

that these services are not available in the public sector. The third source of information is the information gathered by members of the Petitioner alliance over 3 different visits to some of the districts in the Respondent State in the years 2013 and 2014.

8.17 That right to information applications were filed with the Respondent No 1 specifically asking about the status of the formation of the district level committees in each district under the Act, the date when the committee was set up in each district, number of meetings held by the committee and district wise breakup of the number of registered MTP centres including public facilities. A copy of the application dated 03.07.2012 is hereto marked and annexed as **ANNEXURE P-1.**

8.18 That as a first response, Respondent No 1 had transferred the application under Section 6 of the Right to Information Act to the Chief Medical and Health Officers of each district in the respondent State. A copy of the transfer letter dated 13.07.2012 is hereto marked and annexed as **ANNEXURE P-2.**

8.19 That responses were received from the 10 districts. That except for Bilaspur, all other districts informed the applicant that no such district level committee had been set up in the concerned district and the therefore the remaining questions did not require a response. A copy of the table wise break up of responses is hereto marked and annexed as **ANNEXURE P-3** and copies of the responses received from various districts are hereto marked and annexed as **ANNEXURE P-4 (COLLY)**.

8.20 That as a follow up to the information received, a second set of Right to Information applications were filed asking the 25 District Level Chief medical officers about the number of applications for registration under the Act were received by them and the action taken on each. Copy of a sample application dated 15.04.2013 is hereto marked and annexed as **ANNEXURE P-5** and copies of the responses received are hereto marked and annexed as **ANNEXURE P-6 (COLLY).** The responses clearly show that none of the districts have any record of any applications received as the infrastructure and awareness for the same does not exist. This inspite of the fact that the Petitioner is aware that some private hospitals have applied for registration under the law and have received no response from the Respondents.

8.21 The information so gathered through the RTI responses clearly establishes that the private health facilities are providing service outside the purview of the MTP Act as the State has not taken steps to implement the provisions of the Act and set up district level committees which will not only register new centres but also monitor the existing centres to ensure that the quality of services provided is not below the acceptable standard.

8.22 In the light of this, it becomes imperative to examine the availability and quality of services being provided in the public health facilities, especially with regard to the accessibility of safe and legal abortion services.

8.23 It is pertinent to state here that in the Minutes of Review meetings with States' Health Secretaries, States' Mission Directors (NRHM)

and Directors of Health Services held on 11th and 12th of September 2012 in New Delhi it was recorded that, "*it was highlighted that regulation of private clinics under Medical Termination of Pregnancy (MTP) was still weak and Chief Medical Officers were not regulating private clinics effectively. The need to regulate the clinics but at the same time maintain their accessibility to women as very limited numbers of public facilities provide safe abortion services."* Thereby clearly conceding that access to safe abortion services for women in the country, inspite of the law being passed in 1971 and amendments carried out in 2003, were not being provided. A copy of the Minutes of Review meetings with States' Health Secretaries, States' Mission Directors (NRHM) and Directors of Health Services dated 12.09.2012 is hereto marked and annexed as **ANNEXURE P-7.**

8.24 That during the Review Meeting of State Mission Directors, (one of the many accountability processes set in to review the implementation of the NRHM), held on October 31st 2012, it was reported that a number of states including the Respondent State have not set up adequate District Level Committees and therefore the access to safe and legal abortion services is severely lacking.

A copy of the relevant pages of the Minutes of the Review meeting dated 31.10.2012 is hereto marked and annexed as **ANNEXURE P-8**

8.25 That the Common Review Mission has a mandate of review and concurrent evaluation of the NRHM and its implementation in the States. In the 5th Common Review Mission a 12 member team had

visited the Respondent State during 9-15th November 2011 and had reviewed the health facilities in Kanker and Kawardha District. The report highlights the fact that none of the private facilities have been accredited under the Janani Suraksha Yojana (JSY). Further it pointed out that the personnel trained under the MTP Act for conducting MTPs as per law were not present in both the abovesaid districts. Relevant pages of the report are annexed and marked as **ANNEXURE P-9**

8.26 That the Chhattisgarh State Report 2009 confirms the fact that MTP services are rarely provided in public health facilities in the Respondent State and where they are provided, modern approved methods that are known to be safer and less invasive are not utilized.

8.27 It is further pointed out that in a meeting held by the National Programme Coordination Committee on 6th April 2011 which is the focal committee overseeing the project implementation plans (PIPs) of every state for the implementation of NRHM/NHM the fact the 0% budget was allocated for the provision of MTP services at health facilities by the Respondent State for the year 2011-2012. That this clearly indicates that the Respondent State does not hold the need to provide MTP services to women as a priority and has effectively denied women access to a critical health service recognized by law. Copies of the relevant pages of the Minutes of the National Programme Coordination Committee dated 06.04.2011 are hereto marked and annexed as **ANNEXURE P-10.**

8.28 It has been documented that women who are unable to avail public or private health facilities which provide safe abortion services attempt to terminate the unwanted pregnancy by either visiting a quack or by using methods which are extremely harmful to them. Some of these methods include inserting of a stick in their uterus. There are cases of incomplete abortions which some of the health providers in the Respondent State have shared.

8.29 It is pertinent to state here that some of the private health providers in the Respondent State have applied for registration under the MTP Act and have followed up by sending reminders but the same have not been responded to at all.

8.30 That as per estimates by the Shaheed Hospital in Dalli, District Balod about 30 to 40 women come to the hospital every month in a state of emergency due to an incomplete abortion. This hospital caters to a large number of tribal areas in District Balod and surrounding districts. It is necessary to state here that the levels of anemia in the tribal women of the Respondent State are extremely high. In such a situation when there is loss of blood due to an unsafe procedure and an incomplete abortion, the women go in a state of shock which can prove fatal.

8.31 As stated above the reasons for the incomplete abortions are due to unsafe methods used by the women themselves or the procedure administered by a quack. That as an example, it is necessary to state the kind of danger to life and limb that women face due to lack of access to safe and legal abortion services. The above mentioned private health facility had saved the life of a

woman who had undergone an unsafe and illegal abortion which was also incomplete. The abortion was induced by inserting an instrument in the woman's uterus. As a result of this unsafe procedure the intestine of the woman had been pulled out, thereby severely damaging her vital organs. When the woman approached the above said hospital gangrene had set in and she was suffering from septicemia. The hospital had provided her emergency treatment and had also assisted in filing a criminal complaint against the offender.

8.32 It is further pertinent to state here that a number of women do not approach any facility for abortion services due to abortion stigma. This stigma is higher in unmarried women who may become pregnant and would seek confidential, reliable and quality MTP services. This can be illustrated by the fact that the District Hospital in District Balod, which was visited by the members of the Petitioner alliance, maintains a MTP register which records some details of the women who had availed MTP services in the hospital. It is necessary to state here that the district Hospital does not have the provision for a Blood Bank or a Blood Storage Unit and therefore cannot in any circumstance deal with complicated cases of either delivery or MTP. That this register showed a record of 31 MTPs having been conducted from 01.01.2013 till 05.02.2014 and all of the above women were married. When asked about unmarried pregnant women and how do they access services, the members were informed by the staff that providing MTP services for unmarried women was illegal and against the law. However,

there is no such provision in the MTP Act prohibiting unmarried women from access abortion services.

8.33 Since the MTP services are provided by quacks clandestinely the costs that women have to bear are much higher. In many cases these costs were well over 1500 Rupees. Costs will be further reduced if women seek medical attention from their local clinic when they suspect they are pregnant and in turn can avail of the low-cost early abortion procedures. If women have to travel a long distance to confirm their pregnancy they are more likely to wait until they are sure and thus will have to avail of the costlier later abortion procedures. Further, in a number of cases, women carry the pregnancy to term due to lack of any other choice. The respondent by refusing to provide access to safe and legal abortion services, as per law, to the women in the State is forcing them to carry unwanted pregnancies to term, which in itself is a violation of her right to life, right to health and right to choice.

8.34 That if women in the Respondent State are provided access to safe and legal MTP services they will also gain access to counselling services and contraception choices to avoid further unwanted pregnancies and plan pregnancies. One of the recommended aspects of safe abortion services is counseling both pre and post abortion counselling. Counseling is extremely important as it provides the woman with relevant information and assists her in decision making and informs her how to act accordingly.

That relevant portions of the 'Safe Abortion: Technical and Policy Guidance for Health Systems' World Health Organization, Geneva 2012 are hereto marked and annexed as **ANNEXURE P-11**.

8.35 That further it is necessary that a woman has access to a health facility which can deal with post-operative care and addresses any post operative complications. That inaccessible MTP centers have resulted in denial of post operative care and check up to the woman who undergoes a medical termination of pregnancy. Furthermore the Health Assistant or Health worker should visit the client within one week of termination to ensure the clients well being. Thus, there is a possibility that women who fail to attend their follow up visit may still be pregnant. That the Comprehensive Abortion Care Guidelines as mandated by the Ministry of Health and Family Welfare provide for detailed follow up services to be given. The Petitioner seeks to rely on the same and produce a copy.

9. GROUNDS URGED:

The petitioner herein respectfully presents the present writ petition under Article 226 of the Constitution of India inter alia, on the following grounds:

9.1 For the reason that Article 21 of the Constitution of India guarantees, inter alia, the right to life, which the Supreme Court has repeatedly held includes a right to health. As the Supreme Court emphasized in Chameli Singh v. State of UP (1996) 2 SCC 549, "the right to life in any civilized society implies the right to . . . medical care" and the rights enshrined in International Conventions and Indian Constitution cannot be exercised without these "basic human rights."

9.2 For the reason that the right to health as guaranteed under Art. 21 necessarily incorporates the right to reproductive health, and as the Supreme Court explained in Paschim Banga Khet Mazdoor, 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." (1996) 4 SCC 37.

9.3 For the reason that the Delhi High Court in the groundbreaking judgment of Laxmi Mandal v. Deen Dayal Nagar, has helped to further define the right health, recognizing that an 'inalienable" component of the right to life is: "the right to health, which would include the right to access government (public) health facilities and receive a minimum standard of care. In particular this would include the enforcement of the reproductive rights of the mother and the right to nutrition and medical care of the newly born child and continuously thereafter." 2010 W.P. 8853/2003

9.4 For the reason that maternal health services are primarily needed by women the government's failure in providing and removing barriers in access to such care violates Article 14 and 15's promise of nondiscrimination and equal protection under the law. In the landmark case concerning sexual harassment, the Supreme Court in Vishaka and Ors. v. State of Rajasthan, found that "the meaning and content of the fundamental rights guaranteed in the Constitution of India are of sufficient amplitude to encompass all the facets of gender equality." (1997) 6 SCC 241. Subsequently, in Apparel Export Promotion Council v. Chopra, the Court expounded on this notion, proclaiming gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution", and citing CEDAW, the Beijing Declaration, and the ICESCR in support of the State's duty in preventing all forms of discrimination against women. (1999) 1 SCR 117.

9.5 For the reason that despite constitutional proscriptions and CEDAW provisions prohibiting discrimination in accessing reproductive health care, the government has failed to provide access to safe and legal abortion services in Chattisgarh. By virtue of their

reproductive capacity, it is only women that are need of abortion services. And the Government's outright denial of such services, or failure to remove barriers to accessing such care, contravenes its constitutional obligation to provide equality before the law.

9.6 For the reason that the Division Bench of the High Court of Madhya Pradesh in Sandesh Bansal v Union of India and Ors in Writ Petition No. 9061 of 2008 has held that the lack of access to maternal health care is a clear violation of the right to life of the women in the State and has then gone on to lay down specific directions that the State is bound to implement, including access to safe and legal abortion services.

9.7 For the reason that a Single Judge of the High Court Of Madhya Pradesh in Hallobi @ Hallima v State of Madhya Pradesh and Ors Writ Petition No. 408 of 2013 has while recognizing the right of a woman to access abortion services has been emphasized and has further recognized the anguish that a woman undergoes due to an unwanted/ forced pregnancy.

9.8 For the reason that it is the "solemn duty of the Court[s] to protect and uphold the basic human rights of the weaker sections of the society" this petition is being filed under Article 226 of the Constitution of India. The Government has failed to adhere to its legal obligations to protect women's reproductive rights as enshrined in Article 14,15, and 21, related human rights treaties, and domestic schemes. As such, judicial intervention is necessary to redress the continuous violation of rights experienced by women across the Respondent State. Respondents must be held accountable for its failure to remove barriers to care including cost, transport, ill-equipped facilities, denials of services, and inhumane facility conditions.

9.9 For the reason that thus, it is clearly established that the Article 21's right to health necessarily incorporates the right to reproductive health. Turning to Supreme Court and High Court decisions concerning the fundamental right to health, the Indian

Courts have held that all persons are entitled to adequate health care, Mahendra Pratap Singh vs. State of Orissa and emergency medical treatment is "essential" to Article 21's protection of the right to life. In Paschim Banga Khet Mazdoor Samiti case, the Hon'ble Supreme Court discussed the welfare obligations of the government in providing health care and unequivocally defined:

"adequate medical facilities for the people [a]s an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities . . . Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. . . . Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21." (1996) 4 SCC 37.

9.10 For the reason that the Delhi High Court in the groundbreaking judgment in *Laxmi Mandal v. Deen Dayal Harinagar Hospital* & Ors 2010 W.P. 8853/2003, recognized that an 'inalienable" component of the right to life is "the right to health, which would include the right to access government (public) health facilities and receive a minimum standard of care. In particular this would include the enforcement of the reproductive rights of the mother and the right to nutrition and medical care of the newly born child and continuously thereafter."

9.11 For the reason that the Court further explained that, "when it comes to the question of public health, no woman, more so a pregnant woman should be denied facility or treatment at any stage irrespective of her social and economic background. This is the primary function in the public health services. This is where the inalienable right to health which is so inherent in the right to life gets enforced. There cannot be a situation where a pregnant woman who is need of care and assistance is turned away from a Government health facility only on the ground that she has not been able to demonstrate her BPL status or her 'eligibility.'

9.12 For the reason that in so doing, the Court accorded constitutional protection to reproductive health care, recognizing the systemic failures in government's delivery of such services, and ordering compensation for violations of the petitioners' fundamental rights.

9.13 For the reason that relatedly, in passing the NRHM, the Indian Parliament reinforced the Court's finding establishing a minimum threshold of adequacy of services that must be provided including reproductive health services and "appropriate and prompt referral of cases needing specialist care."

9.14 For the reason that notwithstanding clear legal obligations imposed by the Indian Constitution, international human rights law, the Courts, and the NRHM, the Government has failed miserably at providing constitutionally and statutorily required reproductive health care. The facility conditions, health services, and quality of care being provided at the health centers are anything but

adequate, with Petitioner confronted with an onslaught of reproductive health violations during visits of the health centers.

9.15 For the reason that contrary to express service guarantees contained in NRHM, ubiquitous violations of women's reproductive rights are causing preventable maternal mortality and morbidity. The Government's practice of failing to provide critical, reproductive health care either intentionally or negligently contravenes constitutional and international human rights obligations to safeguard women's right to be free from torture, cruel, inhuman or degrading treatment (CIDT).

9.16 For the reason that the UN Manual on Reporting explains that Article 7 of ICCPR not only protects "detainees from ill treatment" or "persons acting outside or without any official authority", "but also in general any person. This point is of particular relevance in situations concerning ... patients in ... medical institutions, whether public or private."

9.17 For the reason that further support is found in K.L. v. Peru, a decision by the UN Human Rights Committee (HRC) that the state's denial of a therapeutic abortion, particularly in cases where pregnancy threatens her physical and mental health, constituted CIDT in contravention of Article 7 of the ICCPR. Specifically, the HRC held that K.L.'s emotional distress and depression were "foreseeable" and the State's failure in "not enabling . . . [K.L.] to benefit from therapeutic abortion was . . . the cause of the suffering she experienced.". Similarly, the Government's failure in "not enabling" pregnant women to benefit from medically

necessary reproductive health services, whether through outright denial, obstacles to accessing care, or delivery of care in deplorable facility conditions, necessarily inflicts suffering and humiliation, threatening their physical and mental health. This type of government action or inaction is "offensive to human dignity" and "constitute[s] an inroad into th[e] right to life" and is thus, prohibited by Article 21 and international human rights law.

9.18 For the reason that lastly, many of the women attempting to procure reproductive health services from the state are women living below the poverty line. The UN Committee on ESCR defines poverty as "condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights." In a figurative sense, poverty is a form of imprisonment, depriving the poor access to a myriad of resources and choices. Like pregnant women held in state custody, BPL pregnant women are also at the mercy of the welfare state, left with no option but to rely on the government for reproductive health care.

9.19 For the reason that Studies have shown that Indian mothers from the richest 20% of the population are over ten times more likely to be attended by a physician during delivery as compared to a mother from the poorest 20%, and over two times more likely to receive antenatal care. As the Supreme Court explained in Murlidhar Dayandeo Kesekar v. Vishwanath Pandu Barde, "[m]any a day have come and gone after 26-1-1950 but no leaf is turned in

the lives of the poor and the gap between the rich and the poor is gradually widening on the brink of being unbridgeable."1995 Supp (2) SCC 549.

9.20 For the reason that the Reproductive health services are services primarily needed by women and the denial of these services is a violation of Articles 14 and 15 of the Constitution of India. The Government's failure to provide, and further, remove barriers in access to reproductive health services violates women's right to nondiscrimination and special protection under Article 14 and 15 and international instruments.

9.21 For the reason that indeed, Article 2 of the ICCPR and the ICESCR compels governments to provide basic human rights without discrimination, with Article 12 and 14 of CEDAW explicitly prohibiting discrimination in access to reproductive health care:

> "(i) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care including those related to family planning."
>
> (ii) 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.

(iii) State must ensure that women have access to family planning services, availability of information and education related to family planning.

9.22 For the reason that critically, the obligation to provide equitable health care to women is immediate and not dependent on an availability of resources. And the law, policy, program, or practice, does not have to be intentionally discriminatory. If the discriminatory effect nullifies or impairs the "recognition, enjoyment or exercise" of the right then it constitutes discrimination.

9.23 For the reason that applying these binding principles here, the Government has clearly failed to provide safe and legal abortion services to women in Chattisgarh. Only women are in need of certain reproductive health services by virtue of their reproductive capacity. Only pregnant women are in need of antenatal and postnatal care, family planning, and assistance in labor and delivery as set forth in the NRHM's service guarantees. Only a pregnant woman's life can be saved with full and equal implementation of reproductive health laws and schemes. Only cases involving women who have died from pregnancy-related causes are in need of a maternal death audits to ascertain the specific cause of death and determine lapses in service. Indeed, the lack of maternal death auditing and aggressive action to lower maternal mortality in Chattisgarh is reflective of persistent gender discrimination.

9.24 For the reason that similar to the Hon'ble Supreme Court's finding that sexual harassment contravenes constitutional promise of ensuring gender equality, depriving women reproductive health

services such as MTPs, emergency obstetrical care, a hygienic and humane labor and maternity ward, and placing insurmountable financial and logistical obstacles in their ability to access life-saving reproductive health care, contravenes the Government's fundamental obligations to provide equal protection, nondiscrimination, and equality before the law.

9.25 In recognizing the right to health, India is responsible for guaranteeing that all health care services are:

> Available – health centers must exist in sufficient quantity to meet the community's needs. This includes trained health personnel and essential drugs.
>
> Accessible – Health care must be physically and economically affordable, provided to all on a non-discriminatory basis.
>
> Acceptable – All health facilities must respect medical ethics and be culturally appropriate
>
> Good quality – This requires trained health personnel, adequate sanitation and safe drinking water. Fact sheet number 31: The right to health.'

9.26 Discrimination based on Tribal Status: Recognizing the history of subjugation against the tribal or adivasi community, numerous provisions of the Constitution of India , including Article 14 and 15, preclude discrimination on the basis of culture, national origin, and ethnicity. Chattisgarh as the State with considerable ST population, is bound to these provisions and must ensure that members of the Adivasi community are treated with equal protection under the law.

9.27 India is also bound to guarantee equal protection and eliminate all forms of discrimination against tribal communities as a signatory to the International Convention on the Elimination Of all Forms of Racial Discrimination. Discrimination against indigenous communities, i.e. members of scheduled tribe and caste, clearly fall under the scope of the Convention. Indeed, General Recommendation No. 29 recognizes "that discrimination based on 'descent' includes discrimination against members of communities based on forms of social stratification such as caste and analogous systems of inherited status which nullify or impair their equal enjoyment of human rights."

9.28 With regards to economic and social rights, Article 5 of the Convention compels the State 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 of the following rights:

> (e) Economic, social and cultural rights, in particular:
>
> > (iv) The right to public health, medical care, social security and social services"

Thus, the Government has an affirmative obligation to ensure that discrimination on the basis of tribal status and caste, whether in practice or policy, be eliminated. The Committee on the Elimination of Racial Discrimination (CERD) issued comments to the Government of India on implementation of the Convention. In particular, the Committee recognized the need for increased

accountability in delivery of health care, noting the high proportions of maternal deaths among women belonging to disadvantaged tribes and castes in India.

9.29 For the reason that the World Health Organization (WHO) Guidelines for Safe Abortion: Technical and Policy Guidance for Health Systems, specifically stated against "unnecessary restrictions on kinds of facilities that provide abortion limit access for women eligible under national law." Such unnecessary restriction on service locations prevents women from accessing services early, raises costs, and may encourage women to seek care from local but unqualified providers.

9.30 For the reason that the 'Technical Guidance on the Application of a Human Rights Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality' as developed by the Office of the High Commissioner on Human Rights of the Human Rights Council, UNO has clearly laid down that the State parties are bound to provide access to acceptable and legal abortion services to women, apart from other aspects related to maternal health and human rights. That this access is from the point of view of a right which is inalienable and cannot be violated.

10. RELIEF SOUGHT

In the light of facts and circumstances of the case, it is respectfully prayed that the Hon'ble Court may be pleased to:

(i) Pass an order directing a writ of mandamus or any other order/direction/writ of mandamus directing the respondents to forthwith implement Sec. 4 (b) of The Medical Termination of Pregnancy Act, 1971 and;

(ii) Pass a writ of mandamus or any other order/direction/writ of mandamus directing the respondents to furnish the status of the implementation of the Medical Termination of Pregnancy Act, 1971 to this Hon'ble Court and;

(iii) Pass a writ of mandamus or any other order/direction/writ of mandamus directing the respondents to take penal action against erring officials in the forthwith formation of District Level Committees and;

(iv) Pass a writ of mandamus or any other order/direction/writ of mandamus directing the respondents to allocate budgets for the establishment of equipped MTP centres in rural areas and;

(v) Pass such other or further Order/s as may be deemed just, fair and proper in the facts and circumstances of the case.

For the kindness of the Hon'ble Court petitioners shall ever as in duty bound, be grateful.

Bilaspur **(Rajni Soren)**

Dated: **Counsel for the Petitioner**

C E R T I F I C A T E

It is hereby certified that due care has been taken in the case to comply with the provisions of Chhattisgarh High Court Rules.

Bilaspur (**Rajni Soren**)

Dated: **Counsel for the Petitioner**